Evaluation of the TCE Programme in Mpumalanga and Limpopo

Evaluation Report

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Humana People to People South Africa

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1 Executive Summary

1.1 Purpose and Objectives of the Evaluation

The purpose of this study is to determine whether the Humana TCE programme has made a significant impact on communities where it has been implemented in terms of improving knowledge about HIV and AIDS, attitudes of personal empowerment and healthy behaviour within the context of the epidemic, and changing sexual and health seeking behaviours.

The evaluation also sets out to identify any additional effects, both positive and negative, and whether positive impacts are likely to be sustained over time.

1.2 Methodology

The evaluation employed integrated mixed methods, with an embedded quasi-experimental cluster design as its foremost feature, comparing the effects of the TCE programme on outcomes of interest across matched treatment and comparison communities. Community level findings are an aggregate of findings from individual and household level clusters.

As a contingency to mitigate the risk of matched communities being found to be non-equivalent on key variables with confounding potential, provision was made for propensity score matching of individual respondents to the household survey.

The primary data collection method was a household survey, supported by interviews and focus groups with stakeholders of interest, and observations made during site visits.

1.3 Findings

1.3.1 The Effect of TCE on Knowledge, Attitudes and Behaviour

- Members of treatment communities are significantly better informed concerning true vectors of transmission, as well as the availability of clinical and other HIV and AIDS related services.
- The household survey revealed no statistically significant differences in reported sexual behaviour between treatment and control groups. However raw means on condom use do favour the treatment communities.
- Although no significant difference was observed in sexual behaviour between treatment and comparison groups, there was a distinct and significant difference in health seeking behaviour. Members of treatment communities are significantly more likely to have gone for VCT; two thirds of treatment group respondents claim to know their HIV status and moreover attribute this to the Humana TCE programme.
- There was also significant differences in the sharing of testing information between partners, with treatment groups far more likely to demonstrate the sharing of statuses, primarily reporting that respondents themselves shared their status, but also that respondents partners' shared their status.
- In a regession model that attempted to identify predictors of behaviour, attitudes reflecting a shared burden of responsibility for sexual behaviour between genders, a regard for gender equality. Attitudes reflecting a traditional perception of women's roles had a negative impact on behaviour.

- In the regression model on behaviour exposure to the TCE intervention also emerged as a very strong predictor of changed behaviour, confirming the effectiveness of the intervention.

1.3.2 The Social Change Effects of TCE

- Qualitative evidence indicates that there are additional benefits derived by the community from TCE, including most apparently the augmentation of its social capital. The intervention acts as a social resource to meet numerous needs, and performs a networking function facilitating acces to existing resources and services.
- The evidence on the effect of TCE in reducing stigma and addressing gender disparities is ambivalent.

1.3.3 The Sustainability of TCE Effects

- There is insufficient evidence to make a pronouncement on the sustainability of measured effects after TCE has exited a community. However, it can be stated that despite the substantial efforts made to address sustainability through the programme, the community has no confidence in their own capacity to continue the efforts in terms of TCE activities after the programme has exited.
- A firm conclusion on sustainability can only be satisfactorily determined through an impact evaluation of Humana TCE.

1.3.4 Implementation Challenges

- Thjs evaluation found that the registering of households is not implemented using a consistent method. The challenges in the context – different systems of mapping households across different authorities, and the informal nature of housing in some areas – renders the current household registering process ineffective. The result is that the household register cannot be used to independently verify programme fidelity and performance.
- Past RDQAs conducted by FHI 360, found that while the design of the household register was problematic, it was consistently implemented in the locations monitored and that the data were verified internally at three reporting levels. FHI 360 has made several recommendations about the design and use of the register to Humana and Humana is presently piloting the Soweto Care System database in an attempt to improve their household registering process and systems.

1.4 Conclusions

Humana TCE is undoubtedly effective in increasing knowledge about HIV and AIDS, improving attitudes of personal responsibility, and significantly improving health seeking behaviours amongst beneficiaries. It achieves these results through a robust theory of change, programme design that relies on innovative behaviour change and monitoring mechanisms, and a compelling message of assuming personal responsibility for your behaviour, your status, your health and that of other members in your community. However, despite this apparently comprehensive programme design and strong effects on every other measure, the key objective of changing sexual behaviour elusive.

Perceptions of the effectiveness of Humana TCE are at risk of being undermined by a system that makes it difficult for independent evaluators to validate households reached. While Humana TCE is designed to ensure the sustainability of effects, the removal of the mechanisms of realising effects – including organisational infrastructure, the extrinsic motivation (financial reward) and the intrinsic motivation (the TCE identity) for taking action - poses a potential risk to sustainability.

Although the underlying theory of change appears sound and has proven effective in realising the majority of intended outcomes, the complete test of its validity and sustainability depends on a comprehensive impact evaluation that adopts as a key objective the assessment of sustainability.

1.5 Recommendations to Humana

1.5.1 Programme Design

- **Changing sexual behaviour:** The TCE experience with introducing effective behaviour change mechanisms for health seeking behaviour, combined with the emerging body of knowledge on sexual behaviour change, holds promise. Three broad recommendations can be made in this regard:
    - Improving TCE effectiveness with regard to sexual behaviour should incorporate the innovative thinking in terms of accountability mechanisms that already work with health seeking behaviour in TCE.
    - The emerging research shows that different approaches work for different groups. Improving effectiveness on changing sexual behaviour may require a focus on a particular demographic e.g. youth, and on a limited outcome e.g. delaying sexual debut.
    - The regression model demonstrates that a set of progressive attitudes towards the role and status of women in the community generally and sexual relationships specifically predicts more responsible behaviours. Including an engendered perspective on education interventions in TCE is therefore recommended.

1.5.2 Programme Implementation

- **Managing household register and beneficiary data**: The entire basis for credible pronouncements on programme fidelity and performance going forward depends on reliable, independently useable, programme records. It is essential that the problems with this data be corrected. Two recommendations are made in this regard:
    - Households need to be registered using a method independent the conflicting methods used by local authorities, and independently verifiable. It is recommended that a GPS system be introduced and employed as the basis for the household register at all Humana sites.
    - All existing household register and beneficiary data needs to captured in electronic format on an electronic platform implemented across the entire Humana organisation. A great deal of routine data is collected and can be enrmously useful to monitor and evaluate performance internally, as well as inform independent external evaluations.

- **Improving prospects for sustainability:** While the evaluation is not in a position to make conclusive pronouncements on sustainability, it may be worth acting on the identified risks to sustainability in the following ways:
    - Address the FOs identity insecurities by introducing emblems to replace their TCE uniforms. This may serve to enhance their confidence in assuming their role as passionates, and the confidence of the community in the fact that sustainable social capital has been built through TCE.
    - Planning more deliberately to ensure the availability of resources for passionates on programme exit. Designate a lcation within a field – the house of a passionate – at which condoms, information producst and support (for HCT, PMTCT and PLWHA) continue to be available. This will require engaging a source for providing these items before programme exit.

1.6 Recommendations to USAID and FHI 360

- Provide funding for equipment and technical assistance to implement and train Humana staff on a GPS based household register.
- Provide funding for equipment and technical assistance to implement and train Humana staff on an organisation wide electronic platform for managing beneficiary data and programme records.
- Provide technical assistance to research and design components for the TCE programme that will support achieving the sec=xual behaviour change objectives of the programme.
- Fund an impact assessment that will provide evidence for a clear pronouncement on the sustainability of the positive programme effects measured in this evaluation.

1.6.1 Recommendations to the National Department of Health

This evaluation confirms a that a perceived lack of confidentiality is a crucial hinderance to people accessing HIV services. Two recommendations are made to departments of health in this regard:

- **Layout of clinics**: It is worthwhile for the Department of Health to look into the layout of clinics to minimise possible discrimination of community members who go to collect condoms or who go for HCT.
- **Confidentiality**: This was a key finding and a concern across all stakeholder groups in all treatment sites (including youth, adult females and males, traditional healers, local leaders). Interventions to ensure that clinic staff maintain confidentiality of community members – from ethics education to disciplinary action – must be instituted.
- **Outreach HIV services**: Evidence from community members suggests that testing and counseling services delivered through a mobile clinic staffed with personel not from the local community are more likely to be utilised than the local facility. Outreach services should be a key component of all HIV services planning.

2 Introduction

According to the World Bank, the prevalence of HIV in South Africa for people aged 15-49 was 17.3% in 2011, the fourth highest prevalence rate in the world behind Swaziland (26.0%), Botswana (23.4%) and Lesotho (23.3%)[1].

As a result, many organizations and donors have responded in support of the South African government's efforts, providing means to address the HIV&AIDS epidemic. The responses range from biomedical to social prevention and mitigation programmes, including the administration of antiretroviral medications, prevention of mother to child transmission, voluntary male circumcision, encouraging HIV counselling and testing (HCT), and sexual responsibility programmes improving consistency of condom use, delaying sexual debut, encouraging fidelity and the reduction of multiple concurrent partnerships.

Accumulating a reliable evidence based understanding of the types of interventions that bring about sustainable change, and how they affect these changes, continues to be a priority for all institutions involved in HIV and AIDS programming. Donors in particular demand evidence that the projects that they are asked to fund make a difference in people's lives and are likely to produce sustainable results.

2.1 Purpose of the Evaluation

Pact SA commissioned Feedback Research & Analytics (FeedbackRA), in partnership with Epicentre, to conduct an evaluation of the Humana People to People Total Control of the Epidemic (TCE) programme. The purpose was to determine the difference this particular programme has made in the lives of those individuals and communities targeted and the likelihood of positive changes persisting after the Humana project has ended and exited beneficiary communiities.

A more detailed discussion of the evaluation purpose and objectives follows in section 3.

2.2 Overview of the Programme

2.2.1 About the Funder

Through its Umbrella Grants Management (UGM) Programme funded by PEPFAR, FHI 360 has become a leader in providing institutional capacity building, technical assistance and grant administration to primarily indigenous organizations implementing HIV/AIDS programmes in South Africa. FHI 360-UGM partner organizations work at national, provincial and local levels and deliver important HIV and AIDS services throughout South Africa. Partners work to provide critical support to orphans and vulnerable children, to prevent the spread of HIV through community mobilization efforts, to support survivors of gender-based violence and to increase access to voluntary counselling and testing. These vital efforts contribute to the reduction of HIV and AIDS in South Africa and mitigate its impact in communities around the country. Humana People to People is one of FHI360's current project partners[2].

[1] World Bank Indicators, 2011, bit.ly/WlqdaM

[2] UGM Brochure (no date)

2.2.2 About Humana People to People

Humana people to people in South Africa (HPP-SA) is a section 21 non-profit company registered in 1995 and founded to respond to the socio-economic needs of underprivileged South Africans. Humana People to People South Africa is a member of the international Humana People to People movement operating 225 projects in 40 countries around the world. One of their flagship interventions is the Total Control of the Epidemic programme.

2.2.3 About the Total Control of the Epidemic Programme

"Only the people can liberate themselves from the HIV and AIDS epidemic"

Humana People to People responded to the epidemic in South Africa by creating the "Total Control of the Epidemic" (TCE) programme in 2000. The TCE programme is a grassroots one-on-one communication and mobilization programme that has run since 2002 with the aim of reaching every person in a community with information, education, and HIV counselling and testing. The aim of creating TCE was to mobilize people for action, so that they could take control of HIV&AIDS and help each other to deal with the consequences of the epidemic. This principle of communities and individuals assuming responsibility and gaining control over the epidemic is captured in the TCE slogan "*only the people can liberate themselves from the HIV and AIDS epidemic*"[3].

The ultimate goal of the TCE programme is to contribute to the reduction in the incidence of HIV infections. The anticipated outcomes of the TCE programme are articulated in terms of changes in knowledge, attitudes, behaviours and skills.

- Changed attitudes and behaviour of community members and members of most at risk groups, manifest as:
    - community members consistently use HIV prevention services;
    - community members have undertaken HCT and know their HIV status;
    - community members avoid risky sexual behaviour and use condoms correctly and consistently;
    - community members no longer discriminate against PLWHA.
- Increased knowledge around HIV transmission and HIV and AIDS prevention and treatment;
- The capacity of local leaders built regarding HIV and AIDS prevention, care and support and stigma reduction; and local leaders develope facilitation and counselling skills.

A more thorough discussion of the TCE programme and its underlying theory of change follows in section 5.

[3] HSRC Report on Impact Evaluation of the TCE Programme in South Africa, 2010

2.3 Structure of the Report

The report begins with a description of the purpose and objectives of the evaluation, followed by an overview of the methodology as a response to the evaluation objectives and programme implementation context. A thorough description of the programme theory of change and implementation mechanisms follows in order to situate the implication of findings for programme design and implementation. A section on the implementation context is included in order to further support the interpretation of findings and the logic of the recommendations flowing from those findings. In addition a description of the programme cntext serves to qualify the methodological choices made in order to execute the evaluation.

The findings chapter follows, presenting evidence for responses to the evaluation questions, arranged by evaluation questions to the extent that findings allow for such a presentation logic. The report concludes with a brief summary of key findings and a set of recommendations focussed on programme implementation and design.

3 Purpose and Objectives of the Evaluation

3.1 Overview

The purpose of this evaluation is to determine whether the TCE programme has made a significant impact on communities where it has been implemented in terms of its intended programmatic outcomes, as well as more broadly. Specifically, the evaluation sets out to assess:

- The extent to which the TCE programme led to changes in knowledge, attitudes and behaviour with regards to the HIV and AIDS epidemic, as well as the extent to which Humana TCE is responsible for measured effects in a multi-intervention environment;
- Whether the capacity of local leaders has been built to facilitate HIV and AIDS prevention in their communities;
- What additional impacts, both positive and detrimental, that may be attributed to the Humana TCE programme;

The evaluation is not focused exclusively on outcomes and impacts however, but attempts to obtain an evidence based understanding of how outcomes and impacts were affected in context. Such an informed understanding would provide a robust basis for programme adjustment, future programme design, and inform the prognosis for the sustainability of observed programme effects, particularly those that are positive.

The evaluation purpose and objectives are operationalised in the evaluation questions presented in Section 3.2.

3.2 Evaluation Questions

The evaluation prioritises two questions posited to **obtain evidence of observed effects**:

1. How effective was the programme in bringing about attitude, knowledge and behaviour change for reducing risk to HIV infections among targeted populations?
2. Did the programme result in a significant impact in the uptake of HIV services by the targeted populations?

Included are evaluation questions to **identify additional effects of interest**:

3. Did the TCE programme contribute to any additional beneficial outcomes and social change?
4. Did the TCE programme contribute to any unintended consequences detrimental to individuals, groups within communities, or communities?
5. Are there any discernible effects on health outcomes in the TCE implementation communities?

The evaluation also sets out to **explain the mechanisms leading to the effects observed** by responding to the following questions:

6. Was the Theory of Change informing the TCE programme adequate for realising programme outcomes in the programme context?

7. What was the level of programme fidelity in implementation? Were deviations from planning responsive to context or a result of inadequate implementation?
8. What contextual factors enabled or constrained programme implementation and the achievement of intended outcomes?

Finally, the evaluation attempts to **delineate the contribution of Humana TCE to the observed effects** by situating it in a multi-programme environment:

9. What is the programming landscape with regards to HIV & AIDS in each of the treatment and comparison communities?
10. What was the TCE contribution to the cumulative effect of all programming in the beneficiary communities?

3.3 Intended Users of the Evaluation

By virtue of having commissioned,this evaluation, USAID and FHI 360 are considered the primary users of this evaluation. In addition to providing a means for accountability, the utility of the evaluation for funder (FHI 360) and donor (USAID) is the contribution it makes to their understanding of what works in prevention, and as such it is likely to support future funding decisions regarding similar programming. It also tests the efficacy of an evaluation approach to large-scale prevention programmes, and in so doing can inform future evaluation decisions.

This evaluation is intended to demonstrate the extent to which the TCE is effective in achieving its objectives, and explicating the mechanisms by which it exerts impact. The evaluation is therefore intended to inform programme adjustment and design decisions for Humana TCE specifically. Humana People to People is also considered a primary user of this evaluation

4 Methodology

4.1 Evaluation Design

The evaluation employed integrated mixed methods, with an embedded quasi-experimental cluster design as its foremost feature. It was designed to obtain comparative measures of effects of the TCE programme on outcomes of interest - changes in knowledge, attitudes and behaviour – across matched treatment and comparison communities. Community level findings are an aggregate of findings from individual and household level clusters, which were randomly seected.

Communities exposed to the TCE programme (treatment communities) were selected and compared to communities with similar characteristics that were not exposed to the TCE programme (comparison communities). Three treatment communities were selected and matched to three comparison communities, with four sites located in Mpumalanga and two sites in Limpopo. Matching was based on a review of community characteristics, guided by a community selection protocol that controlled for known vectors of the HIV and AIDS epidemic, and other variables that influence incidence and prevalence, as described in the literature. In the instance of this evaluation the community selection protocol was impemented as a guide rather than a systematic selection tool. The community selection protocol is presented in Annexure A.

As a contingency to mitigate the risk of matched communities being found to be non-equivalent on key variables with confounding potential, provision was made for propensity score matching of individual respondents to the household survey. Treatment and comparison groups could then be devised statistically based on a scale of exposure to Humana TCE.

4.2 Data Collection Components

The evaluation consisted of three data collection components, namely a front-end analysis involving site visits and interviews; a household survey; and a support study to the household survey consisting of interviews and focus group discussions with a purposive selection of key informants.

4.2.1 The Front-End Analysis

A front-end analysis was conducted that involved visits to the selected sites, engagement with community leaders, and initial focus groups and interviews with key informants, including Humana TCE staff and field officers implementing the programme in treatment sites. In addition to obtaining the necessary access for fieldwork in through consultation with relevant authorities, the purpose of the front-end analysis was twofold: to support site selection for the household survey; and to generate primary data for understanding the implementation context and documenting the Theory of Change.

Treatment sites were identified in collaboration with Humana, and matched to comparison communities that were selected on the basis of community typologies, initially prepared from secondary data sources (primarily StatsSA Community Survey and Census data) and informed by Humana's knowledge of its operational areas. These typologies, and the appropriatness of matched comparison communities, were verified on the front-end analysis site visits. The verification process resulted in a replacement of one comparisoin community initially matched to a treatment site.

Interviews conducted with programme staff generated primary data to inform the documenting of the TCE theory of change, the initial versions of which were based on programme documentation and an earlier evaluation of TCE conducted by the HSRC in 2010. The interviews with programme staff were supplemented by interviews with key informants to generate a primary data set on the nature of the implementation contexts of TCE. The description of contexts arrived at during the evaluation and informing the interpretation of findings were based on these and later interviews and focus group discussion, as well as data from secondary sources (primarily StatsSA Community Survey and Census data).

Finally, the front-end analysis guided the development of the household survey instruments.

4.2.2 The Household Survey

A household survey was conducted as the primary data gathering effort of the evaluation. Individual respondents within households were randomly selected on site, while participating households were randomly selected from programme household registers.

The survey collected data on knowledge, attitudes and behaviour of household members with regards to the HIV and AIDS epidemic, as well as control data on household characterisitics and the programming environment in the community. Two instruments were employed during the household survey:

- A household survey was administered to the head of the household in at least 50 households in each community. The instrument was used to gather data to determine equivalence of matched communities and control for confounding variables. In addition household level data provided an overview of services available to and accessed by the community. Variables included number and gender of household members, the dominant language(s), educational attainment, employment status, morbidity and mortality; as well as services accessed such as HIV Counselling and Testing (HCT), tuberculosis (TB) services, prevention of mother to child transmission (PMTCT) services, other medical services, social protection, material support (clothing, food, donations), psychosocial and educational support.
- A participant survey was administered to at least one individual residing in a sampled household (18 to 65 years of age), in addition to the head of household. The criteria for inclusion was exposure to the TCE programme for those in the treatment sites and non-exposure to the TCE programme for those in the comparison sites. The participant survey focussed on obtaining knowledge, attitude and behaviour data, with less emphasis on household level and control data.

4.2.3 The Support Study

Interviews and focus groups were held with various stakeholders and key informants at treatment sites. Focus groups included adult female and male focus groups held with community members recruited from the household survey; traditional leaders/Indunas; traditional healers; school teachers; clinic staff; and youth in schools. This data collection round allowed for the exploration of questions regarding programme fidelity, mechanisms of change, contextual variables enabling or constraining programme efficacy, unintended consequences of the programme, programme contributions to social change, and the sustainability of programme effects. In addition this component allowed for triangulation of findings across multiple data sets, confirming or contesting findings established through the household survey.

4.3 Sampling

4.3.1 Considerations in the Selecting Matched Sites

There were two important considerations guiding the selection of communities. The first was that the treatment and comparison communities participating in the study present similar characteristics with respect to a set of key identified criteria. These criteria covered basic geographic and demographic variables such as size, rural versus urban, as well as socio-economic conditions such as access to basic services (water and sanitation, electricity, health facilities and education). Similarities between treatment and comparison communities with respect to HIV/AIDS prevalence, was also relevant. Desktop research and interviews with community leaders in selected areas, provided an initial indication of similarities between communities to motivate matching of treatment and comparison communities. Questions pertaining to socio-economic conditions were also included in the household survey and quantitative analysis further determined the extent to which matched communities are similar. A profile of communities is presented in the Findings Chapter.

The second important consideration was that the communities being compared must differ with respect to the implementation of the TCE programme – a treatment community that had been subjected to the TCE programme was matched to a comparison community that had not been exposed. The communities evaluated (treatment sites) were communities in which the intervention had been completed from 2009 to 2011.

4.3.2 The Sampling Process

To sample households in the three treatment sites, Feedback randomly sampled 46% of the fields (the geographic unit that Humana designates as an area of operation), or 24 fields out of a total of 52 fields at each site. The initial sampling strategy for treatment sites included the selection of random households by physically counting each household (captured in hard copy registers) for each field and randomly sampling four households within each field using a randomisation formula in MSExcel.

Household information was then manually captured for each randomly sampled household and included a household number, name of the head of the household, the members of the household and recorded the number of visits that this household had received from the TCE workers. These forms were given to the field teams to assist with the household identification and participant verification to ensure that the right participants were enrolled into the survey.

The methodology was changed when it became evident that the TCE registers could not lead the survey team to the selected households. The field teams continued to recruit participants from the selected villages within each site but upon reaching the selected village they identified the boundaries and then randomly selected multiple rows of houses from which they visited the first three to four eligible households in a row of households. This process was followed in such a way so that households across the whole village were represented in the study.

To sample the comparison sites, Districts provided a list of Wards . In Polokwane, Limpopo, two villages were randomly selected from a total of five wards. In Mpumalanga, the comparison sites (Matsula A and Matsulu B) each included one Ward and all villages were included in each comparison site. The households for the comparison sites were randomly sampled from the municipal household lists and corresponding maps provided by each District. The samples were selected by identifying the total number of households according to the Municipal maps and households provided for each site and using excel to identify every nth household to include as part of the sample.

The target was to reach 50 households and 100 participants in each selected site with the assumption that there will be on average two eligible members in each household. . Feedback RA oversampled the households for three reasons: (1) to enable households to be replaced should members not be available, (2) should there be refusal of the household to participate or (3) should TCE participants no longer be living in the selected household.

4.4 Analytical Strategies

The quantitative data obtained from the household survey effort was subjected to a number of analytical strategies:

1. Treatment communities were treated as a single treatment community, and compared to a single comparison community constituted by combining all comparison communities. This improved the external validity of measured effects by increasing sample size. Comparison of results across matched pairs was reserved for addressing the possibility of measuring no effects across the combined treatment and comparison groups, should this occur.
2. The primary analytical strategy involved a statistical comparison of means across survey items representing variables of interest, in order to identify any significant differences between treatment and comparison communities.
3. In addition a regression model was developed from the accumulated quantitative data in order to provide an indication of the best predictors of behaviour change.
4. Propensity score matching based on a scale of exposure to Humana TCE was conducted to inform the regression model.
5. Clear differences in the equivalence between treatment and comparison communities (gender and age were particularly notable in this regard) were controlled for through a statistical weighting technique before any analysis was conducted.

Qualitative data was subjected to thematic analysis and used as a secondary data source for either corroborating or contesting the quantitative findings. Because the evaluation was designed to ensure the validity and reliability of quantitative data the latter take priority in guiding interpretation and positing of findings.

4.5 Recruitment and Training of Fieldworkers

To recruit field workers, local organizations in each site were contacted to obtain a list of suitable candidates. In all sites, local leaders from the Municipality also provided names of candidates whom they wished to include as part of the fieldwork team. The criteria for recruitment of fieldworkers included: (1) their ability to speak the local language(s), (2) have at least a matric and (3) experience in interviewing or counselling. The fourth criteria required that community members have no prior involvement in the TCE programme. This criteria was to ensure that no bias influenced the data collection process.

Lists of candidates were obtained and reviewed. Candidates with suitable qualifications and experience were identified and short-listed. Identified candidates were scheduled for assessment tests and candidates who passed the tests were scheduled for interviews.

All field workers were suitable to work in the areas in which they were placed. The field workers spoke the local language, had knowledge of the area and were trained and competent in data collection.

4.6 Ethical Considerations

Feedback RA submitted an application to the HSRC Research Ethics Committee for ethics review and obtained permission for the research. The process took two months to conclude. A request was made to the relevant provincial Departments of Health Research and Ethics Committee and the research was approved with no issues of ethical consideration identified. This took three weeks to finalise.

District Municipalities provided letters of support to access all treatment sites and we encountered no challenges accessing the treatment sites. . Access into comparison sites was a challenge. This process to obtain approval to comparison sites (which was eventually received) took approximately three months and required continuous engagement with the comparison sites' District Municipalities. After we obtained letters of support District Municipalities were supportive of the research. he Feedback RA and Epicentre Fieldwork team used an inclusive approach to identify and select field workers. Ward Counsellors were provided the opportunity to select community members with appropriate qualifications to be screened and interviewed

In terms of ethical considerations relating to participants, the evaluation process included:

Voluntary participation: participants were informed that their participation in this study was strictly voluntary and that they were free to withdraw from the study at any time.

Psychological risks: there was no psychological risk to participants in participating in the study. Participants were able to refuse to answer any questions. The fieldwork team provided a contact list of local services for each site in the event that participants may have required additional care and support as a result of being surveyed or interviewed.

Benefits to participants: there were no direct benefits for participants participating in the study. Confidentiality was maintained and researchers ensured privacy during data collection sessions.

Informed consent: following careful explanation of the survey, the fieldwork team gave eligible participants the consent form to read or, if necessary, the consent form was read to the participant by research staff. The research team fully addressed any questions raised by eligible participants. All participants had to sign a consent form to indicate that they understood and agreed to all of the items contained in the consent.

Protection of privacy of individuals: a private space was used to administer the surveys and conduct the focus groups. The interviews were conducted face to face with no other persons in the space/room other than the fieldworker and the participant(s). Only the fieldworker and focus groups participants were present for the focus group.

4.7 Challenges and Limitations to the Evaluation

The following challenges imposed limitations on the intended timeliness of the evaluation process, as well as the reliability and the utility of results. In most instances the limitatoins were addressed to preserve the integrity of the evaluation, and these mitigation strategies are described here. Where no mitigation was introduced it is explicitly stated. Under both eventualities the reader needs to consider whether and to what extent the ultimate reliability and utility of findings is affected.

4.7.1 Challenges with Implementing the Evaluation Design

- **Equivalence of treatment and comparison communities**: The complexities of context renders a matching evaluation design strategy problematic. Despite efforts to control for non-equivalence through a very systematic and theoretically grounded community selection process, it was necessary to resort to statistical weighting for a more credible comparative analysis of treatment versus control conditions. In addition propensity score matching was used to create statistical treatment and comparison groups for the regression modelling exercise.

4.7.2 Challenges with Sampling

- **Sampling limitations**: Humana maintained a list of all households and community members reached by means of Household Registers that were only available in hard copy. Because these registers were kept in the Pietermaritzburg office and there were in excess of 150 registers per site, it was not feasible to include the full list of households in the random sampling process.
- **Locating sampled households**: It became evident early in the data collection that it was impossible to find the selected households using the Humana household registers.
    - There were no maps of the area with Household numbers indicated to enable the sampled households to be located, especially in the more rural areas like Driekoppies in Mpumalanga and Moletjie in Limpopo. There are also no GPS coordinates provided. In addition, maps at the Municipality level had changed and were different to those held by Eskom.
    - Because the system of registering households appears to be inconsistently implemented and highly dependent on Field Officers in their particular fields, it was extremely difficult for the evaluators to locate many cases without field support from Humana.
    - Household numbers were not displayed outside the dwelling in most villages.
    - Many households did not know their household number and referred to Eskom numbers instead of municipal numbers when referring to their house number. Community members did not know each other's household numbers either, which made locating of households extremely difficult.
    - Household numbers were not assigned in any structured way in the community. Household numbers were allocated based on when the structure was built rather than in a consecutive manner based on location.

- Some households were found to have more than one number:- a plot number and a house number. This was not consistent in villages and as a result, some community members knew their plot number while others knew the house number (depending on the leadership status in the area - Kgosi or municipality).

4.7.3 Challenges with the Data Collection Process

- **Fieldworkers for the household survey**: It would have been ideal to have one team trained to complete data collection at all sites in each province. This would have simplified recruitment, training and data collection. However, for this study there was a strong need from the community stakeholders to have their own local people involved in the survey (to benefit their community members). This complicated recruitment and training as it required more field workers to be selected, recruited and trained then initially planned. Furthermore, due to the distances between sites and language requirements, it was not possible to have one team trained to complete data collection at all sites.

4.7.4 Challenges to the Comprehensiveness of the Evaluation

- **Scope of the evaluation:** Some key variables of interest were ommitted from investigation, most notably adherence to treatment and voluntary male circumcision in terms of health seeking behaviour, and the extent to which counseling and testing was undertaken as partners. While VMC was not explicitly included in TCE programming originally and did not feature as a consideration during data collection design, adherence to treatment has been a focus of TCE for some time and the trio strategy is anecdotally successful. The ommission was an oversight in the evaluation design. Consequently some important conclusions on health seeking behaviour could not be posited.
- **Analytical limitations:** Unfortunately the study could not control for the HIV status of respondents, which would offer additional key insights into the potential motivators for health seeking behaviour. The limitation is due to inconsistent or non-responses on the HIV status item. In adition some disaggregations were not executed, notably by age groups, which is becoming increasingly important. The data set is being adjusted to address the latter and the functionality introduced to run such analyses, however those results will not be available for this report.

5 Understanding the TCE Programme

This section provides an overview of the TCE programme based on a desktop review of programme documents, as well as interviews and focus groups held with TCE staff and field officers. Section 5.1 presents the TCE programme according to Humana, describing the programme purpose; its implementation through organisational structure, activities and monitoring mechanisms; and the provisions made in the programme design for the sustainability of its outcomes. Section 5.2 clarifies the programme theory of change and the associated logic model based on a distillation and analysis of programme documents, and the views and perspectives of Humana staff, field officers and passionates in each of the treatment communities.

5.1 TCE According to Humana

This section describes the TCE programme model interms of its objectives, the activities implemented to achieve those objectives, how the organisation and its human resources are structured to execute activities effectively, and how programme fidelity is monitored. In addition TCE is designed to proactively address the risks to sustainability of the results achieved in communities, and those elements are described here.

5.1.1 The Purpose of Humana TCE

"To get every person in every field and area in control of the HIV/AIDS epidemic."

The overall goal of the Humana TCE programme is to mobilise and empower communities to take control take control of the HIV and AIDS epidemic in the lives of each community member. This overarching overarching goal is achieved through the realisation of five supporting objectives that focus on changing on changing sexual and health seeking behaviours, facilitating access to health services, and engaging and engaging with every member of a beneficiary community (see When an individual can answer yes to points 1-4 (60 points), it can be said that the individual is in control of HIV/AIDS in his or her own life. The TCE Compliance Score Card is used to estimate an individual's compliance with the TCE programme. A minimum of 85 points is required in order to be considered TCE Compliant.

Figure 1: Aims of the TCE programme). Empowerment from a TCE standpoint however is operationalised as a programme result realised on an individual level: "*when individuals can answer yes to the first four aspects of TCE Compliance Score card, they are in control of HIV and AIDS in their lives*".

To be declared TCE Compliant means that the individual meets the demands of taking control of HIV/AIDS in his or her life. In the process of becoming TCE compliant, the individual needs to make a decision about HIV prevention in his or her own life and take action to adapt to an HIV risk free lifestyle. For an HIV negative person this means behaving in such a way as to remain HIV free, while for and HIV positive person the emphasis is on remaining healthy and not transmitting the virus to others. The different criteria to be scored on the card are listed in Figure 2: TCE Compliance Score Card elements.

When an individual can answer yes to points 1-4 (60 points), it can be said that the individual is in control of HIV/AIDS in his or her own life. The TCE Compliance Score Card is used to estimate an individual's compliance with the TCE programme. A minimum of 85 points is required in order to be considered TCE Compliant.

Figure 1: Aims of the TCE programme

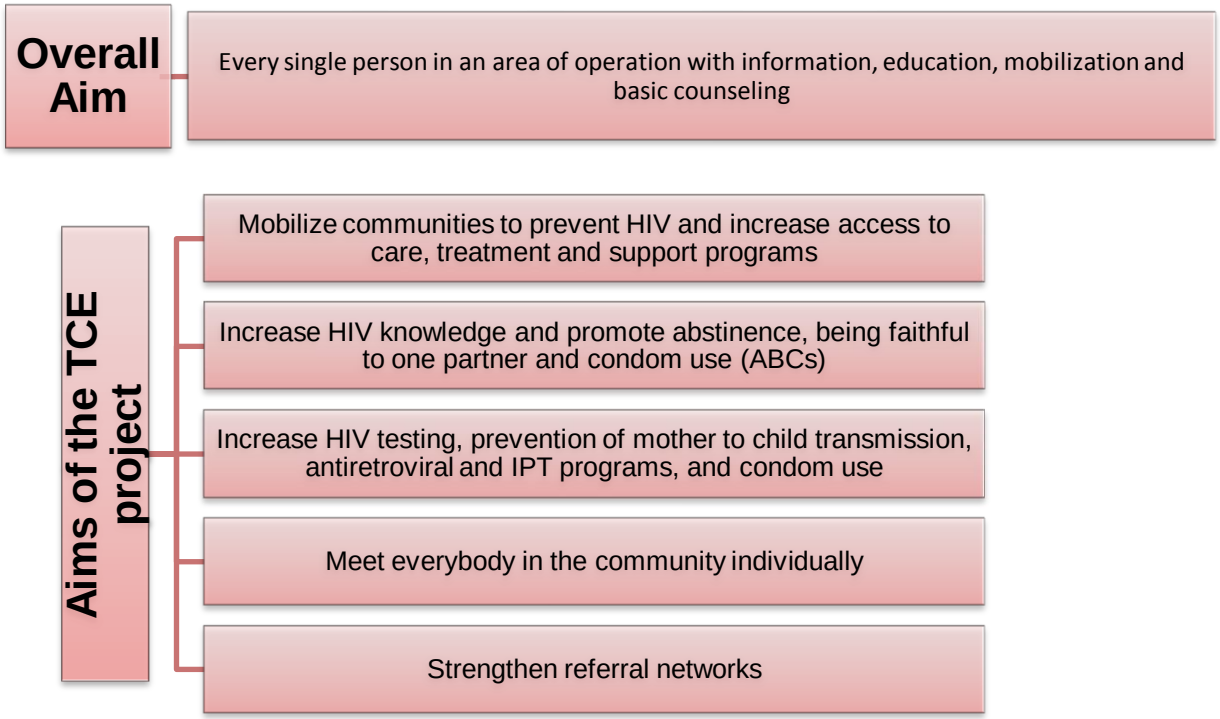
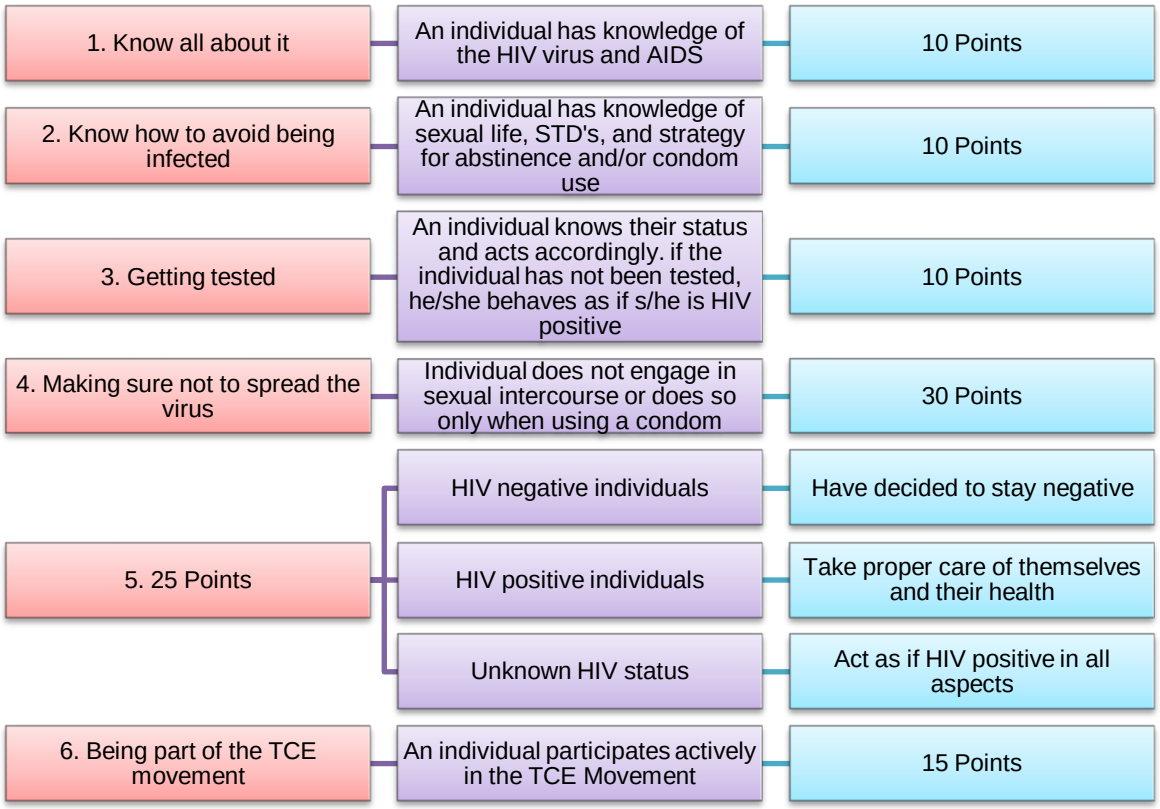


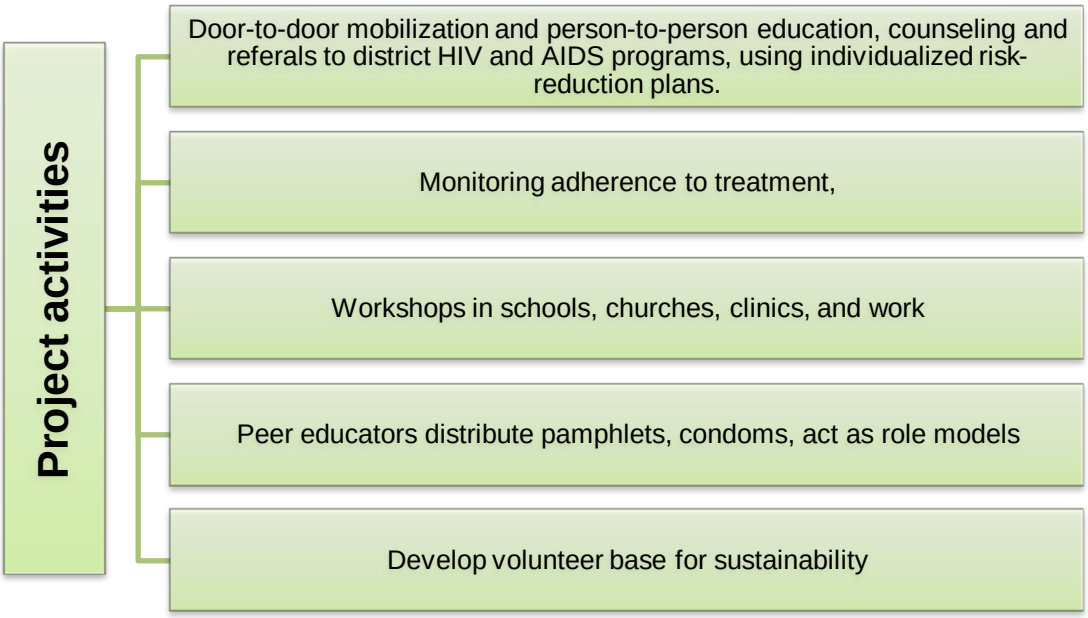
Figure 2: TCE Compliance Score Card elements



5.1.2 Programme Activities

The TCE programme pursues its purpose through various activities that contribute to the total control of the HIV/AIDS epidemic and reduction in the rate of new infections amongst the targeted communities. These activities are represented in Figure 3: TCE project activities, and detailed in the discussion following.

Figure 3: TCE project activities



Door-to-door campaigns: These campaigns allow for the registration of every household in the TCE area, identifies every member of that household and informs them about TCE, HIV/AIDS, healthcare services, access to information and referral services.

The field officer follows up with these households throughout the three-year period to ensure full understanding of the epidemic, HCT, referrals and mobilization. These campaigns aim to ensure that everyone in the household is TCE compliant and that 'at risk groups' are identified and follow-ups are made.

The unique person-to-person approach of the programme ensures that people are reached at a level that enables them to listen and ask questions in order to thoroughly understand. During each visit, the field officer ensures that the TCE scorecard is worked through with the aim of each household member to become TCE compliant.

Condom distribution and outlets: The TCE programme maintains that 'condoms are the single, most efficient, available technology to reduce sexual transmission of HIV'. Therefore, TCE informs about the correct use of condoms though practical demonstrations and provides the community with access to condoms. There are condom outlets established throughout communities in local shops, clubs, clinics and centres where community members can have easy access to them. The condoms are provided in large quantities.

The HIV Counselling and Testing (HCT) Programme: This programme has the objective of ensuring that everyone in the TCE area gets counselling and testing. TCE staff train their Field Officers in counselling and invite qualified nurses from the Department of Health to assess whether they qualify as lay-counsellors. The Field Officers in turn train the Passionates to mobilise the community for testing. TCE staff organize mobile testing facilities with the Department of Health or other NGOs in the community so that there is easy access to testing during community workshops, talk shows or sports tournaments.

Referrals and Follow up: TCE does referrals to the nearest clinics and hospitals for PMTCT, TB prevention, social services, HCT, CD4 count and STIs treatment. TCE also focuses on the systematic tracking of patients on treatment to ensure they receive the necessary care and support. Field Officers also identify and track defaulters together with the local health authorities.

Community Outreach and awareness campaigns: Comprehensive community outreach campaigns have as their primary objective to educate and equip everyone in the community about HIV and AIDS, getting tested, living with the virus and how to access condoms and healthcare facilities. The main objective is to ensure that everyone in the community is TCE compliant, which refers to limiting the spread of HIV and AIDS. The campaigns also reach out to pregnant mothers to introduce them to PMTCT Programmes in local clinics.

Youth are reached through life skills lessons at schools which aim to address issues such as peer pressure, attitudes and making the right choices. Local leaders introduce TCE to the school principals and propose to have the TCE school programme in specific schools, conducting lessons for 29 weeks on different topics. Themes covered include teenage pregnancy, HIV and AIDS and related issues.

5.1.3 Organisational Structure

Programme activities are executed through a leadership and structure that mimics a military organisational arrangement. One TCE area is a geographical area of 100,000 people, which is divided into small geographic units called fields. In such an area, 50 Field Officers are recruited, trained and deployed, each to a field with 2000 people. Over a period of three years, the task of the Field Officer is to go from house to house and reach every single person on a one-to-one basis.

In each field the TCE Field Officer along with local volunteers will campaign and mobilise the population to fight the epidemic in a variety of ways until the epidemic is under control. While each Field Officer is assigned 2000 people to reach, there is a mechanism at the household level whereby each client is supported by two other people (one being a family member (passionate) and the other being the Field Officer).

TCE has structures for meetings where Field Officers in groups of ten (called a Patrol) and groups of fifty (called a Troop) meet bi-weekly to report and evaluate their work and performance.

A Patrol Leader has leadership of nine other Field Officers in sharing experiences. A Troop Commander has the daily leadership of 50 Field Officers, including reporting, planning, and accounting. The Division Commander leads 250 Field Officers. The task for the leadership is to ensure that Field Officers are informed, educated, equipped, willing and mobilized to do their door-to-door campaigns.

5.1.4 Programme Monitoring

Programme progress and programme fidelity are both subject to systematic monitoring.

Programme Progress: Humana implements TCE in a selected community over a three year concerted action effort. The Perpendicular Estimate System (PES) has been created as a basic tool for the TCE Field Officer to estimate the status of the TCE Programme in achieving its goal - Total Control of the Epidemic - for every single person in the Field and for the Field as a whole. The accumulated results of the PES system provides an indication of the TCE Compliance status of the entire community.

Programme Fidelity: The household register is a the master record of reach into a community and is used as the basis for monitoring the extent to which field officers are implementing TCE according to plan. It falls to a contingent of Humana TCE staff known as Special Forces to implement programme fidelity monitoring, based on household register data, and following a multi-pronged process as described below.

- Special Forces provide three to five support visits per week where they visit households with Field Officers. The purpose is to monitor the effectiveness in the way the Field Officers implement household visits.
- Special Forces conduct three to five surprise visits per week. These are scheduled as part of the weekly plan. Surprise visits work in such a way that the Special Forces person checks the WAR room to determine where a Field Officer plans to work, s/he then goes to the area and asks community members in the area whether they have seen the TCE person and would track the Field Officer to monitor whether s/he is where they claimed they would be.

- Special Forces conduct internal impact assessments where they randomly select three to five households per week and visit these to check whether the Field Officer spoke to the people and to determine what was learnt.
- Validating of household visits occurs quarterly where Field Officers count each other's registers. The activity is supervised by a Troop Commander or Special Forces person.
- Counting and questioning is done weekly where the Patrol Leader will share with the full team how many households were reached in total and highlight key achievements in performance such as identifying a Field Officer who exceeded his/her targets to mobilize others for testing. Random questions and checking of household registers is also done at this meeting.

It should also be noted that based on RDQA recommendations from FHI 360, Humana is piloting a Sweto Care System database in which on a weekly basis data capturers enter the household registry data and they database entries are then checked by other Humana staff with the original registry entries.

5.1.5 Ensuring Sustainability

The TCE programme is designed as a temporary action implemented in a target community as a concerted effort over a 3 year campaign period. Humana is intensely conscious of the risks to sustainability of the effects it achieves in that time once it exits a community. Consequently the programme design incorporates features that attempt to directly address and mitigate the risks to sustainability. These features focus on whole community mobilisation, but also consider strategies for transitioning of field officers.

Whole community mobilisation: In addition to reaching every member of a community and attaining community level TCE compliance, the programme attempts to recruit various community member groupings into specific activities to address the effects of HIV and AIDS. The TRIO system links community members who go on to ARV treatment with two passionates - community members who have taken the sixth step of the TCE Compliance Score card - to support individual on treatment with adherence. A passionate could be a friend, family member, or neighbour, who will monitor the individual's intake of ARV on a daily basis. In addition to supporting adherence, passionates are mobilised to support home based care activities, to start income generating activities to support the sick and their families, and generally to advocate amongst community members for the achievment of TCE goals.

In addition local leadership is seen as the cornerstone of programme effectiveness and sustainability, and are included in implementaion from programme initiation. Leadership endorses TCE and facilities implementation. Local leaders continue to work with TCE throughout the three year period. The local leaders are recruited to work as WAR (Ward Activity Room) leaders. A WAR is a clinic, school, chiefs house or church, where Field Officers keep their attendance registers and sign in and out of work daily from these WAR rooms.

Field officer transition: Field officers are recriuted from the local community, receive training, are mentored and gain work experience throughout a 3 year action. Humana maintans that the training and work experience improve the prospects of field officers, and there is anecdotal evidence of employability post TCE implementation. In addition Humana has had success in some target communities in facilitating the transition of field officers into the employ of the Provincial Departments of Health or local government as community workers.

5.2 Clarifying the TCE Programme Theory of Change

The following section presents a distillation of the theory of change based on a programme document review and substantially influenced by the interviews with TCE personnel and Field Officers who implemented TCE from 2009 to 2011 in the three treatment sites[4]. The extent to which Humana TCE is successful in achieving programme objectives is a test of the validity of the theory of change in context. This evaluation explicates the theory of change in order to offer a preliminary assessment of the theory of change informing programme design, and to make any recommendations for adjusting programme design if necessary.

[4] A focus group was arranged with Field Officers in the TCE offices in Mpumalanga and in Limpopo

5.2.1 Principles Underlying the Humana TCE Theory of Change

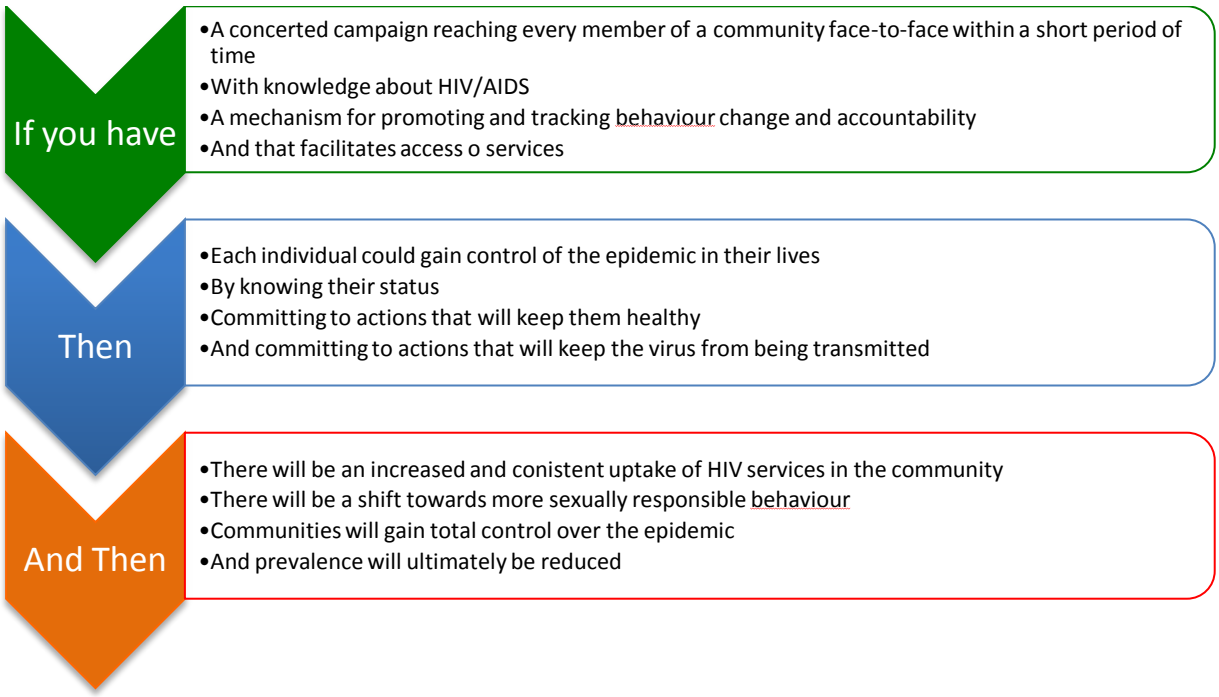
It is apparent that there are three key assumptions informing the design of Humana TCE. The most prevalent is the emphasis on **personal accountability for change.** The Compliance Scorecard is emblematic of this emphasis, as is the primary programme delivery mechanism – multiple personal engagements between the fieldworker and a programme beneficiary, during which the basis for engagement is the accounting for agreed acts representing progress on a journey of change.

The second assumption is that **thorough and sustained change requires a changed community environment**. Numerous Humana objectives and activities are driven by this assumption, including the emphasis on winning over community leaders and reaching every community member. Programme staff at every level are keenly aware of the potential of stigma and discrimination to derail the achievement of total control over the epidemic, and the conversion of an entire community to the cause is informed by this awareness. The most obvious manifestation of this underlying assumption is the overarching programme strategy, which is an overwhelming and sustained campaign at a community level, systematically planned and executed, over a prescribed period of time.

The third principle is the perspective that **resources for addressing the epidemic are available to communities but are under-utilised**. The emphasis on facilitating access to treatment and referrals to other service providers are key elements of the TCE strategy and illustrative of this principle.

The theory of change eimplie by these principles and manifest in the programme design is summarised in Figure 4.

Figure 4: TCE Programme Theory of Change



6 Profiling the Treatment and Comparison Communities

A reasonable degree of equivalence is necessary to ensure that the quasi-experimental design maintains its integrity. Any potential systematic differences between communities that might confound comparability of results must be eliminated to the extent possible.

The front end study confirmed that the selected treatment site (Tzaneen) and matched comparison site (Moletje in Polokwane) in Limpopo were suitable. It further confirmed that treatment site one (Tonga) and matched comparison site one (Matsulu A) in Mpumalanga were well matched. However, treatment site two (Driekoppies) was matched with Umjindi as comparison site two and, as a result of the front end study interviews, was deemed unsuitable as a match because the community in Umjindi had already been exposed to the TCE programme. Consequently Matsulu B was identified as a more suitable comparison site two and included in the evaluation.

This section provides a brief description of the socio-economic dynamics of each of the sites within their respective municipalities and provinces, discusses further challenges with matching and the mitigation strategies adopted to improve the integrity of the sample.

6.1 Background on the Selected Sites

6.1.1 The Mpumalanga Matched Communities

The two treatment sites (Tonga and Driekoppies) and their matched comparison sites (Matsulu A and B) are located within Mpumalanga Province in one of the three provincial Districts, namely, Ehlanzeni. The unemployment rate in Mpumalanga is officially 16%, while 44% of households in the province are living in poverty. HIV prevalence is 21%.

Driekoppies (treatment community one) is a very small coomunity in Mpumalanga, commonly identified with the proximate Driekoppies Dam. Driekoppies is classified as rural, and is serviced with electricity, a clinic and schools. The hospital and police station are about 10km away and offices for social workers and social grants are about 13km from the community. There are reportedly high levels of sexual abuse and rape in the community[5].

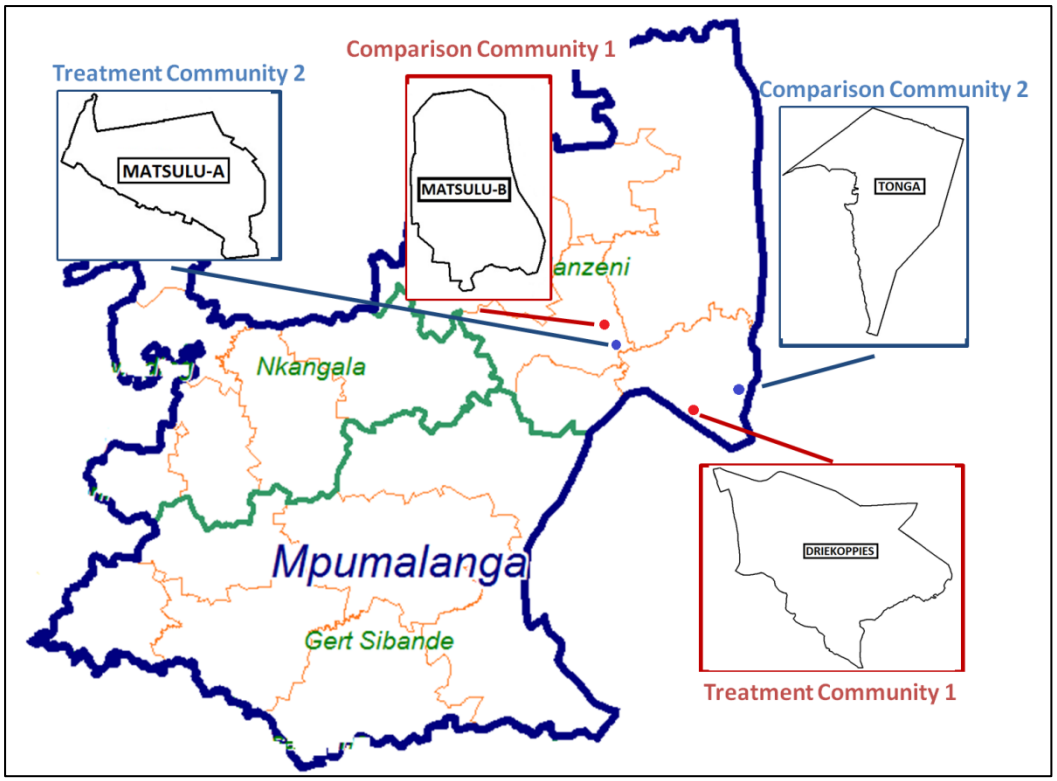
Tonga (treatment community two) is classified as a semi-rural area. There is a police station, magistrates court, home affairs offices, SASA offices, offices for child-abuse and a centre to address all abuse issues. The municipality's population trends young, with a substantial proportion of school-going age. However, beyond the age of twenty years, many leave to further their education and to search for better work opportunities. The unemployment rate in Tonga is 25%. In 2001, 24% of households had no formal income, while 60% earned an annual household income of less than R20 000[6].

[5] Source: IDP 2012-2013

[6] Source: IDP 2012-2013

Matsulu B and Matsulu A (comparison sites two and one respectively) are wards located within Mbombela Local Municipality, one of the municipalities located in Ehlanzeni District Municipality. The municipality had an estimate of 137,353 households in 2007. The number of unemployed residents is estimated to be 52,290 and 41% of the community earn an income of less than R1600 per month. Only 11.5% of the community earn more than R3500 per month. HIV/Aids is the predominant challenge of the area and according to the Department of Health survey (2009), Mbombela had an HIV/AIDS prevalence of 43%[7].

The following graphically depicts the selected sites within Mpumalanga.



The front-end study identified the following similarities between the matched sites of Tonga and Matsulu A as well as Driekoppies and Matsulu B[8]:

- Tonga and Matsulu A are not strictly urban, but reflect the suburban characteristics typical of medium sized townships. Driekoppies and Matsulu B are both more rural than Tonga and Matsulu A
- SiSwati is the main language spoken in all four areas.
- Conditions and access to roads and Infrastructure are similar for matched communities. In Tonga and Matsulu A, roads are in relatively good condition, although some are not tarred. In Driekoppies and Matsulu B roads are generally in a poor condition.

[7] Source: IDP 2012-2017

[8] Findings are presented from interviews with municipalities and local stakeholders familiar with the sites, as well as from desktop review

- The larger of households have pit toilets. In Tonga and Matsulu A the pit toilets are in a reasonably good condition and households are steadily moving away from pit toilets to septic tanks. Pit toilets in Driekoppies and Matsulu B are generally in poor condition.
- Water supply is a major challenge for both matched pairs.
- There is a demand for housing and both areas are experiencing a housing backlog.
- HIV prevalence is relatively high with Tonga at 47.3% and Matsulu A at 42.4%.
- Driekoppies and Matsulu B both experience more than 35 % unemployment rate.

6.1.2 The Limpopo Matched Communities

In Limpopo Province, the third treatment site (Tzaneen) is in one of the five District Municipalities (Mopani) and it's matched comparison site (Moletjie) is in another District Municipality (Capricorn). Limpopo consists of 25 local municipalities. The Population of the province is estimated at 5.2m of which 54.6% is women, 45.4% is men and youth at 39.4%. The unemployment rate is estimated at 26,8%, the HIV infection is at 21.5%[9].

The Greater Tzaneen Municipality had a total population of 375,588 in 2001[10]. According to the Statistics South Africa 2007 Community Survey, the unemployment figure within Greater Tzaneen Municipality was 20%. Twenty nine percent (29%) of the total population in the municipality does not have any source of income. Seventy percent (70%) of the income earned by households is below the minimum living levels (R 9,600 per annum). There is a high level of HIV prevalence (figures could not be identified for the Municipality)[11].

The Polokwane Municipality, located within the Capricorn District is 23% urbanised and 71% still rural. The Moletjie Cluster is one of the four clusters within the Municipality. The Polokwane municipal area is home to approximately 561 772 people[12]. The general education levels are low and poverty is a major problem in the area. Polokwane is an area with limited water resources and electrification is a challenge in some areas.

The front-end study identified the following similarities between Tzaneen (the treatment site) and Moletjie (the comparison site):

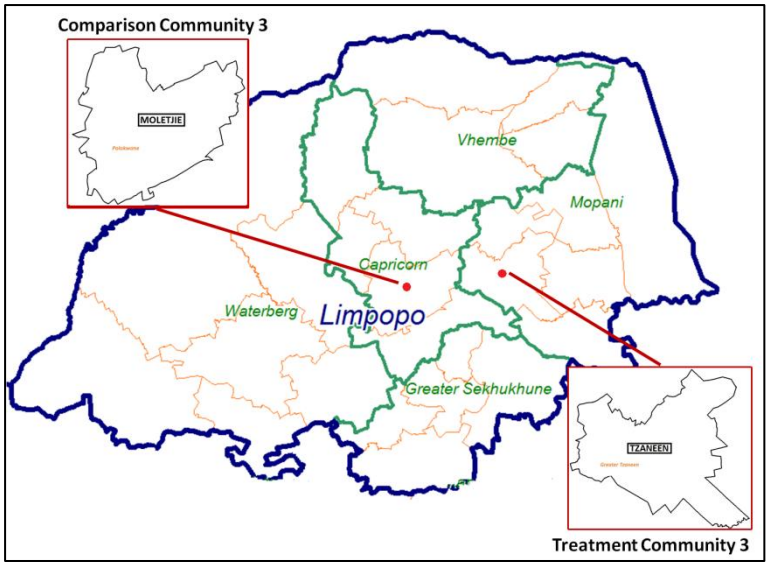
- Both are rural;
- There are areas that are semi-urban and both sites have a mixture of deep rural and peri-urban;
- Road conditions for both sites have tarred areas in peri-urban areas with poor road conditions in deep rural areas; and
- Most households have pit toilets in both sites

[9] STATS SA. 2010. Quarter 1 statistics

[10] Census Statistics South African of 2001

[11] Integrated Development Plan. 2012/2013

[12] Statssa: Community Survey, 2007



6.2 Weighting for Equivalence

The household survey further profiled sampled participants to determine the equivalence of the matched communities.

In terms of access to basic services, almost all participants had electricity in their households (97% of comparison and 98% of treatment communities).

The majority had a traditional pit latrine in terms of the toilet facility in their household (79% of comparison and 77% of treatment communities).

The main source of drinking water differed slightly between the comparison and treatment communities as follows:

Table 1: Water and sanitation in sampled communities

		Comparison	Treatment
Main source of drinking water	Piped into dwelling	16%	35%
	Piped into yard	61%	50%
	Public tap/standpipe	15%	4%

However, findings showed that overall, there were marked differences between samples on age and age and gender variables. In comparison sites the number of participants below the age of 29 years was 29 years was much higher and participants above the age of 51 years was much higher than for for treatment sites. In terms of gender, comparison sites had 59% of females in the sampled sites sites compared to 80% females surveyed in treatment sites.

Table 2illustrates differences and similarities between sites before weighting of the data.

Table 2: Profile of sampled participants before weighting of data to ensure equivalent samples

		Categories					
		Comparison			Treatment		
		Area			Area		
		Capricorn	Matsulu A	Matsulu B	Driekoppies	Tonga	Tzaneen
Languages_spoken	Afrikaans						2%
	English	1%					
	Sepedi	99%					14%
	Sepedi, Tsonga						2%
	Southern Sotho						4%
	Swazi		95%	100%	100%	100%	
	Tonga		2%				
	Tsonga						76%
	Zulu		3%				
	Zulu, Tsonga						2%
Age	<= 29.0	35%	31%	43%	18%	20%	10%
	30.0 - 38.0	22%	25%	27%	28%	31%	18%
	39.0 - 50.0	25%	28%	16%	23%	24%	28%
	51.0+	19%	16%	14%	31%	24%	44%
Age (average)	Mean	38	38	35	43	42	49
Gender	Female	65%	53%	56%	78%	84%	78%
	Male	35%	47%	44%	22%	16%	22%
People above 18 in house	Mean	3.9	2.9	3.0	3.1	3.7	4.2
Number of males	Mean	2	2	2	2	2	2
Number of females	Mean	2.2	1.8	2.1	1.9	2.1	2.5

Due to the variances between the treatment and comparison communities, the data was weighted to eliminate outliers in terms of gender and age so that statistical analysis could be run on equivalent samples. As Stats SA data does not report to this level and AMPS data is not available per town it was decided to weight the two samples to an overall demographic. The sections that follow present analysis from both quantitative and qualitative findings in response to the key evaluation questions. **Error! Not a valid bookmark self-reference.** illustrates the profile of the comparison and treatment sites overall after weighting of the data. The weighting process is detailed in Annexure C.

Table 3: Profile of comparison and treatment communities after weighting of data to ensure equivalent samples

		Comparison	**Treatment**
Languages	Swazi	54%	65%
	Sepedi	44%	5%
Age	Under 30	27%	35%
	30 to 44	35%	33%
	45 to 59	27%	26%

	60+	11%	7%
	Mean	39.9	38
Gender	Female	59%	69%
	Male	42%	31%
Degree of Urbanisation	Rural	67%	60%
	Urban	33%	40%

6.3 Final Sample Size

The following table illustrates the number of Household Composition Forms and Participant Surveys completed in each site. A total of 366 Household Composition Forms and 611 Participant Surveys were completed for this study.

Table 4: Number of Household Composition Forms and Participant Surveys completed per site

Household Survey Final number of participants surveyed			
Type of group	**Site**	**Completion of Household Composition Form**	**Participation in the survey**
Comparison Community 3	Moletjie	70	120
Treatment Community 3	Tzaneen	50	99
Comparison Community 2	Matsulu B	59	101
Treatment Community 2	Tonga	52	91
Comparison Community 1	Matsulu A	61	99
Treatment Community 1	Driekoppies	74	101

7 Findings

The findings are considered in light of the evaluation questions posed for this study. Quantitative and qualitative findings, as well as experiences in the field, were triangulated to respond to each question. This section provides a discussion in response to each of the evaluation questions.

7.1 Programme Effectiveness from Programme Records and Previous Evaluations

In 2010 the HSRC conducted an evaluation of the Humana TCE in a single matched community pair, one treatment and the other a control. A survey of a representative sample of respondents from each community provided the primary data set for analysis. The headline findings included:

- 93.8% of treatment community respondents said the programme had increased resolve to get tested
- 94.2% of treatment community respondents said Humana TCE helped them take control of the epidemic
- 90.2% of treatment community respondents said it had impacted their sexual behaviour and practices

While these results represent self-reported change in attitudes, and only imply a change in behaviour, a key measure of behaviour in the evaluation did demonstrate a significant difference across treatment and control communities. A significantly larger proportion of the treatment community respondents (62.3%) reported actually being tested, compared with respondents in the control area (55%).

If these impacts are indicative of the effectiveness of Humana TCE across communities they should be replicated to some extent in the current evaluation. Implementation records from the sites included in this evaluation suggest that, at least as far as reach is concerned, Humana TCE is positioned to realise similar effects. Table 4: Number of Household Composition Forms and Participant Surveys completed per site, shows the numbers reached through the TCE programme in the communities included in the sample for this evaluation. Of particular interest are the numbers visited and registered, the indicators of progress through the TCE programme, and specific health seeking behaviours monitored.

The numbers of people visited and registered for the TCE programme are noteworthy. When compared to the number of visits recorded it is apparent that programme participants are being visited multiple times, an approximate mean of 3 visits per programme participant, though the actual distribution of visits per individual cannot be determned from the summary. A review of progress through the programme milestones however provides some interesting insights: over 70% of people registered on the programme prepare an indvidual PES plan, over 65% become TCE compliant, and approximately 6% are recorded as being active as passionates. In addition field officers succeed in directly facilitating access to testing and PMTCT services.

These initial figures from routine programme data demonstrate strong reach and promise significant outcomes. The evaluation performs as an indirect verification of the reach data to some extent, and tests the expectations of effect that they reflect.

Table 5: TCE benchmarks and achievements per implementation site (provided by Humana People to People).

		Driekoppies		Tonga		Tzaneen	
NO	12 main figures of TCE	CAMPAIGN GOALS TO DATE	TOTAL ACHIEVED	CAMPAIGN GOALS TO DATE	TOTAL ACHIEVED	CAMPAIGN GOALS TO DATE	TOTAL ACHIEVED
1	Visited and registered 1. time	102,000	103,053	100,000	101,419	100,000	105,543
2	Total number of visits	306,000	321,271	300,000	361,400	300,000	361,825
3	Mobilized for HIV Testing	20,400	22,708	20,000	20,175	20,000	18,537
4	Active as TCE Passionates	5,100	7,634	5,000	6,578	5,000	11,299
5	Made an individual PES plan	71,400	83,983	70,000	88,250	70,000	72,754
6	TCE Compliance	66,300	78,374	65,000	72,798	65,000	67,744
7	Lessons given	6,732	7,586	6,600	7295	6,450	11,848
8	People in lessons	102,000	99,921	100,000	93,689	97,750	164,381
9	Condoms distributed	4,080,000	5,393,909	4,000,000	4,712,842	4,060,000	6,081,280
10	Pregnant mothers mobilized for PMTCT	5,100	4,817	5,000	4,779	4,910	3,749
11	Households registered	18,360	19,837	18,000	18,160	18,000	24,134
12	Registered in non-HH register	0	80	0	53	0	222
13	Mothers enrolled for PMTCT	0	506	0	374	0	311

7.2 Changes in Knowledge, Attitudes and Behaviour

How effective was the programme in bringing about attitude, knowledge and behaviour change for reducing risk to HIV infections among targeted populations?

7.2.1 Knowledge

Household survey results indicated that while individuals in the treatment group remain vulnerable to myths concerning transmission – such as contracting the virus through witchcraft or the sharing of utensils – the conclusive finding is that there is a significant difference in knowledge favouring the treatment group. Members of treatment communities are better informed concerning true vectors of transmission, as well as the availability of clinical and other HIV and AIDS related services. The finding suggests a greater depth of knowledge regarding HIV and AIDS related matters in the treatment communities, as opposed to the comparison communities. The key results on knowledge, with statistical significance, are presented in Table 6.

There is no statistically discernible difference in knowledge regarding condom use between treatment and comparison communities. Total proportions reporting appropriate condom use across both treatment and comparison communities are high. This represents a positive finding in that knowledge about the benefits and appropriate use of condoms is ubiquitous.

An increase in knowledge in treatment communities is consistently confirmed in the qualitative data, emerging as a persistent theme, specifically amongst traditional healers and youth. While it is tenuous to attribute increase in knowledge on transmission vectors to Humana TCE - simply because those messages are now commonly heard across multiple sources – it is plausible to posit that knowledge on clinical and treatment issues is attributable to Humana TCE.

Table 6: Key differences in knowledge between treatment and comparison groups

Knowledge Item	Response	Mean	
		Treatment	Comparison
Transmission through sharing of utensils	YES	36%	14%
Transmission through witchcraft	YES	14%	6%
Transmission during delivery	YES	84%	65%
Transmission during breast feeding	YES	87%	77%
Drugs help HIV infected people live longer	YES	84%	71%
The individual has heard of VCT service	YES	89%	50%

Table 7: Knowledge regarding condom use

Knowledge Item	Response	Mean	
		Treatment	Comparison
OK to reuse condoms after washing	YES	5%	3.1%
	NO	95%	96.9%
Condoms protect against STDs	YES	95.5%	96.1%
	NO	4.5%	3.9%
Condoms contain HIV	YES	3.3%	5.8%
	NO	96.7%	94.2%
Its embarrassing to buy condoms	YES	8.6%	4.8%
	NO	91.4%	95.2%

The rationale for this conclusion is the following: survey results demonstrate that while comparison groups focussed on the importance of condom use and abstinence, treatment groups were far more likely to say the main messages were to get tested for HIV, avoid sex with multiple partners and those who inject drugs intravenously, to not discriminate against others with AIDS and that there are anti-retroviral drugs available that extend the life expectancy of those living with HIV. Emphasis on this breadth of knowledge is not as common as an emphasis on basic knowledge about transmission and condom use, and Humana TCE is the foremost source of knowledge on HIV and AIDS in treatment communities (40% of treatment group respondents attribute knowledge gained to Humana, with the next highest attribution given to radio, with 21% of responses). In addition interviewees and focus group respondents from treatment communities expressed uncommon knowledge themes, supporting the plausibility of such a conclusion.

Breadth of knowledge

"The treatment boosts the immune system" (Youth)

"We are now able to differentiate between TB and the traditional illness" (Traditional Healers)

7.2.2 Sexual Behaviour

The household survey revealed no statistically significant differences in reported sexual behaviour between treatment and control groups. However raw means on condom use do favour the treatment communities. The substantial difference in having younger partners is explained to some extent by the fact that comparison groups have more male respondents, even after weighting. Both groups were equally likely to engage in unprotected sex, have multiple sexual partners, have inter-generational sexual relations, pay for sex and have sex while intoxicated. However there is a significant difference between the responses of treatment and comparison groups when asked whether only the partner was intoxcated at last sexual encounter. The result favouring the comparison community may be partly attributable to the influence of TCE, but must be qualified by the observation that the comparison groups has more males in it, even after weighting. It is conceivable that the indicator reflects the power differential in sexual relationships, and that women might be compelled to meet the sexual demands of male partners.

Table 8: Comparing sexual behaviour across treatment and comparison groups

Behaviour	Treatment	Comparison
Used a condom at last sexual encounter	59%	58%
Always use a condom during sex	56%	49%
Limit sex to one partner	59%	60%
Have a partner who is more than 10 years younger	2%	10%

Behaviour	Treatment	Comparison
Have sexual partner who is more than 10 years older	18%	19%
Have paid for sex in the past	3%	4%
Drunk at last sexual encounter	22%	23%
Only partner drunk at last sexual encounter	27%	12%

For the most part focus groups and interviews reflected these patterns of sexual behaviour. Of interest however is that male focus groups claimed a general increase in condom use, which they attribute to the Humana TCE programme. This evidence may corroborate the finding implied by the raw means score from the household survey, however the difference in means does not pass tests for statistical significance.

Increased condom use

"People are using more condoms then they did before" (Male focus group)

"There has been an increase in the correct use of condoms" (Male focus group)

Although not measured through the participant survey, reduced pregnancy in schools was highlighted across youth focus groups and teachers interviewed in all treatment sites. At best this result in the qualitative data suggests an hypothesis that requires further testing and corroboration from additional evidence.

7.2.3 Improvements in Health and Help Seeking Behaviour

Did the programme result in a significant impact in the uptake of HIV services by the targeted populations?

Although no significant difference was observed in sexual behaviour between treatment and comparison groups, there was a distinct and significant difference in testing behaviour (see Table 9: Testing behaviour). Two thirds of treatment group respondents claim to know their HIV status and moreover attribute this to the Humana TCE programme. There were also significant differences in the sharing of testing information between partners, with treatment groups far more likely to demonstrate the sharing of statuses, primarily reporting that respondents themselves shared their status, but also that respondents partners' shared their status. This latter result is exceptionally noteworthy, considering the very poor results in respondent's partners sharing their status in the comparison group. It is also reasonable to attribute this result to Humana TCE.

It possibly indicates the tacit influence of the programme at community level, but more likely the sensitisation of respondents to the necessity of, as well as their right to, obtaining that information from partners, and acting based on that knowledge. However this result and its interpretation would require a qualification – data on the extent to which VCT was undertaken as partners. Unfortunately this data was not collected in the household survey.

The qualitative data support the finding that there is a significant increase in testing for HIV by treatment groups, as well as in the uptake of PMTCT services, and accessing other services such as psychosocial and material support (see Table 10: Health and help seeking behaviours). Qualitative findings support the significant differences found in quantitative findings in terms of the uptake of HIV services by the targeted communities. Focus groups referred specifically to the 'increased referral to clinics for HCT in general and to the increase in PMTCT. These two themes were highlighted across all treatment sites.

Moreover treatment group members are far more likely to access other areas of social support than members of comparison groups. This is in part directly attributable to Humana TCE and their provision of services, and TCE referral of clients to other service providers. It is not possible to distinguish to what extent an increase in health seeking behaviour has prompted an increase in help seeking behaviour more generally, but this too seems a plausible hypothesis, ripe for testing.

Table 9: Testing behaviour

Behaviour	Treatment	Comparison
Know if last sexual partner was tested	49%	17%
Last sexual partner disclosed test results	19%	0%
Told partner you were tested	75%	16%
Never been tested	12%	22%

HCT Testing

"We normally invite TCE to come and test them before their graduation (from training to be a traditional healer)" (Traditional healers).

Increase in PMTCT

"Children are safe from HIV because of PMTCT" (Female Focus group)

"More woman at child bearing age test for HIV as they are encouraged to test through PMTCT" (Male focus group)

"People who are pregnant are testing for HIV" (Female Focus group)

In addition the qualitative findings reflect the claim in the treatment communities that there is an increase in the use of ARTs. While the household survey did not collect data on ART adherence, the body of evidence as a whole would tend to support the plausibility of increased ART use and improved adherence, because it demonstrates as significant difference between treatment and comparison communities on health seeking behaviours the programme focuses on. However, the qualitative data also reflects a persistent deficit in some health seeking behaviours, including adherence.

Increased use of ART

"Some of the facilities even run short of the ARVs due to the increased uptake" (Male focus group)

"TCE was effective - a lot of patients have come in for testing" (Clinic)

"The clinic is calling us more so we know more children are going for testing" (School teachers)

"The key change is children and adults coming to be tested" (Local Aids Council)

"More people are testing for HIV now than they did three years ago" (Male Focus group)

Table 10: Health and help seeking behaviours

Behaviour	Treatment	Comparison
Received medical support	57%	50%
Received VCT	82%	42%
Received PMTCT	28%	15%
Received material support	10%	3%
Received psychosocial support	34%	24%
Community has access to support services	72%	53%

7.2.4 Persistent Deficits in Sexually Responsible and Health Seeking Behaviour

The positive findings on health seeking behaviours moderates the impression given in the focus group and interview data that health seeking behaviour is low. What the qualitative data does indicate is that despite progress in treatment communities a deficit in health seeking behaviour persists and that community members are keenly aware of such behaviour.

Lack of health seeking and sexually responsible behaviour emerged in four themes: non-disclosure and disregard for others, late uptake of treatment, a tendency to test when already ill, and reluctance to adhere to treatment. Rather than invalidating the positive findings of the household survey, these data suggest a generalised sensitisation to health seeking behaviour and an accompanying inclination to note when there is a deficit in this regard amongst fellow community members.

Data on adherence was not collected in the household survey and the effectiveness of TCE activities to ensure adherence could not be convincingly assessed. Therefore the import of the qualitative data on adherence is not clear. What is apparent from the limited evidence is that adherence continues to be perceived as a concern in treatment communities - as it is generally in HIV and AIDS programming - and as such offers an endorsement of TCE activities that attempt to address the lack of adherence prevalent in treatment communities.

Lack of adherence to treatment

"There are community members who still feel uncomfortable about taking treatment" (Male focus group)

Similarly the emphasis of TCE on individuals knowing their status and assuming personal responsibility for their sexual behaviour is legitimised by the characterisation of irresponsible sexual behaviour by focus group participants and interviewees as wilful non-disclosure and negligent disregard for the well-being of others.

Irresponsible sexual behaviour

"HIV positive people... Adopt an attitude that says that they are not going to die alone...The king does not die alone, but dies together with his soldiers" (Female focus group)

"Those who are already infected tend not to disclose to their partners and the community" (Female Focus group)

While responses on adherence and sexual behaviour confirm what is already known and validate current programmematic strategies, something new might be learned from the data on belated testing and treatment. Themes concerning late testing and late uptake in treatment co-occur with a concern for maintaining confidentiality and explain these behaviours to some extent. They are therefore both an endorsement of TCE activities, as well as suggestive of how programme outcomes might be improved.

Late uptake of treatment

"Some people ... Only start taking it (treatment) when it is too late" (Male focus group)

"The majority of people only test when they are very sick" (Male focus group)

Reluctance to test and seek treatment is mitigated in circumstances where confidentiality is assured. Thus a preference for mobile clinics was expressed when discussing testing and treatment, because confidentiality is more likely to be preserved when community members are not being served by a clinic staffed with neighbours, acquaintances and relations.

Maintaining confidentiality

"It was easier to test at the tent than the clinic... Confidentiality was maintained" (Female focus group)

"If mobile clinics come to the community people get tested" (Caregivers)

"Ninety nine percent of people now go and get tested when the mobile clinic comes (Caregivers)

Contrastingly, reluctance to test and seek treatment is exacerbated in circumstances where confidentiality is undermined. Two such circumstances were identified by focus group participants and interviewees. Firstly, respondents suggested that clinic staff and nurses specifically are not maintaining confidentiality. In fact high levels of distrust of nurses was frequently expressed. Secondly, the layout at clinics and the processing of patients for testing is perceived by community members to encourage stigmatisation and discrimination.

Clinic layout and patient processing

"The division at the clinics with the section for HIV/AIDS ... makes people uncomfortable about collecting their treatment" (Female Focus group)

“The position where condoms are placed in the clinics (often at the back) discourages youth to go since they will be seen” (Youth)

Having community members test and go to a specific door afterwards for counselling should they be HIV positive, also discourages them from going for being tested. “When they test positive, they have to go to the other room and if negative they walk out of the back door” (Clinic)

7.2.5 Attitudes

In addition to investigating attitudes towards PLWHA (see) and attitudes towards sexual responsibility and health seeking behaviours, the evaluation considered additional attitudes that the literature indicates may be predictive of sexual behaviour.

The household survey measured attitudes in 4 categories: 1) attitudes towards sexual license for men, 2) attitudes towards promiscuous or sexually risky behaviour, attitudes towards the role of women in sexual relationships including 3) expectations of a traditional conservatism versus equality for women, and 4) attitudes towards the burden for sexual responsibility being placed on women. The only significantly measureable difference in attitudes in these domains between treatment and comparison groups is a higher likelihood that treatment group members would grant sexual license to men. The result is perhaps explained by the fact that without weighting the treatment group is predominantly female and more rural, suggesting the possibility of a more traditional inclination towards gender roles. While not producing particularly useful results when testing for a difference in means, the attitudinal scale did offer some interesting insights when employed in a regression analysis of predictors of behaviour (see 7.2.6).

7.2.6 Cumulative Personal Change

A multiple regression analysis was run between overall behaviour (sexually responsible and health health seeking) as the dependent variable on the one hand, and independent factors including including knowledge, attitudes as described in the preceding section, propensity for exposure to the exposure to the programme, expressed on a level of support scale. Statistical details of the model are model are represented in Table 11: Levels of support received, and

Figure 5: Statistical regression model of predictors of changed behaviour. While the r squared is low, due to limited variance in the behavioural metric (specifically the component on sexually responsible behaviour), the results are nevertheless valid and useful.

The regression model indicates that an attitude that insists on women assuming a traditionally conservative role impacts negatively on responsible sexual and health seeking behaviours. This may reflect a power disparity in sexual relations that grants men license to act out high risk sexual behaviours while denying women in relationship with such men the right to seek testing, treatment or insist on disclosure of partner's status. The power disparity also curtails the potential for indirect effects that a programme such as TCE might exert on non-participants. With participation of women generally higher than men (despite additional effort at recruiting male participants) female participants act as the link between programme and non-participating male members of the household. The effectiveness of women in influencing their male household members is likely dependent on the extent to which their status is non-traditional (in a culturally patriarchal system).

This finding is further corroborated by the more interesting findings on the predictive power of certain attitudes. Attitudes reflecting an inclination to accept a shared burden of responsibility for appropriate sexual behaviour across genders, and a regard for gender equality, both positively impacted behaviour. This result triangulates with the finding on the first factor, and accentuates the importance of redressing power disparities in sexual relations. It would appear that empowering women through TCE is likely to result in improved performance of the programme on measures of behaviour change.

The level of exposure to TCE however is a strong predictor of positive behaviour. This is a self-evident finding: TCE holds beneficiaries accountable for engaging in health seeking behaviours. Based on the results of difference in means testing reported earlier it is unlikely that exposure to TCE predicts any significant improvements in sexually responsible behaviour however, other than potentially more consistency in the appropriate use of condoms.

Table 11: Levels of support received

				Support_level		
				None	One to three	Four and above
				Count	Count	Count
Comparison	Comparison	Area_2	Capricorn	135	117	
			Matsulu A	36	68	42
			Matsulu B	31	113	30
	Treatment	Area_2	Driekoppies	1	49	33
			Tonga	16	26	44
			Tzaneen		79	42

Figure 5: Statistical regression model of predictors of changed behaviour

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.231[a]	.053	.044	1.19464

a. Predictors: (Constant), Knowledge, License, Promiscuity, Genders equal yet perceived differently, Women's traditional role, Girl's burden, Support_level

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	54.137	7	7.734	5.419	.000[b]
	Residual	960.335	673	1.427		
	Total	1014.472	680			

a. Dependent Variable: Behaviour_consolidated

b. Predictors: (Constant), Knowledge, License, Promiscuity, Genders equal yet perceived differently, Women's traditional role, Girl's burden, Support_level

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.268	.232		1.157	.248
	License	.013	.051	.009	.246	.806
	Promiscuity	-.008	.045	-.007	-.173	.863
	Women's traditional role	-.184	.046	-.152	-3.984	.000
	Genders equal yet perceived differently	.076	.045	.064	1.697	.090
	Girl's burden	.097	.045	.082	2.163	.031
	Support_level	.082	.029	.113	2.887	.004
	Knowledge	.084	.043	.075	1.969	.049

a. Dependent Variable: Behaviour_consolidated

7.3 Additional Beneficial Outcomes of the TCE Programme

Did the TCE programme contribute to any additional beneficial outcomes and social change?

Additional beneficial outcomes identified from the TCE programme include: (1) increased collaboration amongst stakeholders, (2) support provided to HIV negative as well as HIV positive community members, (3) being visible, present and available when needed by the community, (4) being a trustworthy source as a platform for sharing in confidence, and (5) how the Field Officers interacted in the community. These themes are further described below.

7.3.1 Improved Collaboration Amongst Stakeholders

Qualitative data recognised the positive role Humana assumes in communities through TCE in facilitating collaboration between key groups, such as clinic staff and the Local Aids Council. Examples of collaboration cited include Humana's facilitation of large community campaigns that would include multiple organisations in a concerted information sharing and treatmet delivery effort. For instance community campaigns were arranged where stalls were erected by various organisations and service providers at a community site, information was disseminated, HCT promoted, and counselling provided. Examples were also given of TCE staff referring programme participants to complementary services. In this and other ways, the TCE programme is seen as playing a role in strengthening collaboration amongst community stakeholders. A local Aids Council member stated,

> *"Through them [TCE] the relationship has been built between us and the other stakeholders"*

7.3.2 A Visible, Reliable, and Accessible Social Resource

Participants in all communities mentioned that the red t-shirts allowed the community members to easily identify the presence of the Field Officers. The visibility and presence of TCE Field Officers suggested that they were available to support community members. The following two quotes suggest the importance of the red t-shirt and visible presence.

Accessible social resource

"The presence of TCE has provided significant changes in the community" (Female focus group)

"It is the people in the community with the red t-shirts that helped us and gave us information" (youth)

"I cannot trust the teacher, I only trust the people with the red t-shirts" (Youth)

"People prefer us (to the nurses) - it's a trust aspect" (Field Officers)

Participants, mainly the youth, indicated their trust in TCE Field Officers. The first quote also identifies the importance of the red t-shirts, as this is how the youth identifies the TCE Field Officer. The second quote demonstrates a common understanding of the Field Officers, who often reported that community members, including the youth, tended to trust the Field Officer more than the clinic nurses.

Participants described the positive experience they had when dealing with Field Officers. Most participants mentioned the compassion, passion, and respect that they had for the community members and for their work.

Passionate involvement

"The job they [Field Officers] are doing is in their veins, they love the job" (Youth)

"They were so passionate as if they were real nurses ... All of them treated us with respect" (Clinic staff)

Focus group participants in particular emphasised the role that TCE Field Officers played in providing emotional and other support, particularly to both positive and negative youth, as well as care and support for PLWHA. The following quotes illustrate the type of support that was considered invaluable to many community members:

Emotional support and advice

"Even if you are in a huge problem, they [TCE] are there to advise us" (Youth)

"I sometimes have family issues at home but she [Field Officer] was there to support me" (Youth)

Care and support for PLWHA

"[TCE] provided care to those who are bed ridden" (Female focus group)

"They [TCE] helped those who needed to be assisted like cleaning for them, bathing them and changing them" (Male focus group)

The dynamics of stigma continue to exercise a negative influence on programme implementation, and this is reflected in some focus group observations concerning Field Officer's support to especially PLWHA. Because the TCE programme provided so much care and support to PLWHA some participants tended to avoid Field Officers for fear of community members assuming they were HIV positive, and as a result finiding themeselves stigmatised.

7.4 Social Change Aspects of the TCE Programme

The introduction chapter illustrated that some of the anticipated outcomes of the TCE programme included the desire for community members to no longer discriminate against PLWHA and for the capacity of local leaders to be built regarding HIV and AIDS prevention, care and support and stigma reduction. Findings are presented in regard to these intended social changes.

7.4.1 Discrimination and Stigma Reduction

Initially the household survey data appears to indicate that treatment communities are more likely to be prejudicial towards PLWHA. However a closer review of the scale in the light of programmatic emphases in Humana TCE suggests other interpretations. The programme emphasises assuming personal responsibility for behaviour and the right to keep your status confidential. Seen in this light the results suggest that discrimination against PLWHA is low in both treatment and comparison communities. However a firm conclusion on these results cannot be convincingly posited, due to the unexpected inappropriateness of the scale in the programme context.

Qualitative findings show that there were mixed perceptions amongst participants in all sites when it came to discrimination – some participants reported it as present and others said that it had decreased. The following quotes represent the perception of discrimination being present in treatment communities.

Discrimination is still rife:

"There is still a problem of discrimination and stigmatization" (Female focus group).

"There is still high stigma around HIV/AIDS" (Male focus group)

"They (the clinic) don't allow us to get condoms because we are young" (Youth)

Fear of discrimination:

"If someone has an HIV test and comes back knowing he/she is HIV positive, they don't know how their family will view them" (Youth)

Fear of disclosure:

"Youth are scared to go there (clinics) if they have STIs and private things because these people (nurses) really talk" (Youth)

"Nurses communicate with each other if someone has HIV/AIDS" (64) "nurses disclose and don't keep their confidentiality" (Youth)

Other qualitative data indicated that discrimination had been reduced as a direct result of the TCE programme and increased disclosure across the treatment sites.

Reduced discrimination

"TCE changes one's attitude" (School teachers)

"TCE has made people to love their neighbours and that this (HIV) can happen to anyone in the community" (Male focus group)

"Because of the knowledge they [community members] get from the clinic and those doing door to door so that is why it [discrimination] has reduced" (Traditional healers)

"Family members are accepting their sick members" (Female focus group)

Increased disclosure

"There are more people who are comfortable disclosing their HIV status" (Male focus group)

"When TCE was there people were no longer hiding" (Traditional healers)

7.4.2 Building the Capacity of Local Leadership

In its deliberate focus on building the capacity of local leaders to support prevention efforts and the effective response of communities to the epidemic more generally, TCE appears to have an emphatically positive influence of the role of traditional healers.

Qualitative findings clearly identify Traditional Healers as local leaders who have increased their knowledge and changed their behaviours as an outcome of the TCE programme. Traditional Healers across all treatment sites indicated having learned from the TCE programme, as noted by one Traditional Healer, "We are now able to differentiate between TB and the traditional illness" (Tonga and Driekoppies Traditional Healer). The main social changes include Traditional Healers' requirement of clients to get tested before treating them. A measure of effect in this regard should be included in the household survey for future evaluations of TCE.

Traditional healers mobilised

"Every client who visits us has to be tested" (Traditional Healer)

"We mobilize the client for HCT before treated" (Traditional Healer)

7.4.3 Addressing Gender Based Disparities

The qualitative data supports the possible interpretation of household survey data that females are more inclined to engage in health seeking behaviours. Male focus groups identified that males were more reluctant than females to be tested for HIV. The following two quotes illustrate this finding

> *"The fear of testing and knowing ones status makes men vulnerable - this is driven by a fear of HIV" (Male focus group)*
>
> *"Men are generally resistant to test for HIV" (Male focus group)*

Some qualitative data suggested that males, once identified as HIV positive, are also more resistant to taking treatment. As one female interviewee noted,

> *"There are generally fewer men who collect treatment from the clinics than woman." (Female focus group)*

These qualitative findings are supported by the nature of the research samples. The treatment group is over-represented by females, suggesting that women are more amenable to participation in a prevention programme such as Humana TCE, and by extension to engage in health seeking behaviour.

Data also suggested that women are more vulnerable to stigmatisation than men. Stigmatisation for women was perpetuated by men, as men tended to blame women for getting infected. For example, they blamed women for getting drunk and engaging in unsafe sex.

> *"Woman are weak when under the influence of alcohol and thus get vulnerable" (Male focus group)*

Women are not just rendered vulnerable to stigmatisation by the power disparities in sexual relationships, but it was also indicated that they are at greater risk of infection as a result.

> *"Men control when, where and how sex occurs as they tend to have power and money" (Male focus group)*

Interestingly no responses were volunteered on the extent to which TCE has promoted change in gender disparities. It would be hasty to draw conclusions from this gap in the data, however it should be noted because of the strong correlations between attitudes towards women's pace in society and sexual and jhealth seeking behaviours emerging from the data as a whole. It would also be important to more data deliberately exploring these correlations in future evaluations of Humana.

7.5 Social and Economic Distortions in the Wake of TCE

Did the TCE programme contribute to any unintended consequences detrimental to individuals, groups within communities, or communities?

The most obvious distortions emerging from the qualitative data are associated with local TCE staff, specifically field officers, and these have implications for sustainability of programme effects.

Field Officers interviewed across the sites identified several changes brought about by the end of the programme as being problematic, related specifically to resources and identity.

Discontinuation of the stipend was a highly anxiety provoking change for Field Officers. They now perceive themselves to be abandoned to the 'spiral of poverty', from which they had expereinced temporary relief due to being 'employed' through the TCE programme. As one Field Officer stated what many others reflected upon,

> "We are not happy the time TCE closed... We had jobs and now we don't have jobs"

In addition to stipends FOs benefit from a number of training interventions that equip them for their role in TCE. There is anecdotal evidence that the training and work experience has improved the employment prospects of FOs, and a number have transitioned into related work, in the employ of provincial health departments or halth NGOs. The extent to which this mitigates the effects of their TCE income being discontinued is not clear from this evaluation, and would be better addressed in a subsequent impact assessment of the TCE programme.

Field Officers also expressed feeling ill equipped to continue with their work as Passionates. Resources for conducting their work have been removed. Specifically, the structures that were institutionalised to drive the outreach were dissolved post-implementation. Besides the stipends being provided to Field Officers during the three-year programme being eliminated, Field Officers access to condoms, pamphlets and support (such as regular meetings between Field Officers, Troop Commanders and Division Commanders to share experiences and provide numbers reached) that is needed to continue driving activities is no longer available.

An important theme emerging from the focus group discussions in this regard is that Field Officers had felt empowered by their very visible identity as TCE staff. The removal of the emblem of identity – their red t-shirts – left them feeling, at least in the immediate wake of programme exit, disempowered.

While there may be additional, wider distortions associated with the implementation and the exit of programme with such a broad reach in a community, these did not emerge from the data specifically. It may be worth including a more deliberate attempt to explore such potential distortions in future TCE evaluations.

7.6 The Influence of the Implementation Context

What contextual factors enabled or constrained programme implementation and the achievement of intended outcomes?

Focus group participants were asked about what places individuals in their community at risk of getting HIV. Alcohol, culture, poverty, informal prostitution and unprotected sex were all highlighted by participants as factors placing individuals in the community at risk of HIV/Aids.

Alcohol was highlighted as the major risk factor, followed by culture, poverty and then informal prostitution. Having unprotected sex was not mentioned as often by those interviewed, but is often associated with informal prostitution and poverty as well as alcohol. The following paragraphs elaborates further on the prevalent themes.

7.6.1 Alcohol

Participants across treatment sites and amongst most stakeholder groups highlighted alcohol as a theme. Participants indicated that alcohol leads to informal prostitution because young girls go to the taverns or shebeens without money and men offer to buy them drinks, expecting sex in return. This was analysed from a gender perspective above (e.g. blaming women) however these quotes also illustrate the role of alcohol in spreading HIV.

> “There are mis-perceptions that if a person buys another a drink, they can have sex with them” (police officer?)

> "They like going to the tavern and when they arrive they don’t have any money and a guy offers some of them a drink - I take his offer and when I am drunk he takes me to have sex without playing it safe" (Youth)

Alcohol is further related to unprotected sex due to the effect of alcohol on behaviour. Qualitative data suggest that people become negligent when intoxicated and fail to use a condom.

7.6.2 Poverty

Focus group participants highlighted poverty as being a key risk factor in that it leads to informal prostitution as a means of income. Some data also suggested that there is a financial benefit associated with having unprotected sex when taking part in informal prostitution. It appears that women ‘woman are paid more for sex when they don’t use condoms. Poverty also results in men having to leave their wives to go and work far from home resulting in men acquiring sexual partners in their area of work and as is known, having more than one sexual partner places individuals at a higher risk of contracting HIV/AIDS.

7.6.3 Cultural Practices

Certain cultural practices are a risk factor relating to HIV and AIDS. Various myths and practices were mentioned by participants. A few examples of how culture was used to explain the spread and fear of HIV and AIDS are provide below.

> "Some of the issues that makes HIV to spread is ... Traditions and culture" (Traditional healer)
>
> "Some people conduct ancestral rituals for people who are HIV positive or have AIDS instead of taking them to the doctors, clinics or hospitals" (Female Focus group)
>
> "Some still consult traditional healers together with the treatment and thus do not take the treatment correctly" (Female focus group)

7.7 Sustainability

The evaluation was not positioned to collect sufficient evidence to make a pronouncement on the sustainability of Humana TCE outcomes. An impact evaluation conducted in communities in which Humana TCE had been implemented a number of years previously would be required to posit credible findings on sustainability. The evaluation could collect evidence concerning the mechanisms integrated into the programme design in order to ensure sustainability, as well as the identifiable risks to sustainability inherent in the programme design and implementation context.

7.7.1 Mechanisms for Ensuring Sustainability

TCE adopts an explicit exit strategy for each of its 'actions' in order to ensure a smooth transition for communities to a post TCE condition. In addition the programme has a number of mechanisms embedded in its design to ensure sustainability. The most prominent is the mandating of community members known as 'passionates' to continue with prevention activism once TCE has exited from the community. The programme takes care to equip community leaders with the capacity to provide prevention related care and support, and attempts to build a referral network during implementation that connects various social service providers to coordinate a community rooted response to the epidemic and other social needs. There are even efforts made to transition local Humana TCE staff into government employ locally.

Importantly it should be noted that TCE's theory of change is based on a set of assumptions that should result in a tipping point at which an entire community is not only sensitised but converted to the cause, with a concomitant change in the balance of individual behaviour that will stay and ultimately reverse prevalence. Change, under these circumstances, should theoretically proceed driven by its own momentum.

Participants across treatment sites indicated a perceived sustainability of TCE, as quoted, "They are still following what they have learnt" (Caregivers, Traditional Healers). However, measuring sustainability goes beyond perceptions.

7.7.2 Risks to Sustainability

The primary risks to sustainability are inherent in the elimination of the proven mechanisms driving change, among which are the material incentives for action and the sense of identity empowering TCE field workers with tacit intrinsic motivation.

There is insufficient evidence to state that there are no more effects after the TCE programme has left a community. However, it can be stated that the evidence from focus groups and interviews suggests that the community has no confidence in their ability to continue a programme of prevention efforts after TCE has exited.

Passionates who were Field Officers during TCE implementation were intrinsically motivated through their identity as TCE agents. The removal of **their red t-shirts** permanently is emblematic of the relinquishing of that identity, and they express a sense of disempowered and inability to continue with post-programme efforts.

In addition community members attribute authority and credibility to the institutionally endorsed identity of TCE agents. As soon as the programme completes the three years, the community's faith in the capacity of individuals to institute mechanisms to perpetuate or sustain change is undermined. The removal of red t-shirts was again invoked by respondents as symbolic of the removal of identity, mandate and credibility to continue in their role as leaders of prevention efforts in their communities.

It is apparent from the qualitative data that in the absence of formal, institutional mechanisms treatment communities do not consider themselves equipped post TCE to institute their own mechanisms. In focus groups, participants highlighted that TCE provided indispensable resources for the work of prevention. Participants wanted to have TCE back in their communities and to have permanent structures to provide the support and resources required to ensure sustainability. As quoted:

Provision of resources with presence of TCE

"TCE provided them (learners) with resources (condoms, pamphlets)..." (School teacher)

"They (TCE) were working hard ... Supplying us with condoms" (Road and Transport worker)

Permanent TCE structures

"If only we could have fixed people for a fixed clinic as permanent" (Clinic)

"In each community build something that is TCE" (school teachers)

Loss of support and resources

"We will not manage to do that extended job that they have been doing" (Traditional healers)

"We don't have resources like testing kits" (NGO)

7.8 Assessing the Validity of the Theory of Change

Was the Theory of Change informing the TCE programme adequate for the realising of programme outcomes in the programme context? What was the level of programme fidelity in implementation? Were deviations from planning responsive to context or a result of inadequate implementation?

To fully respond to this question, this section re-visits the key assumptions informing the TCE programme design, and presents evidence on their validity. It then reports on key implementation challenges that would undermine the testing of the theory of change and therefore any conclusions on its validity.

7.8.1 The Evidence for the Assumptions

A Mechanism to Change Behaviour: The main objective of the TCE programme as described by Humana is "*to get every person in every field and area in control of the HIV/AIDS epidemic*". Taking control of HIV and AIDS is dependent on having suficient knowledge concerning the epidemic, and taking personal responsibility for sexual and health seeking behaviours. The emphasis on personal responsibility is one of the two primary assumptions of efficacy informing programme design. Humana TCE is distinctive in that it introduces a specific mechanism to implement behaviour change through personal responsibility – the PES plan, the scorecard monitoring the implementation of the personal plan, and the milestone of TCE compliance.

The behaviour monitoring mechanisms are a significant programming innovation and its effectiveness is partially vindicated by evaluation results – members of treatment communities are far more likely to have engaged in the health seeking behaviours specified as milestones in the scorecard – testing and counseling specifically. Unfortunately, and this is not a challenge unique to TCE but a common finding across prevention interventions, even the behaviour monitoring innovations introduced through TCE have no measureable effect on changing sexual behaviour.

A Mechanism for Sustaining Change: The second primary assumption informing programme design is that by reaching an entire community within a short period of time a tipping point can be reached that shifts the shared consensus on what is acceptable behaviour. In this way changes in sexual ad health seeking behaviours can be sustained independent of an exteral intervention. As discussed in the section on sustainability (see section 7.7), the TCE theory of change and programme design implements multile mechanisms to ensure the sustainability of programme effects. Together with ubiquitous it is reasonable to assume that everything possible has beend done to support the sustainability of results. This assumption remains untested because TCE has yet to be sujected to a proper impact evaluation.

The conclusion then is that the emerging evidence endorses the TOC in part, but it needs strengthening on terms of changing sexual behaviour, and it requires testing in terms of sustainability.

7.8.2 Risks to Perceptions of Implementation Fidelity

The programme objective of reaching every person in a community is enabled by a systematic clustering approach that is a innovative feature of the programme design. The result is that programme performance in terms of reach is very compelling. However the experience of the evaluation field team suggests that reach was not ubiquitous. Households were repeatedly encountered that claimed not to have been visited and individuals were not reached through the door-to-door campaigns (there were many who were visited by the fieldwork team but were not exposed to TCE). A possible interpretation in this regard is that in implementation TCE assumes a strong home-based care focus – the field work team suggests that Field Officers would visit households in an area repeatedly with many surrounding households that may have needed intervention not being visited. It is quite likely however that the problem is systems related.

The **household register** is a document for monitoring field officers and **monitoring the programme implementation**. Special Forces reportedly use the household Register to track down the performance and effectiveness of each Field Officer (see section 5.1.4.). However, despite a thorough verification process implemented by Humana, the inconsistent and outdated methods for maintaining the household register meant that not only was independent verification of the household register data impossible without Field Officer support, but there was no way of explaining discrepancies in household register data versus what was encountered in the field. There is also the challenge of neither Field Officers nor Field Commanders being able to point out a particular area (location) in which sampled households are located for the Feedback research team of fieldworkers to visit. This implies flaws in the household location tracking system.

It should be noted that, in an RDQA conducted by FHI 360 where TCE was being implemented, of 22 randomly selected households from the Household Register that were visited, and physically identified by the appropriate Field Officer, all were found to be visited by the Field Officer for the time period queried. While the accuracy of the data in the household register was confirmed in the FHI 360 RDQA, problems with the registry design as well as confidentiality issues were acknowledged and recommendations for addressing these were proposed (echoed in the recommendations of this evaluation). Based on FHI 360 recommendations, Humana has moved forward with piloting the Soweto Care System database which consolidates all data on a household and makes retrieving and verifying household data more timely and reliable.

However, as long as household data cannot be independently used and verified the conclusive testing of the compelling theory of change implicit in the TCE programme design cannot be convincingly tested.

7.9 Reasonably Assessing Contribution

What is the programming landscape with regards to HIV & AIDS in each of the treatment and comparison communities? What was the TCE contribution to the cumulative effect of all programming in the beneficiary communities?

Communities such as those in which Humana TCE is implemented are frequently beneficiaries of numerous interventions. It is critical to build a case for contribution of the specific programme to measured changes that are likely the result of concerted efforts executed by multiple institutions through multiple programmes.

In the household survey respondents were asked to indicate the sources of various types of social services, including health services. Specifically they were requested to indicate which organisations provided them with the service, and which organisation facilitated access to the service. It is overwhelmingly clear that Humana TCE played the dominant role in both providing and facilitating access to the services that resulted in the changes measured during this evaluation. Based on these results it is reasonable to conclude that the programmes contribution to measured effects is substantial.

The household survey results were corroborated by the focus groups and interviews. Focus group participants recognized TCE and did not really know about other organisations that can render anything similar, except for the home-based caregivers. People know more about TCE than any other organization.

Table 12: Humana TCE's contribution to measured effects

Services provided or access facilitated	Source	Treatment	Comparison
Which organisation provided VCT?	TCE	68%	4%
	Clinic	24%	67%
	Other	8%	29%
Which organisation assisted you to access VCT?	TCE	71%	9%
	Clinic	12%	49%
	Other	17%	42%
Which organisation provided PMTCT?	TCE	70%	0%
	Clinic	24%	80%
	Other	6%	20%
Which organisation assisted you to access PMTCT?	TCE	51%	0%
	Clinic	15%	32%
	Other	34%	68%
Which organisation provided you with other	TCE	32%	0%

support services?	Clinic	34%	81%
	Other	34%	29%

The prominence of Humana in target communities is illustrated by the citing of the TCE programme most often when survey respondents were asked about the source of support received. In comparison communities it is the health facility that is cited most frequently, even though the types of support inquired after in the household survey are not restricted to health services.

Not only does there appear to be no organisation with an equivalent prominence in the treatment or control communities, but it is further evident that while Humana does not offer all services or indeed provide them, it acts as an effective mechanism for access, directly and substantially augmenting numbers accessing services. There is ample evidence across all data sets to demonstrate that where the effects discussed were measured Humana's contribution to their magnitude is significant and indispensable. It is apparent from this that Humana is effective.

8 Conclusions

Humana TCE is undoubtedly effective in increasing knowledge about HIV and AIDS, improving attitudes of personal responsibility and significantly improving health seeking behaviours amongst beneficiaries. It achieves these results through a robust theory of change and programme design that relies on innovative behaviour change and monitoring mechanisms and a compelling message of assuming personal responsibility for behaviour, status, one's own health and that of other members in one's community. Despite this apparently comprehensive programme design and strong effects on every other measure, the key objective of changing sexual behaviour however remains elusive.

Perceptions of the effectiveness of Humana TCE are at risk of being undermined by an inconsistent system for registering households reached. This flaw is severe in that, despite robust internal mechanisms for monitoring programme fidelity, and data quality assessments confirming accuracy of household register data, the integrity of programme record keeping and monitoring can be brought into question due to the fact that independent verification, without significant support from programme staff to locate beneficiary househholds for example, is not possible.

While Humana TCE is designed to ensure the sustainability of effects, the removal of the mechanisms of realising effects – including organisational infrastructure, the extrinsic motivation (financial reward) and the intrinsic motivation (the TCE identity) for taking action - poses a potential risk to sustainability. It should be emphasised that the testing of sustainability was beyond the scope of this evaluation and should be considered for inclusion in future evaluation efforts.

While the underlying theory of change appears sound and has proven effective in realising outcomes, the complete test of its validity depends on a comprehensive impact evaluation that adopts as a key objective the assessment of sustainability. This is critical because sustainability of effects is arguably the most prominent promise of this exceptionally effective intervention.

While the evaluation focussed on and arranged findings according to specified evaluation questions, table presents an evaluation scorecard that summarises the evaluation scope and findings from the perspective of stated TCE objectives.

Table 13: Evaluation scorecard against TCE objectives

Humana Objective Evaluated	Performance			Notes
Change in attitude and behaviour of community members and most at risk groups	Attitudes	Health Seeking Behaviour	Sexual Behaviour	The evaluation differentiates between sexual and health seeking behaviour. It does not disaggregate by MARPS.
Community members consistently use HIV prevention services				Treatment communities significantly more likely to access health and other services. VMC and ART adherence not in household

		survey data.
Community members have undertaken HCT and know their HIV status		Treatment community members significantly more likely to have gone for VCT/HCT
Community members avoid risky sexual behaviour and use condoms correctly and consistently;		No significant difference between treatment and comparison communities in this regard.
Community members no longer discriminate against PLWHA		Mixed, inconclusive results
Increase in knowledge around HIV transmission and HIV and AIDS prevention and treatment		Treatment community members test significanty better on knowledge items than comoparison community members.
The capacity of local leaders is built regarding HIV and AIDS prevention, care and support and stigma reduction		Not directly investigated, inconclusive results.
Local leaders have developed facilitation and counselling skills		Not directly investigated, inconclusive results.

9 Recommendations

9.1 Recommendations to Humana

9.1.1 Programme Design

- **Changing sexual behaviour:** TCE demonstrates a challenge common across even successful prevention programmes – very liitle change is shown in sexual behaviour. There is an emerging body of research on what works in programmes, especially youth focussed programmes, that could be used to revisit programme design. The TCE experience with introducing effective behaviour change mechanisms for health seeking behaviour, combined with the emerging body of knowledge on sexual behaviour change, holds promise. Three broad recommendations can be made in this regard:
    - Improving TCE effectiveness with regard to sexual behaviour should incorporate the innovative thinking in terms of accountability mechanisms that already work with health seeking behaviour in TCE.
    - The emerging research shows that different approaches work for different groups. Improving effectiveness on changing sexual behaviour may require a focus on a particular demographic e.g. youth, and on a limited outcome e.g. delaying sexual debut. A tailored component in TCE is somewhat contrary to the broader, all-inclusive, theory of change, but may be necessary to begin making progress on this front.
    - The regression model demonstrates that a set of progressive attitudes towards the role and status of women in the community generally and sexual relationships specifically predicts more responsible behaviours. Including an engendered perspective on education interventions in TCE is therefore recommended.

9.1.2 Programme Implementation

- **Managing household register and beneficiary data**: The entire basis for credible pronouncements on programme fidelity and performance going forward depends on reliable, independently useable, programme records. It is essential that the problems with this data be corrected. Two recommendations are made in this regard:
    - Households need to be registered using a method independent the conflicting methods used by local authorities, and independently verifiable. It is recommended that a GS system be introduced and employed as the basis for the household register at all Humana sites.

  - All existing household register and beneficiary data needs to captured in electronic format on an electronic platform implemented across the entire Humana organisation. A great deal of routine data is collected and can be enrmously useful to monitor and evaluate performance internally, as well as inform independent external evaluations. Unfortunately the lack of uniform platform and the consistent electronic capture of data undermines the utility of the large and potentially invaluable volumes of data. It also significantly increases the effort required to verify the quality of the data, as well as identify and correct the causes of quality deficits consistently and timeously.

- Improving prospects for sustainability: While the evaluation is not in a position to make conclusive pronouncements on sustainability, it may be worth acting on the identified risks to sustainability in the following ways:
  - Address the FOs identity insecurities by introducing emblems to replace their TCE uniforms. This may serve to enhance their confidence in assuming their role as passionates, and the confidence of the community in the fact that sustainable social capital has been built through TCE.
  - Planning more deliberately to ensure the availability of resources for passionates on programme exit. Designate a lcation within a field – the house of a passionate – at which condoms, information producst and support (for HCT, PMTCT and PLWHA) continue to be available. This will require engaging a source for providing these items before programme exit.

9.2 Recommendations to USAID and FHI 360

- Provide funding for equipment and technical assistance to implement and train Humana staff on a GPS based household register.
- Provide funding for equipment and technical assistance to implement and train Humana staff on an organisation wide electronic platform for managing beneficiary data and programme records.
- Provide technical assistance to research and design components for the TCE programme that will support achieving the sec=xual behaviour change objectives of the programme.
- Fund an impact assessment that will provide evidence for a clear pronouncement on the sustainability of the positive programme effects measured in this evaluation.

9.3 Recommendations to the National Department of Health

This evaluation confirms a that a perceived lack of confidentiality is a crucial hinderance to people accessing HIV services. Two recommendations are made to departments of health in this regard:

- **Layout of clinics**: It is worthwhile for the Department of Health to look into the layout of clinics to minimise possible discrimination of community members who go to collect condoms or who go for HCT.

- **Confidentiality**: This was a key finding and a concern across all stakeholder groups in all treatment sites (including youth, adult females and males, traditional healers, local leaders). Interventions to ensure that clinic staff maintain confidentiality of community members – from ethics education to disciplinary action – must be instituted.
- **Outreach HIV services**: Evidence from community members suggests that testing and counseling services delivered through a mobile clinic staffed with personel not from the local community are more likely to be utilised than the local facility. Outreach services should be a key component of all HIV services planning.

ANNEXURE A: Community Selection Protocol

Community Selection Criteria

To ensure equivalence and the integrity of the quasi-experimental design, all the selection criteria in the table following should be met. However it may prove difficult to obtain evidence from an authoritative source to confirm equivalence on all the listed criteria. It may be sufficient to obtain confirmation of equivalence against the listed criteria from a panel of key informants, but some objective evidence is preferred.

To accommodate decision-making in the likely absence of objective evidence the criteria are presented in a hierarchy. The extent to which the meeting of equivalence criteria is essential is a matter of judgement for each evaluation instance where this protocol might be replicated. It is also important to remember that, provided the sample is large enough, statistical solutions can be applied to the sample and the data to compensate for a lack of group equivalence in the research design.

The Limpopo treatment community will be compared with the comparison community in Limpopo. The Mpumalanga treatment communities will be compared with the comparison communities in Mpumalanga. Findings for each provinces will be compared across provinces to determine whether the differences between treatment and comparison communities are similar across both provinces:

Please complete the following table by responding to each of the Level questions:

Level 1 Criteria	Yes/No	Provide reason where applicable	Evidence
1. The selected communities must each be identifiable as a community. It should be possible to geographically delineate each community and there should be some authoritative consensus on their classification as a community. 2. Both communities should be classified similarly with regards to their degree of urbanization. The two communities should be of similar size as measured by number of households. 3. The two communities should be similar in terms of their language, cultural and ethnic diversity or homogeneity. There should be no glaring systematic difference in this regard. 4. The communities should share a similar rate of employment. 5. The communities should share a similar level of income per household.			

Level 2 Criteria	Yes/No	Provide reason where applicable	Evidence
1. There should be no significant differences between communities in the makeup and size of households. 2. The two communities should have a similar level of access to basic services including water and sanitation, electricity supply, refuse removal and disposal, education and any key social welfare services supplied by the state. 3. The nature and state of housing should be similar in the two participating communities. 4. Key health indicators such as infant and maternal mortality rates should be similar. 5. The susceptibility of the two communities to HIV and AIDS should be similar as measured at a higher societal but not necessarily at community level. In other words if the district in which the first community is located has a 10% seroprevalence rate, then the comparison community should fall within a district with a 10% seroprevalence rate.			
Level 3 Criteria	Yes/No	Provide reason where applicable	Evidence
1. The communities should have a similar security profile. There should be no significant systematic difference in terms of social conflict or levels of crime. 2. There should be no significant cultural, values or belief based differences between the two communities that might influence community members' perspectives on sexual behaviour, HIV and AIDS, circumcision and the rights of women and children. 3. The two communities should share similar distributions in terms of adult literacy and highest levels of education. 4. There should be similar proportions of Most At Risk Populations in both communities participating in the study.			

5. There should be no significant differences in the nature and prevalence of substance abuse across the two communities. There should be no significant differences in migratory patterns of the two communities.			

ANNEXURE B: Summary of completed surveys and focus groups

Table 14 summarises the number of households located and sampled per site and the number of participants surveyed.

Table 14: Located households and participants surveyed – Quantitative data collection

Province	Site location	Type of site	Number of house-holds sampled	House-hold compo-sition forms completed	Number of Partici-pants who con-sented	Number participants recruited and questionnaire completed	Notes
Mpumalanga	Tonga	Treat-ment	192	54	90	90	Oversampling was applied.
Mpumalanga	Driekoppies	Treat-ment	160	68	105	105	Oversampling and alternative method was used.
Mpumalanga	Matsulu A	Com-parison	125	61	99	99	Despite oversampling, the target was reached on the first sample.
Mpumalanga	Matsulu B	Com-parison	125	59	101	101	Oversampling and alternative method was used.
Limpopo	Tzaneen	Treat-ment	100	50	100	100	Alternative sampling method was used.
Limpopo	Moletjie	Com-parison	120	70	120	120	Alternative sampling method was used.

Annexure A provides further detail on households and community members participating in this evaluation[13].

[13] *Note: This table is generated from the field reports and may differ from the final analysis*

Table 15 below provides an indication of the focus groups held with various stakeholders.

Table 15: Stakeholder focus groups held - Qualitative data collection

Province	Site	Number of participants	Stakeholder group	Gender (male/female/mixed)
Mpumalanga	Tonga	4	Adult community members recruited from hh surveys completed	Female
Mpumalanga	Tonga & Driekoppies	5	Traditional healers	Mixed
Mpumalanga	Tonga	5	Adult community members recruited from hh surveys completed	Male
Mpumalanga	Tonga	7	Traditional leaders / Indunas	Male
Mpumalanga	Tonga	5	Local leaders – Ward Counsellors	Mixed
Mpumalanga	Umjindi	6	High School – Grade 11	Mixed (2 boys, 4 girls)
Mpumalanga	Umjindi	4	Local Aids Council	Mixed
Mpumalanga	Driekoppies	6	Adult community members recruited from hh surveys completed	Female
Mpumalanga	Driekoppies	5	Adult community members recruited from hh surveys completed	Male
Mpumalanga	Driekoppies	7	High School – Grade 10 and Grade 11	Mixed (2 boys, 5 girls)
Mpumalanga	Umjindi	5	School teachers	Mixed
Limpopo	Tzaneen	5	Traditional leaders / Indunas	Male
Limpopo	Tzaneen	4	Traditional healers	Female
Limpopo	Tzaneen	10	High School – Grade 11	mixed gender
Limpopo	Tzaneen	9	Youth club	Soccer youth club - males
Limpopo	Tzaneen	7	Youth club	Netball youth club - females
Limpopo	Tzaneen	4	Adult community members recruited from hh surveys completed	Male
Limpopo	Tzaneen	4	Adult community members recruited from hh surveys completed	Female

ANNEXURE C: Instruments

FINAL FOCUS GROUP GUIDE
Overall guidance

INTRODUCTION

Feedback Research & Analytics has been appointed to conduct an evaluation of an HIV-related program. During the discussion we would like to explore your views to better understand changes in attitude and behaviour of community members and most at risk groups; the level of increase in knowledge around HIV transmission, prevention and treatment as a result of HIV prevention and education programs, as well as whether the capacity of local leaders has been built regarding HIV and AIDS prevention, care and support and stigma reduction.

Section 5 should be completed only for treatment group participants

We do not expect you to reveal private personal information about yourself. We are interested in hearing your frank views and opinions in response to the questions.

CONFIDENTIALITY

Information you provide in this discussion is strictly confidential. No names will be used in reporting research findings. Quotes will be anonymous and general themes will be reported on. The discussion group is a safe environment for you to share your perceptions and experience.

We also ask that each of you respect the confidentiality of the group. Thank you for taking the time to be interviewed.

Before we start, I have an information sheet for each of you and you must sign consent so that we can proceed with the discussion (read introduction and obtain signed consent)	**Consent signed** YES……01 NO…….. 02 **Information sheet provided to FG participants** YES……01

	NO…….. 02

Interviewer:		**Date of interview:**	
Type of group (code)		**Number of participants**	
Community (Tzaneen, Tonga, Driekoppies, Mankweng, Matsulu A, Matsulu B)		**Province**	

Probe for examples or stories during discussion.

HIV/AIDS in the community

1. A discussion about HIV and AIDS in your community (risky behaviour and prevention)? (10 minutes)

a) What puts individuals in your community at **risk** of getting HIV? Probe for reasons and examples. (Probe further for alcohol, Multiple and Concurrent Partners, violence, poverty, transactional sex, intergenerational sex, condom use, etc. based on themes discussed)

b) Are there any differences in **risky behaviour** between men and women? (Probe on differences in engaging in risky behaviour as well as the reasons given for why these differences exist)

c) What are the best ways to **prevent** HIV? In your view, do most people in the community apply these ways to prevent HIV? (Interviewer to collect some stories to describe the reality within the community)

2. A discussion to better understand attitudes and knowledge as well as contributors and hindering factors around HIV services in the community? (40-50 minutes)

The following table to guide the conversation – it is important for the moderator to gather stories and probe two to three times to ensure detail is captured for the reality experienced in the community

	What services do community members need when it comes to HIV-related matters? (Tick services that are spoken about in each column – do not probe yet for these services)	(a) HIV Counselling and Testing	(b) PMTCT	(c) Support received by having someone to talk to, learn from for HIV or get info/condoms	(d) Going for Anti-Retroviral Treatment (ART) for those who are HIV positive	(e) Support received by becoming part of an HIV-related support group	(f) Support received by someone taking community members for testing and/or treatment	(g) Other_____ ___
201	There are some services that you haven't mentioned such as…. (Moderator to do a quick check of services not mentioned and probe. Does your community make use of … (Tick services the group agrees exist)							
202	Knowledge:	Do people test even when they are healthy?	Do people Make use of PMTCT services when they are pregnant?	N/A	Do people who know their status know about ART?	N/A	N/A	
203	What is the general attitude of your community towards making use of (a)?	..undertaking HIV Counselling and Testing?	Make use of PMTCT services when they are pregnant?		ART for those who are HIV positive			
204	Behaviours: Do members of your community generally..	..know their HIV status in your community?	..make use of PMTCT services when	..have someone to talk to who helps in the		..belong in a support group to support PLWHA		

	What services do community members need when it comes to HIV-related matters? (Tick services that are spoken about in each column – do not probe yet for these services)	(a) HIV Counselling and Testing	(b) PMTCT	(c) Support received by having someone to talk to, learn from for HIV or get info/condoms	(d) Going for Anti-Retroviral Treatment (ART) for those who are HIV positive	(e) Support received by becoming part of an HIV-related support group	(f) Support received by someone taking community members for testing and/or treatment	(g) Other_____ ___
			they are pregnant?	community?		or to support each other in any other way?		
205	Change in behaviour over time: If you think back to 2009 and 2010 and compare the number people in your community going for/receiving (a).. .. Has the level of … (a) decreased or increased in the last three years? (show a level with your hand and determine what the journey in the community has been from 2009 until now) Tell me about this change (the reasons for the change should be probed – ask for stories to demonstrate why the change) ASK QUESTIONS FOR (b), (c), (d), (e)							
206	What are the benefits of (a) as experienced by the community? ASK THE SAME FOR (b), (c), (d), (e)							
207	What factors prevent community members from							

	What services do community members need when it comes to HIV-related matters? (Tick services that are spoken about in each column – do not probe yet for these services)	(a) HIV Counselling and Testing	(b) PMTCT	(c) Support received by having someone to talk to, learn from for HIV or get info/condoms	(d) Going for Anti-Retroviral Treatment (ART) for those who are HIV positive	(e) Support received by becoming part of an HIV-related support group	(f) Support received by someone taking community members for testing and/or treatment	(g) Other_____ ___
	receiving (a)? Determine the difficulties and probe further to gain a good understanding of each of the challenges/difficulties These could be related to accessibility, fear, structural aspects, etc.) ASK THE SAME FOR (b), (c), (d), (e)							
208	Has there ever been anything that encouraged community members to… ASK THE SAME FOR (b), (c), (d), (e)	undertake HIV Counselling and Testing to know their HIV status?						

a) Have you or your friends been prompted to test for HIV or go to a clinic or a temporary tent for HIV-related services? Give details, stories, examples. Probe for who prompted them to go, how they experienced it.

b) Have you ever belonged to a **support group** of any kind that had anything to do with HIV and AIDS prevention or care – this could have been a cultural or sports group, a discussion group, a group that encourages others to take their medication, etc.

Probe and explore who started the support group, gather stories with examples.

c) Have you or your friends ever had any HIV-related programs in your community from 2009 to 2012?

	Name of program/NGO	(a) NGO/PROGRAM A	(b) NGO/PROGRAM B	(c) NGO/PROGRAM C	(d) NGO/PROGRAM D	(e) NGO/PROGRAM E	(f) NGO/PROGRAM F
(i)	What is the name of the program/NGO that came to your community?						
(ii)	What did this program/NGO do (their core services)						
(iii)	In what way were their services valuable to you and your friends?						
(iv)	What would you do to make the (PROGRAM A) better so that it meets the needs of communities in a better way?						
(v)	Do you have any other comments you wish to make about the program/NGO						

3. Think about those community members who are HIV positive … (5-10 minutes)?

a) Are people living with HIV in this community discriminated against? If so, in what way?

b) Has discrimination of PLWHA decreased or increased in the last three years? (show a level with your hand and determine what the journey in the community has been from 2009 until now)

c) Has there ever been anything that encouraged community members to stop discriminating against PLWHA? Explore the responses and probe further based on responses (probe programs should these be mentioned – capture the stories)

FOR MANKWENG AND MATSULU ONLY… (TZANEEN, TONGA AND DRIEKOPPIES TO COMPLETE SECTION 5

4. Concluding remarks

That is the end of the discussion. Is there anything else you would like to add or say about TCE?

5. Exploring effectiveness of the TCE program (20 minutes) FOR TZANEEN, TONGA AND DRIEKOPPIES ONLY

a) Have you heard of the Total Control of the Epidemic (TCE) program run by Humana (the people with the red t-shirts and barrettes?

b) What did this program do?

c) Are there other programs in your community that serve the same purpose? (list each program and describe the differences between TCE and all other programs that exist)

d) In your opinion, did people change their behaviours when the TCE people (with the red t-shirts) talked to them?

e) What types of behaviours changed due to TCE people with red t-shirts visiting your community (probe for participants to describe the changes they noticed around them)

f) What other beneficial outcomes did the TCE program bring about? (probe in the areas of information about HIV, going for VCT, perceptions of PLWHA, support groups, community mobilization and care of OVC)

g) Are there any other aspects that you or your community have benefitted from as a result of the TCE program?

h) Have there been any detrimental effects of the TCE program for you or your community? Explore

i) Let us pretend for a few minutes that you are a president and I implement TCE for you in your country. What is it that TCE must do to be a better program for communities? (If they indicate to come back to their community, explain that they as president only have a certain amount of funds and that the aim is to reach all communities in South Africa. Probe what else could be done)

j) How can we ensure that the efforts by TCE are continued in your community? (make participants aware that there is no more money from TCE and probe efforts that could be continued by the community itself – this could include any local support existing in the community)

k) Is there anything else you would like to add or say about TCE?

That is the end of the discussion.

Thank you for your participation.

Household number						
Participant number						
Interviewer number						
Team number						
Original household or contingency household:	Original .....01 Contingency ...02					

Number of times follow up was made on original household?	
Questionnaire no.	
Date of interview	
Quality controlled (Epi-centre):	
Follow-up required (Feedback):	

HOUSEHOLD COMPOSITION FORM
TCE HIV PREVENTION PROGRAM - HOUSEHOLD SURVEY

NOTE 1 TO INTERVIEWER: YOU MUST WEAR YOUR TAG IDENTIFYING YOU AS A FEEDBACK RESEARCH & ANALYTICS RESEARCHER CONDUCTING A HOUSEHOLD SURVEY. ENSURE YOU INTRODUCE YOURSELF USING THE INFORMATION SHEET THAT YOU WILL LEAVE WITH THE PERSON(S) INTERVIEWED.

NOTE 2: THE COMPOSITION FORM IS COMPLETED FIRST. QUESTIONS 101 AND 102 ARE KEY TO DETERMINE WHETHER YOU CONTINUE COMPLETION OF THE COMPOSITION FORM – THERE SHOULD BE TWO PERSONS IN THE HOUSEHOLD WHO ARE ELIGIBLE TO COMPLETE A PARTICIPANT SURVEY. IF THERE IS ONLY ONE PERSON IN THE HOUSEHOLD, YOU IDENTIFY A REPLACEMENT HOUSEHOLD.

NOTE 3: CIRCLE RESPONSE CODES

NOTE 4: ONCE THE COMPOSITION FORM IS COMPLETED, DETERMINE WHETHER THE SAME PERSON IS ELIGIBLE TO COMPLETE THE PARTICIPANT SURVEY. THE SECOND PERSON IN THE HOUSEHOLD ONLY COMPLETES THE PARTICIPANT SURVEY.

101	How many people 18 years and above live in this household?		If two or more continue to 102. If only one person, end the interview
102	How many of these persons are male and how many are female?	MALE……01 FEMALE……..02	
Thank you for your time. We must have two persons in this household who are eligible to be interviewed as part of our study. Because that is not the case, I need to end the interview with you. Thank you very much for your time.			
103	**ONLY FOR TREATMENT SITES (TZANEEN, TONGA AND DRIEKOPPIES)** Do you know how many people 18 years and above in this household have been visited by a TCE person with a red t-shirt and a red barrette?	YES……01 NO…….. 02 NOT SURE……03 CAPTURE NUMBER OF PEOPLE IN THE HOUSEHOLD…….	If only one person, end the interview.
Thank you for your time. We must have two persons in this household who have been visited by a TCE person for us to conduct an interview in this household as part of our study. Because that is not the case, I need to end the interview with you. Thank you very much for your time.			
104	Do you have 45 minutes for me to go through this part of the survey?	YES……01 NO…….. 02	If yes, skip to 107
105	If no… is there someone else in your household who can complete the survey now?	YES……01 NO…….. 02 Name of person……..	
106	If no… when can I come back to interview you?	DATE…… TIME……..	
107	Before we start, I have an information sheet for you and you must sign consent so that we can proceed with the discussion (read introduction and obtain signed consent	**Consent signed** YES……01 NO…….. 02 **Information sheet provided to interviewee** YES……01 NO…….. 02	

10.1.1 Section A Household Details

Complete the following household information:

201	Province:		
202	Area:	Tzaneen……01 Capricorn……02 Tonga……03 Driekoppies……04 Matsulu……05	
203	Village/location name:		
204	Urban / rural / deep rural / semi-rural:	Urban……02 Semi-urban……03 Rural……04 Deep rural……05 Other……06 (specify)_____	
205	Languages spoken in this household:	English……01 Afrikaans……02 Ndebele ……03 Sepedi……04 Xhosa ……05 Venda ……06	Tswana ……07 Southern Sotho ……08 Zulu ……09 Swazi ……10 Tonga ……11
206	Language requested for interview:		
207	Participant age:		
208	Participant gender:		

10.1.2 Section B Household Descriptives

……..Circle the relevant answer

	QUESTION	CODING CATEGORIES	SKIP
301	What is the main source of drinking water for members of your household?	PIPED INTO DWELLING . . . . . 11 PIPED TO YARD/PLOT . . . . . 12 PUBLIC TAP/STANDPIPE . . . . . 13 TUBE WELL OR BOREHOLE . . . . . .21 DUG WELL PROTECTED WELL . . . . . 31 UNPROTECTED WELL . . . . . .32 WATER FROM SPRING PROTECTED SPRING . . . . . 41 UNPROTECTED SPRING . . . . . .42 RAINWATER . . . . . 51 TANKER TRUCK . . . . . 61 CART WITH SMALL TANK . . . . . 71 SURFACE WATER (RIVER/DAM/ LAKE/POND/STREAM/CANAL/ IRRIGATION CHANNEL) . . . . . 81 BOTTLED WATER . . . . . 91 OTHER(SPECIFY) 96 _____ _____	
302	What kind of toilet facility do members of your household usually use?	FLUSH TOILET ……..01 POUR FLUSH TOILET . . . . . .02 TRADITIONAL PIT LATRINE … 03 VENTILATED IMPROVED PIT LATRINE (VIP) . . . . . 04 NO FACILITY/BUSH/FIELD . . . . 05 OTHER(SPECIFY) 96 _____	
303	Does your household have electricity?	YES……01 NO…….. 02	

10.1.3 Section C Household register

… Describe the members in your household by completing the following table (TABLE 400)

						IF 5YRS OR OLDER			IF 18YRS OR OLDER		IF AGE 0-17YRS					
PERSON NO.	**USUAL RESIDENTS**	**REL'SHIP TO HEAD OF HH**	**GENDER**	**AGE**	**MARITAL STATUS**	**EDUCATION**			**EMPLOYMENT STATUS**	**SICK PERSONS**	**SURVIVORSHIP AND RESIDENCE OF BIOLOGICAL PARENTS**					
	Name of person who usually lives in your household starting with head of household	What is the relationship of (name) to the head of the household **(USE CODES)**	Is (name) male or female? **1=male; 2=female**	How old is (name) in years?	(What is (name)'s current marital status	Has (name) ever attended school? **IF NO, SKIP TO (11)** **Y=1; N=2**	What is the highest level of school (name) completed? (**USE CODES**)	Did (name) attend school during this year? **Y=1; N=2 DK=98**	Is (name) engaged in any paid work? If yes, what kind of employment or business? (**USE CODES**)	Has (name) been very sick for at least 3 months during 2009, 2010 or 2011 so that (name) was too sick to work or do normal activities? **Y=1; N=2 DK=98**	Is (name)'s natural mother alive? **(IF NO OR DK, SKIP)**	Does (name)'s natural mother usually live in this household? **Y=MOTHER'S LINE NO.; N=00**	Is (name)'s natural mother sick? **Y=1; N=2 DK=98**	Is (name)'s natural father alive? **(IF NO OR DK, SKIP)**	Does (name)'s natural father usually live in this household? **Y=FATHER'S LINE NO.; N=00**	Is (name)'s natural father sick? **Y=1; N=2 DK=98**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8) code	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
01																
02																
03																
04																
05																
06																
07																
08																
09																

CODES FOR Q(3): RELATIONSHIP TO HOUSEHOLD HEAD CODES FOR EMPLOYMENT STATUS
01- HEAD
02- WIFE/HUSBAND / PARTNER BY MARRIAGE
03- SON/ DAUGHTER
04- SON-IN-LAW/ DAUGHTER-IN -LAW
05- GRANDCHILD
06- PARENT
07- PARENT-IN-LAW
08- BROTHER/SISTER
09- NIECE/NEPHEW BY BLOOD
10- NIECE/NEPHEW BY MARRIAGE
11- CO-WIFE
12- OTHER RELATIVE
13- ADOPTED/FOSTER/STEP CHILD
14- NOT RELATED
98- DON'T KNOW (DK)

CODES FOR Q(6): MARITAL STATUS
1=MARRIED/ LIVING TOGETHER
2=DIVORCED/ SEPARATED
3=WIDOWED
4=NEVER MARRIED AND NEVER LIVED TOGETHER

CODES FOR Q(8): EDUCATION
01- NO SCHOOLING
02- LESS THAN GRADE 8
03- LESS THAN GRADE 12
04- GRADE 12 (NOT COMPLETE)
05- GRADE 12 (WITHOUT EXEMPTION)
06- GRADE 12 (WITH EXEMPTION)
07- A DIPLOMA WITH LESS THAN GRADE 12
08- A CERTIFICATE WITH LESS THAN GRADE 12
09- A DEPLOMA WITH GRADE 12
10- A CERTIFICATE WITH GRADE 12
11- BACHELOR DEGREE
12- HONOURS DEGREE
13- HIGHER DEGREE
14- POST-GRADUATE DIPLOMA

CODES FOR Q(10): EMPLOYMENT STATUS
01- PERMANENT PAID EMPLOYEE
02- TEMPORARY PAID EMPLOYEE
03- SELF EMPLOYED
04- WORKING EMPLOYER
05- PAID VOLUNTEER
06- UNPAID VOLUNTEER
07- UNEMPLOYED

(18)	Who else is available either 15-18years (any gender) or above 18 years (another gender to you) who is available to answer some questions after our interview?	(**INSERT PERSON NO.**)

10.1.4 Section D morbidity and treatment support

Please complete for each sick person in your household?

	QUESTION	CODING CATEGORIES	SKIP
501	How many sick people aged 18-64 years (**IF NONE, RECORD 00**)	☐☐	(IF OO, SKIP TO 514)

ENTER IN QUESTION 502 THE LINE NUMBER AND NAME OF EACH SICK PERSON AGE 18-64, BEGINNING WITH THE FIRST SICK PERSON LISTED TABLE 400 (THE HOUSEHOLD SCHEDULE). IF THERE ARE MORE THAN 3 SICK PEOPLE, USE ADDITIONAL QUESTIONNAIRE(S). READ THE INTRODUCTION THAT FOLLOWS. THEN ASK QUESTIONS 502 - 505 AS APPROPRIATE FOR EACH OF THE PERSONS AGED 18-64 REPORTED AS HAVING BEEN VERY SICK.

You told me that in your household one (some) of the members of your household has(ve) been very sick during 2009, 2010, 2011 or 2012. We are interested in learning about the care and support that they may have received for that/each of those persons.

		First sick person	Second sick person	Third sick person
502	NAME AND LINE NUMBER FROM COLUMN 1 AND 2 OF THE HH SCHEDULE (TABLE 400)	☐☐ line number (insert code from first column) Name_____	☐☐ line number (insert code from first column) Name_____	☐☐ line number (insert code from first column) Name_____
503	Did (name) spend one night or more in a health facility during (NAME's) illness?	YES.....01 NO..... 02	YES.....01 NO..... 02	YES.....01 NO..... 02
504	If yes, how many nights?	☐☐	☐☐	☐☐
505	What illness did (NAME) have? **(USE CODES – PROBE FOR THE MOST DOMINANT DISEASE)**			

CODES FOR Q(505): ILLNESS

FEVER, MALARIA 01 DIARRHOEA 02 STOMACH ACHE 03 FLU 07 VOMITING 04	UPPER RESPIRATORY (SINUSES) 05 LOWER RESPIRATORY (CHEST, LUNGS) 06 ASTHMA 08 HEADACHE 09	SKIN PROBLEM 10 DENTAL PROBLEM 11 EYE PROBLEM 12 EAR/NOSE/THROAT 13 BACKACHE 14 BURN 22 WOUND 24 HEART PROBLEM 15	BLOOD PRESSURE 16 PAIN WHEN PASSING URINE 17 DIABETES 18	MENTAL DISORDER 19 TB 20 SEXUALLY TRANSMITTED 21 BURN 22 FRACTURE 23 WOUND 24	UNSPECIFIED LONG-TERM ILLNESS 27 HIV/AIDS 28 TYPHOID 29 POISONING 25 PREGNANCY RELATED 26

Medical Treatment Support				
506	In 2009, 2010, 2011 or 2012, has your household received any **medical support such as medical tests, medical care, supplies or medicine**?	YES……01 NO…….. 02 Don't know……98		If NO, skip to 514
507	For which members of your household did you receive medical treatment or support?			
508	NAME AND LINE NUMBER FROM COLUMN 1 AND 2 OF THE HH SCHEDULE (TABLE 400)	**First person** ☐☐ line number (insert code from first column) Name_____	**Second person** ☐☐ line number (insert code from first column) Name_____	**Third person** ☐☐ line number (insert code from first column) Name_____
509	Who provided these services for (NAME)? **(PROBE TO IDENTIFY THE TYPES OF ORGANISATIONS AND TICK THE APPROPRIATE CODE/CODES)** **(IF THEY CANNOT REMEMBER THE NAME, PROBE AN IDENTIFIER, EG. A PERSON WITH A RED T-SHIRT AND BARRET, A HOME-BASED CARE-GIVER, ETC.)**	NAME OF ORGANISATION	NAME OF ORGANISATION	NAME OF ORGANISATION
510	A: Government facility (hospital) B: Government facility (clinic) C: Civil Society Organisation	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____
511	Who else supported the person to access medical services? **(PROBE TO IDENTIFY THE TYPES OF ORGANISATIONS AND TICK THE APPROPRIATE CODE/CODES)** **(IF THEY CANNOT REMEMBER THE NAME, PROBE AN IDENTIFIER, EG. A PERSON WITH A RED T-SHIRT AND BARRET, A HOME-BASED CARE-GIVER, ETC.)**	NAME OF ORGANISATION	NAME OF ORGANISATION	NAME OF ORGANISATION
512	A: Government facility (hospital) B: Government facility (clinic) C: Civil Society Organisation	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____
513	How far did they/you travel to get to these services?	Service comes to us …. 1 Less than 2 KM …. 2 More than 2 KM but less	Service comes to us …. 1 Less than 2 KM …. 2 More than 2 KM but less	Service comes to us …. 1 Less than 2 KM …. 2 More than 2 KM but less

		than 5 KM ..... 3 More than 5 KM but less than 10 KM ..... 4 More than 10 KM 5	than 5 KM ..... 3 More than 5 KM but less than 10 KM ..... 4 More than 10 KM 5	than 5 KM ..... 3 More than 5 KM but less than 10 KM ..... 4 More than 10 KM 5

Services of Interest					
514	In 2009, 2010, 2011 or 2012, has anyone in your household received **voluntary counselling and testing?**			YES.....01 NO..... 02 Don't know.....98	If NO, skip to 522
515	Which members of your household?				
516	NAME AND LINE NUMBER FROM COLUMN 1 AND 2 OF THE HH SCHEDULE (TABLE 400)	**First person** ☐☐ line number (insert code from first column) Name_____	**Second person** ☐☐ line number (insert code from first column) Name_____	**Third person** ☐☐ line number (insert code from first column) Name_____	
517	Who provided these services for (NAME)? **(PROBE TO IDENTIFY THE TYPES OF ORGANISATIONS AND TICK THE APPROPRIATE CODE/CODES) (IF THEY CANNOT REMEMBER THE NAME, PROBE AN IDENTIFIER, EG. A PERSON WITH A RED T-SHIRT AND BARRET, A HOME-BASED CARE-GIVER, ETC.)**	NAME OF ORGANISATION	NAME OF ORGANISATION	NAME OF ORGANISATION	
518	A: Government facility (hospital) B: Government facility (clinic) C: Civil Society Organisation	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	
519	Who else supported the person to access VCT services? **(PROBE TO IDENTIFY THE TYPES OF ORGANISATIONS AND TICK THE APPROPRIATE CODE/CODES) (IF THEY CANNOT REMEMBER THE NAME, PROBE AN IDENTIFIER, EG. A PERSON WITH A RED T-SHIRT AND BARRET, A HOME-BASED CARE-GIVER, ETC.)**	NAME OF ORGANISATION	NAME OF ORGANISATION	NAME OF ORGANISATION	

520	A: Government facility (hospital) B: Government facility (clinic) C: Civil Society Organisation	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	
521	How far did they/you travel to get to these services?	Service comes to us …1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	Service comes to us …1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	Service comes to us …1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	
522	In 2009, 2010, 2011 or 2012, has anyone in your household received care for **Tuberculosis?**			YES……..01 NO…….. 02 Don't know……98	If NO, skip to 530
523	Which members of your household?				
524	NAME AND LINE NUMBER FROM COLUMN 1 AND 2 OF THE HH SCHEDULE (TABLE 400)	**First person** ☐☐ line number (insert code from first column) Name_____ __	**Second person** ☐☐ line number (insert code from first column) Name_____ __	**Third person** ☐☐ line number (insert code from first column) Name_____ _	
525	Who provided these services for (NAME)? **(PROBE TO IDENTIFY THE TYPES OF ORGANISATIONS AND TICK THE APPROPRIATE CODE/CODES)** **(IF THEY CANNOT REMEMBER THE NAME, PROBE AN IDENTIFIER, EG. A PERSON WITH A RED T-SHIRT AND BARRET, A HOME-BASED CARE-GIVER, ETC.)**	NAME OF ORGANISATION	NAME OF ORGANISATION	NAME OF ORGANISATION	
526	A: Government facility (hospital) B: Government facility (clinic) C: Civil Society Organisation	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	
527	Who else supported the person to access TB services? **(PROBE TO IDENTIFY THE TYPES OF**	NAME OF ORGANISATION	NAME OF ORGANISATION	NAME OF ORGANISATION	

	ORGANISATIONS AND TICK THE APPROPRIATE CODE/CODES) (IF THEY CANNOT REMEMBER THE NAME, PROBE AN IDENTIFIER, EG. A PERSON WITH A RED T-SHIRT AND BARRET, A HOME-BASED CARE-GIVER, ETC.)				
528	A: Government facility (hospital) B: Government facility (clinic) C: Civil Society Organisation	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	
529	How far did they/you travel to get to these services?	Service comes to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	Service comes to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	Service comes to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	
530	In 2009, 2010, 2011 or 2012, has anyone in your household received **PMTCT services?**			YES……01 NO…….. 02 Don't know……98	If NO, skip to Section E
531	Which members of your household?				
532	NAME AND LINE NUMBER FROM COLUMN 1 AND 2 OF THE HH SCHEDULE (TABLE 400)	**First person** ☐☐ line number (insert code from first column) Name_____	**Second person** ☐☐ line number (insert code from first column) Name_____	**Third person** ☐☐ line number (insert code from first column) Name_____	
533	Who provided these services for (NAME)? **(PROBE TO IDENTIFY THE TYPES OF ORGANISATIONS AND TICK THE APPROPRIATE CODE/CODES) (IF THEY CANNOT REMEMBER THE NAME, PROBE AN IDENTIFIER, EG. A PERSON WITH A RED T-SHIRT AND BARRET, A HOME-BASED CARE-GIVER, ETC.)**	NAME OF ORGANISATION	NAME OF ORGANISATION	NAME OF ORGANISATION	
534	A: Government facility (hospital) B: Government facility (clinic) C: Civil Society Organisation	A: _____ B: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____	

		C: _____	C: _____	C: _____	
535	Who else supported the person to PMTCT services? **(PROBE TO IDENTIFY THE TYPES OF ORGANISATIONS AND TICK THE APPROPRIATE CODE/CODES)** **(IF THEY CANNOT REMEMBER THE NAME, PROBE AN IDENTIFIER, EG. A PERSON WITH A RED T-SHIRT AND BARRET, A HOME-BASED CARE-GIVER, ETC.)**	NAME OF ORGANISATION	NAME OF ORGANISATION	NAME OF ORGANISATION	
536	A: Government facility (hospital) B: Government facility (clinic) C: Civil Society Organisation	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	A: _____ B: _____ C: _____ C: _____ C: _____	
537	How far did they/you travel to get to these services?	Service comes to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	Service comes to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	Service comes to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	

10.1.5 Section E mortality

Complete the following table (Table 600) describing anyone in your household who has died in the last five years.

Name of person	Age at death	Gender	Year they passed away	Relationship to Head of Household	Cause of death
(1) **(IF NO-ONE=00)**	**(2)**	**(3)**	**(4)**	**(5)** **(USE CODES)**	**(6)** **(USE CODES)**
	….years old	MALE……01 FEMALE…….. 02			

CODES FOR Q(5): RELATIONSHIP TO HOUSEHOLD HEAD CODES FOR EMPLOYMENT STATUS	CODES FOR Q(6): CAUSE OF DEATH

01- HEAD 02- WIFE/HUSBAND / PARTNER BY MARRIAGE 03- SON/ DAUGHTER 04- SON-IN-LAW/ DAUGHTER-IN -LAW 05- GRANDCHILD 06- PARENT 07- PARENT-IN-LAW 08- BROTHER/SISTER 09- NIECE/NEPHEW BY BLOOD 10- NIECE/NEPHEW BY MARRIAGE 11- CO-WIFE 12- OTHER RELATIVE 13- ADOPTED/FOSTER/STEP CHILD 14- NOT RELATED 98- DON'T KNOW (DK)	1= MALARIA 2=PNEMONIA 3=AIDS 4=TETANUS 5=TB 6=MALNUTRITION 7=ANAEMIA 8=CHILD BIRTH/PREGNANCY 9=SUDDEN DEATH 10=ASTHMA 11=CANCER 12=URINARY OBSTRUCTION 13=POISINING 14=SUICIDE 15=ACCIDENT 16=MEASLES 17=OTHER (SPECIFY…._ 98=DON'T KNOW

10.1.6 Section F Social Protection

701	Who in the household receives a grant? **(COMPLETE 702)** What type of grant? **(COMPLETE 703)**			
702	**Person A** ☐☐ line number (insert code from first column, Table 400) Name___________	**Person B** ☐☐ line number (insert code from first column, Table 400) Name___________	**Person C** ☐☐ line number (insert code from first column, Table 400) Name___________	**Person D** ☐☐ line number (insert code from first column, Table 400) Name___________
703	GRANT FOR OLDER PERSONS……………01 DISABILITY GRANT……… 02 WAR VETERANS GRANT……03 CHILD GRANT FOR FOSTER CARE……. 04 CARE DEPENDENCY GRANT… 05 CHILD SUPPORT GRANT……………… 06 GRANT IN AID (for older persons needing help)………………… 07	GRANT FOR OLDER PERSONS……………01 DISABILITY GRANT……… 02 WAR VETERANS GRANT……03 CHILD GRANT FOR FOSTER CARE……. 04 CARE DEPENDENCY GRANT… 05 CHILD SUPPORT GRANT……………… 06 GRANT IN AID (for older persons needing help)………………… 07	GRANT FOR OLDER PERSONS……………01 DISABILITY GRANT……… 02 WAR VETERANS GRANT……03 CHILD GRANT FOR FOSTER CARE……. 04 CARE DEPENDENCY GRANT… 05 CHILD SUPPORT GRANT……………… 06 GRANT IN AID (for older persons needing help)………………… 07	GRANT FOR OLDER PERSONS……………01 DISABILITY GRANT……… 02 WAR VETERANS GRANT……03 CHILD GRANT FOR FOSTER CARE……. 04 CARE DEPENDENCY GRANT… 05 CHILD SUPPORT GRANT……………… 06 GRANT IN AID (for older persons needing help)………………… 07

	HIV/AIDS GRANT….. 08 OTHER (SPECIFY)…..	HIV/AIDS GRANT….. 08 OTHER (SPECIFY)…..	HIV/AIDS GRANT….. 08 OTHER (SPECIFY)…..	HIV/AIDS GRANT….. 08 OTHER (SPECIFY)…..

10.1.7 Section G Material Support

Material support refers to clothing, food or other donations

801	In 2009, 2010, 2011 or 2012, did anyone in your household receive **any material support such as clothing, food or other donations?**			YES……..01 NO…….. 02 Don't know……98	If NO, skip to 806
802	Which members of your household? **(COMPLETE 803)**				
803	NAME AND LINE NUMBER FROM COLUMN 1 AND 2 OF THE HH SCHEDULE (TABLE 400)	**First person** ☐☐ line number (insert code from first column) Name_____ __	**Second person** ☐☐ line number (insert code from first column) Name_____ __	**Third person** ☐☐ line number (insert code from first column) Name_____ _	
804	**From whom was support received?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation** **D: A tent put up by the Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	
805	**How far did you travel to get to these services?**	Service came to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	Service came to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	Service came to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	

806	**Can people in your community get material support services?**	YES……01 NO…….. 02 DON'T KNOW…..03	YES……01 NO…….. 02 DON'T KNOW…..03	YES……01 NO…….. 02 DON'T KNOW…..03	
807	**From whom can they receive such support?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation** **D: A tent put up by the Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	
808	**How far would you travel to get to these services?**	Service came to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	Service came to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	Service came to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	

10.1.8 Section H Household Economic Strengthening

Household economic strengthening refers to interventions that support people in starting their own business, participating in community interventions that create provision for the household, creating your own food supply and other activities that strengthen your ability as a household to earn income.

901	In 2009, 2010, 2011 or 2012, did anyone in your household receive **any support to improve your ability as a household to earn an income material support such as clothing, food or other donations?**			YES……01 NO…….. 02 Don't know……98	If NO, skip to 907
902	Which members of your household? **(COMPLETE 903)**				
903	NAME AND LINE NUMBER FROM COLUMN 1 AND 2 OF THE HH SCHEDULE (TABLE 400)	**First person** ☐☐ line number (insert code from first column) Name_____	**Second person** ☐☐ line number (insert code from first column) Name_____	**Third person** ☐☐ line number (insert code from first column) Name_____	

904	**From whom was support received?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation** **D: A tent put up by the Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	
905	**What type of support was received? (open-ended question)**				
906	**How far did you travel to get to these services?**	Service came to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	Service came to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	Service came to us …. 1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM …….. 5	
907	**Can people in your community get such support services?**	YES……01 NO…….. 02	YES……01 NO…….. 02	YES……01 NO…….. 02	
908	**If yes, from whom?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation** **D: A tent put up by the Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	
909	**How far did you travel to get to these services?**	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	

10.1.9 Section I Social Support

This refers to support such as help in household work, training for a caregiver, training to become a volunteer, legal services and similar social support

1001	In 2009, 2010, 2011 or 2012, did anyone in your household receive **any social support such as help in household work, training for a caregiver, training to become a volunteer, legal services and similar social support?**			YES……..01 NO…….. 02 Don't know……98	If NO, skip to 1007
1002	Which members of your household? **(COMPLETE 1003)**				
1003	NAME AND LINE NUMBER FROM COLUMN 1 AND 2 OF THE HH SCHEDULE (TABLE 400)	**First person** ☐☐ line number (insert code from first column) Name_____	**Second person** ☐☐ line number (insert code from first column) Name_____	**Third person** ☐☐ line number (insert code from first column) Name_____	
1004	**From whom was support received?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____	
1005	**What type of support was social support was received? (open-ended question)**				
1006	**How far did you travel to get to these services?**	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	
1007	**Can people in your community get such support services?**	YES……..01 NO…….. 02	YES……..01 NO…….. 02	YES……..01 NO…….. 02	
1008	**If yes, from whom?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation** **D: A tent put up by the Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	
1009	**How far would you travel to get to these services?**	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less	

		than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	

10.1.10 section J Psychosocial Support

This refers to support such as having someone available to talk to, having someone assist you with anything related to going for VCT, PMTCT or TB testing, checking on whether medication is taken and other similar activities.

1101	In 2009, 2010, 2011 or 2012, did anyone in your household receive **any psycho-social support such having someone available to talk to, having someone assist you with anything related to going for VCT, PMTCT or TB testing, checking on whether medication is taken, becoming part of an HIV-related support group and other similar activities?**			YES……01 NO…… 02 Don't know……98	If NO, skip to
1102	Which members of your household? **(COMPLETE 1103)**				
1103	NAME AND LINE NUMBER FROM COLUMN 1 AND 2 OF THE HH SCHEDULE (TABLE 400)	**First person** ☐☐ line number (insert code from first column) Name_____	**Second person** ☐☐ line number (insert code from first column) Name_____	**Third person** ☐☐ line number (insert code from first column) Name_____	
1104	**From whom was support received?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation** **D: A tent put up by the Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	
1105	**What type of support was psycho-social support was received? (open-ended question)**				
1106	**How far did you travel to get to these**	Service came to us ….1 Less than 2 KM …. 2	Service came to us ….1 Less than 2 KM …. 2	Service came to us ….1 Less than 2 KM …. 2	

	services?	More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	
1107	**Can people in your community get such support services?**	YES……01 NO…….. 02	YES……01 NO…….. 02	YES……01 NO…….. 02	
1108	**If yes, from whom?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation** **D: A tent put up by the Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	
1109	**How far did you travel to get to these services?**	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	

10.1.11 Section K Educational Support

This refers to provision of pamphlets and information as well as talks relating to HIV and AIDS

1201	In 2009, 2010, 2011 or 2012, did anyone in your household receive **any** pamphlets and information as well as talks relating to HIV and AIDS**?**			YES……01 NO…….. 02 Don't know……98	If NO, skip to
1202	Which members of your household? **(COMPLETE 1203)**				
1203	NAME AND LINE NUMBER FROM COLUMN 1 AND 2 OF THE HH SCHEDULE (TABLE 400)	**First person** ☐☐ line number (insert code from first column) Name_____	**Second person** ☐☐ line number (insert code from first column) Name_____	**Third person** ☐☐ line number (insert code from first column) Name_____	

		—	—	–	
1204	**From whom was support received?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation** **D: A tent put up by the Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	
1205	**What type of support was received? (open-ended question)**				
1206	**How far did you travel to get to these services?**	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	Service came to us ….1 Less than 2 KM …. 2 More than 2 KM but less than 5 KM ……3 More than 5 KM but less than 10 KM …… 4 More than 10 KM ….. 5	
1207	**Can people in your community get such support services?**	YES……01 NO…….. 02	YES……01 NO…….. 02	YES……01 NO…….. 02	
1208	**If yes, from whom?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation** **D: A tent put up by the Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	
1209	**From whom was support received?** **A: Government facility (hospital)** **B: Government facility (clinic)** **C: Civil Society Organisation** **D: A tent put up by the Civil Society Organisation**	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	NAME OF ORGANISATION: A: _____ B: _____ C: _____ C: _____ D: _____	

CONCLUDING REMARKS

1301	Are you willing to now complete a 20 minute participant form?	YES……01 NO…….. 02	If yes, move to 1303 If no, move to 1302
1302	Thank you for your time in completing the household information. Who in your household (18	NAME……01	

	years or older) is available to complete a 20 minute participant form with me? R10 voucher provided to interviewee:	NAME…….. 02 NAME……03 NAME…….. 04 YES……01 NO…….. 02	
1303	Thank you for being willing to continue with the participant form? Before I proceed with your participant form, could you please tell me who else in your household (18 years or older) is available to complete a 20 minute participant form with me?	NAME……01 NAME…….. 02 NAME……03 NAME…….. 04	Ensure at least two persons can complete the participant form
1304	**ONLY FOR TREATMENT SITES (TZANEEN, TONGA AND DRIEKOPPIES)** **NOTE TO INTERVIEWER: This question will assist you to prioritise who to speak to in the household (interview those listed under (A), then (B), then (C), then (D) – maximum of the top four to be interviewed** Could you please tell me who in your household..	(A) IS OR WAS AT SOME POINT ACTIVE AS A PASSIONATE IN THE COMMUNITY? (NAME)……01 (NAME)……02 (B) IS OR WAS TCE COMPLIANT? (NAME)……01 (NAME)……02 (C) KNOWS THEIR STATUS? (NAME)……01 (NAME)……02 (D) HAS MORE INFORMATION AND UNDERSTANDING OF HIV DUE TO TCE? (NAME)……01 (NAME)……02	
1305	After completing your interview, may I proceed with interviewing the (name the top participants listed)?	YES……01 NO…….. 02	

Household number						
Participant number						
Interviewer number						
Team number						

Questionnaire no.	
Date of interview	
Quality controlled (Epi-centre):	
Follow-up required (Feedback):	

PARTICIPANT FORM - HOUSEHOLD SURVEY
TCE HIV PREVENTION PROGRAM

INSTRUCTION TO INTERVIEWER: **THIS FORM IS COMPLETED ONLY AFTER COMPLETION OF THE COMPOSITION FORM**
Note 1: (TREATMENT SITES ONLY – TZANEEN, TONGA AND DRIEKOPPIES): Ensure you interview the HH survey participant who have had the most exposure to TCE based on inputs provided to question 1304 (start with those listed in (A), then (B), etc. Do not interview anyone in Tzaneen, Tonga and Driekoppies who has not been exposed to TCE.

Note 2: (COMPARISON SITES ONLY – MANKWENG, MATSULU A AND MATSULU B): Should a HH survey participant have had exposure to TCE, do not continue the interview.

Note 3: At least two eligible participants should complete this form in each household. Eligible participants meet the age criteria (18 years and older) and quota's provided by Humana for gender breakdown reached (60% female and 40% male)

1401	Are you willing to complete a 20 minute participant form?	YES…… 01 YES, BUT NOT RIGHT NOW…….02 NO…….. 03	If yes, move to 1404 If yes, but not now, move to 1403 If no, move to 1402
1402	If no… End the interview and move to the next person		
1403	If yes, but not right now… When can I come back to interview you?	DATE…… TIME……..	
1404a	**ONLY FOR TREATMENT SITES (TZANEEN, TONGA AND DRIEKOPPIES)** **NOTE TO INTERVIEWER: This question will assist you to clarify the level of exposure of the participant to TCE and to determine whether you continue the interview** Could you please tell me...	**MARK THE HIGHEST RESPONSE** (i) WERE YOU AT SOME POINT ACTIVE AS A PASSIONATE IN THE COMMUNITY THROUGH THE TCE PROGRAM? YES……01 NO…….. 02 (ii) WERE YOU TCE COMPLIANT? YES……01 NO…….. 02 (iii) DID YOU KNOW YOUR STATUS AS A RESULT OF TCE? YES……01 NO…….. 02 (iv) DID YOU HAVE MORE INFORMATION AND UNDERSTANDING OF HIV DUE TO TCE? YES……01 NO…….. 02	If no exposure to TCE, end the interview
1404b	Are there members in your household who you believe have had more exposure to TCE than you have had?	YES……01 NAME A: _____ NAME B: _____ NAME C: _____ NAME D: _____ NO…….. 02	If there are at least two other members in the HH with more exposure who are available, end the interview and ask to speak to (A), (B), etc.
1404c	**ONLY FOR COMPARISON SITES (MANKWENG, MATSULU A & MATSULU B)** **NOTE TO INTERVIEWER: This question will assist you to determine whether you continue the interview** Could you please tell me, have you ever been visited by a TCE person with a red t-shirt and a red barrette	YES……01 NO…….. 02	If yes, end the interview
1405	Thank you for being willing to complete the participant form with me? Before we start, I have an information sheet for you and	**Consent signed** YES……01 NO…….. 02	

	you must sign consent so that we can proceed with the discussion (read introduction and obtain signed consent	**Information sheet provided to interviewee** YES……01 NO…….. 02	

10.1.12 Section L knowledge, attitude and practice

In the questions below I would like to determine your knowledge, attitude and practice relating to HIV and AIDS

	QUESTION	CODING CATEGORIES	SKIP
1501	Have you ever heard of an illness called AIDS?	YES……01 NO…….. 02	(If no, skip to 1122)
1502	Can people reduce their chance of getting the HIV virus by having just one uninfected sex partner who has sexual intercourse with no other partners?	YES……01 NO…….. 02 DON'T KNOW…..98	
1503	Can people get the HIV virus from mosquito or other insect bites?	YES……01 NO…….. 02 DON'T KNOW…..98	
1504	Can people reduce their chance of getting the HIV virus by using a condom every time they have sex?	YES……01 NO…….. 02 DON'T KNOW…..98	
1505	Can people get the HIV virus by sharing utensils with a person who has AIDS?	YES……01 NO…….. 02 DON'T KNOW…..98	
1506	Can people get the HIV virus because of witchcraft or other supernatural means?	YES……01 NO…….. 02 DON'T KNOW…..98	
1507	Is it possible for a healthy-looking person to have the HIV virus?	YES……01 NO…….. 02 DON'T KNOW…..98	
1508	Do you think that your chances of getting AIDS are small, moderate or great or is there no risk at all?	YES……01 NO…….. 02 DON'T KNOW…..98	
1509	Do you think you can get HIV if you help someone who is bleeding and you touch their blood?	YES……01 NO…….. 02 DON'T KNOW…..98	
1510	From which source have you learned most about HIV and AIDS? **(RECORD ONLY ONE RESPONSE)**	RADIO . . . . . A TELEVISION . . . . . B FILM . . . . . C DRAMA . . . . . D NEWSPAPERS/MAGAZINES .....E BROCHURES . . . . . F POSTERS . . . . . G BILLBOARDS . . . . . H COMMUNITY NOTICES . . . . . I FAMILY . . . . . J FRIENDS . . . . . K PEERS . . . . . L HEALTH WORKERS . . . . . M TEACHERS . . . . . N POLITICAL LEADERS . . . . . O TRADITIONAL LEADERS . . . . . P RELIGIOUS LEADERS . . . . . Q INTERNET..... R TCE PEOPLE WITH RED T-SHIRTS AND RED BARRETS..... S OTHER X (SPECIFY)	
1511	What are the three most important messages you have learned about HIV and AIDS from this resource? **(RECORD ONLY ONE RESPONSE)**	ABSTAIN FROM SEX . . . . . .A USE CONDOMS . . . . . .B LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER..... C LIMIT NUMBER OF SEXUAL PARTNERS . . . D FOLLOW THE ABC'S . . . . . E AVOID SEX WITH PROSTITUTES...F AVOID SEX WITH PERSONS WHO...G HAVE MANY PARTNERS.....H AVOID SEX WITH HOMOSEXUALS.....I AVOID SEX WITH PERSONS WHO.....J INJECT DRUGS INTRAVENOUSLY.....K AVOID BLOOD TRANSFUSIONS.....L ANTI-RETROVIRAL DRUGS AVAILABLE….M PREVENT MOTHER-TO-CHILD TRANSMISSION….N AVOID DISCRIMINATION AGAINST PERSONS LIVING WITH AIDS..... O	

		ANYONE CAN GET AIDS……P GET TESTED FOR AIDS (HIV)…….Q AIDS IS A KILLER……..R DON'T TAKE CHANCES……S OTHER ……X (SPECIFY)……	
1512	Can the virus that causes AIDS be transmitted from a mother to her baby: During pregnancy? During delivery? By breastfeeding?	**Yes=1 No=2 DK=98** **During pregnancy?** YES……01 NO…….. 02 DON'T KNOW…..98 **During delivery?** YES……01 NO…….. 02 DON'T KNOW…..98 **By breastfeeding?** YES……01 NO…….. 02 DON'T KNOW…..98	
1513	Are there any drugs that a doctor or nurse can give to a woman infected with the HIV virus to reduce the risk of transmission to the baby?	YES……01 NO…….. 02 DON'T KNOW…..98	
1514	Have you heard of any special drugs that people infected with the HIV virus can take to help them live longer?	YES……01 NO…….. 02	If no, skip to 1122
1515	What drugs do you know about? **PROBE: Any other drugs?** **RECORD ALL MENTIONED.**	ANTI-RETROVIRAL DRUGS (ARVs) A SEPTRIN/COTRIMOXAZOLE B HERBAL DRUGS . . . . . C OTHER DRUGS X (SPECIFY) DON'T KNOW . . . . . Z	
1516	For how long should a person with the HIV virus take ARVs?	LESS THAN ONE YEAR . . . . . 1 ONE YEAR OR MORE . . . . . 2 REST OF LIFE . . . . . 3 OTHER 96 (SPECIFY)…… DON'T KNOW 98	
1517	How old should a person be before being taught about using a condom to prevent HIV and AIDS? **OPEN ENDED**		
1518	Have you ever heard of VCT?	YES……01 NO…….. 02 NOT SURE…..98	
1519	If a trained counsellor came to your home and offered you free HIV counselling and testing, would you be willing to have an HIV test done in your home?	YES……01 NO…….. 02 NOT SURE…..98	
1520	Have you received any support from someone who came to your home and encouraged you to go for VCT? If so, who was it?	YES……01 Name of organisation (identifier)_____ NO…….. 02 NOT SURE…..98	
1521	What else have you received from this person that has made a positive change in your life? **RECORD ALL MENTIONED.**	SOMEONE TO TALK TO……01 SOMEONE TO SUPPORT ME WHEN GOING FOR HIV AND AIDS RELATED SERVICES……..02 PROVIDING THE CORRECT INFORMATION AND KNOWLEDGE ON HIV AND AIDS……03 BECOMING PART OF A SUPPORT GROUP……04 BECOMING A PASSIONATE……05 OTHER 06 (SPECIFY)…… ……..	
1522	Have you ever used a condom?	YES……01 NO…….. 02 NOT SURE…..98	
1523	It is okay to re-use a condom after washing it?	YES……01 NO…….. 02 NOT SURE…..98	
1524	Condoms protect against sexually transmitted diseases	YES……01 NO…….. 02 NOT SURE…..98	
1525	Condoms contain HIV	YES……01 NO…….. 02 NOT SURE…..98	
1526	Buying/getting condoms is embarrassing	YES……01 NO…….. 02 NOT SURE…..98	

10.1.13 Section M STIGMA

1601	Would you buy fresh vegetables from a vendor who has the HIV virus?	YES……01 NO…….. 02 NOT SURE…..98	
1602	If a member of your family got infected with the virus that causes AIDS, would you want it to remain a secret or not?	YES, REMAIN A SECRET……01 NO…….. 02 DK/NOT SURE…..98	
1603	If a teacher has the HIV virus, should she be allowed to continue teaching in the school?	SHOULD BE ALLOWED . . . . . 1 SHOULD NOT BE ALLOWED ……..2 DK/NOT SURE/DEPENDS 98	
1604	If a relative of yours became sick with the virus that causes AIDS, would you be willing to care for her or him in your own household?	YES……01 NO…….. 02 DK/NOT SURE…..98	
1605	Do you personally know someone who has been denied involvement in social events, religious services, or community events in the last 12 months because he or she is suspected to have the HIV virus or has the HIV virus?	YES……01 NO…….. 02	
1606	Do you personally know someone who has been verbally abused or teased in the last 12 months because he or she is suspected to have the HIV virus or has the HIV virus?	YES……01 NO…….. 02	
Do you agree or disagree with the following statements…			
1607	People with the HIV virus should be ashamed of themselves	AGREE……01 DISAGREE…….. 02 DK/NO OPINION …..98	
1608	People with the HIV virus should be blamed for bringing the disease into the community	AGREE……01 DISAGREE…….. 02 DK/NO OPINION …..98	

10.1.14 Section N TRANSACTIONAL SEX

INSTRUCTION TO INTERVIEWER: MAKE SURE THESE QUESTIONS ARE ASKED IN A PRIVATE PLACE AND NO ONE ELSE IS PRESENT, ANDNO ONE ELSE CAN HEAR THE QUESTIONS BEING ASKED

Now I would like to ask you some questions about your recent sexual activity.
Let me assure you once again that your answers are completely confidential.
Your personal information will be separated from your responses so that no one will be able to link your responses to you.

1701	In the last 12 months, were you paid / did you pay anyone in exchange for having sexual intercourse?	YES……01 NO…….. 02	**(IF NO, SKIP TO 1401)**
1702	In the last 12 months, were you given anything (clothes, food, gifts) / did you give anyone anything (clothes, food, gifts) in exchange for having sexual intercourse?	YES……01 NO…….. 02	**(IF NO, SKIP TO 1401)**
1703	Did you know if the person with whom you had sex that time had ever been tested for the HIV virus?	YES……01 NO…….. 02	
1704	Did that person tell you the result of their HIV test?	YES……01 NO…….. 02	**(IF NO, SKIP TO 1306)**
1705	Did the test show that the person had the HIV virus?	YES……01 NO…….. 02	
1706	Did you tell this person your HIV status?	YES……01 NO…….. 02	
1707	The last time you were paid or paid someone in exchange for sexual intercourse, was a condom used?	YES……01 NO…….. 02	
1708	The last time you were given anything (clothes, food, gifts) or gave anything (clothes, food, gifts) to someone in exchange for sexual intercourse, was a condom used?	YES……01 NO…….. 02	
1709	Was a condom used during sexual intercourse every time you were paid or paid someone in exchange for having sexual intercourse in the last 12 months?	YES……01 NO…….. 02	
1710	Was a condom used during sexual intercourse every time you were you were given anything (clothes, food, gifts) or gave anything (clothes, food, gifts) to someone in exchange for having sexual intercourse in the last 12 months?	YES……01 NO…….. 02	

10.1.15 Section o partnering

1801	Are you currently married or living together with a man as if married?	YES, CURRENTLY MARRIED………………01 YES, CURRENTLY WITH A MAN…………. 02 NO, NOT IN UNION…………….. 03	**(IF YES (01 OR 02), SKIP TO 1404)**
1802	Have you ever been married or lived together with a man as if married?	YES, FORMELY MARRIED…………………… 01 YES, LIVED WITH A MAN ………………02 NO…………….. 03	**(IF NO (03), SKIP TO 1308)**
1803	What is your marital status now -are you widowed, divorced or separated?	WIDOWED……………………………………… 1 DIVORCED……………………………………… 2 SEPARATED…………………………………… 3	**(SKIP TO 1308)** **(SKIP TO 1308)** **(SKIP TO 1308)**
1804	Is your husband or partner living with you or is he staying elsewhere?	LIVING TOGETHER…………………………… 1 STAYING ELSEWHERE……………………… 2	
1805	Does your husband/partner have other wives or does he live with other women as if married?	YES………………01 NO…………….. 02 DK………………03	
1806	Including yourself, in total, how many wives or other partners does your husband live with now as if married? **IF DON'T KNOW RECORD 98**	Other wives/partners = _______________	
1807	How old was your husband or partner at his last birthday? **IF DON'T KNOW RECORD 98**	Age at last birthday: First husband/partner = _______________ Second husband/partner = _____________ Third husband/partner = _______________	

1808	When was the last time you were tested for the HIV virus?	WITHIN THE LAST 3 MONTHS………………… 1 MORE THAN 3 MONTHS AGO BUT LESS THAN A YEAR AGO…………………… 2 MORE THAN A YEAR AGO…………………… 3 CAN'T REMEMBER……………………………. 4 NEVER BEEN TESTED………………………… 5	
1809	Do you know your status?	YES………………01 NO…………….. 02	
1810	Are you willing to tell us your status? If yes…	YES, I AM HIV NEGATIVE………………01 YES, I AM HIV POSITVE…………………02 NO, I AM NOT WILLING TO SHARE MY STATUS……………………..……………. 03	
1811	In total how many different people have you had sexual intercourse with in the last 12 months? **IF NONE, RECORD 00**	NUMBER OF SEXUAL PARTNERS__________	**IF '00' SKIP TO 644**

RECENT SEXUAL HISTORY…

	COMPLETE THE QUESTIONS BELOW:	**LAST SEXUAL PARTNER**	**SECOND TO LAST SEXUAL PARTNER**	**THIRD TO LAST SEXUAL PARTNER**
1912	When was the last time you had sexual intercourse?	DAYS……………………... 1 WEEKS……………………. 2 MONTHS…………………. 3 YEARS………………………4	DAYS……………………... 1 WEEKS……………………. 2 MONTHS…………………. 3 YEARS………………………4	DAYS……………………... 1 WEEKS……………………. 2 MONTHS…………………. 3 YEARS………………………4
1913	**FOCUS ON LAST SEXUAL PARTNER AND COMPLETE 1913-1926** The last time you had sexual intercourse (with the last, second to last, third to last), sexual partner, was a condom used?	YES………………01 NO…………….. 02 DON'T REMEMBER….03	YES………………01 NO…………….. 02 DON'T REMEMBER….03	YES………………01 NO…………….. 02 DON'T REMEMBER….03
1914	Was a condom used every time you had sexual intercourse with the (last, second to last, third to last) partner in the past 12 months?	YES………………01 NO…………….. 02 DON'T REMEMBER….03	YES………………01 NO…………….. 02 DON'T REMEMBER….03	YES………………01 NO…………….. 02 DON'T REMEMBER….03
1915	What was your relationship to this (second, third) person with whom you had sexual intercourse?	HUSBAND………….. 1 LIVE-IN PARTNER…………2 BOYFRIEND BUT NOT LIVE-IN…. 3 CASUAL ACQUAINTANCE. 4 PROSTITUTE………………. 5 OTHER ……………………6 (SPECIFY) …………………………………	HUSBAND………….. 1 LIVE-IN PARTNER…………2 BOYFRIEND BUT NOT LIVE-IN…. 3 CASUAL ACQUAINTANCE. 4 PROSTITUTE………………. 5 OTHER ……………………6 (SPECIFY) …………………………………	HUSBAND………….. 1 LIVE-IN PARTNER…………2 BOYFRIEND BUT NOT LIVE-IN…. 3 CASUAL ACQUAINTANCE. 4 PROSTITUTE………………. 5 OTHER ……………………6 (SPECIFY) …………………………………
1916	Do you currently have a relationship with this sexual partner?	YES………………01 NO…………….. 02	YES………………01 NO…………….. 02	YES………………01 NO…………….. 02
1917	How long have you had or did you have a sexual relationship with this person?	DAYS……………………... 1 WEEKS……………………. 2 MONTHS…………………. 3 YEARS………………………4	DAYS……………………... 1 WEEKS……………………. 2 MONTHS…………………. 3 YEARS………………………4	DAYS……………………... 1 WEEKS……………………. 2 MONTHS…………………. 3 YEARS………………………4
1918	Do you know if this person was ever tested for HIV virus?	YES………………01 NO…………….. 02	YES………………01 NO…………….. 02	YES………………01 NO…………….. 02

		NOT SURE….03	NOT SURE….03	NOT SURE….03
1919	Did this person tell you the result of their test?	YES………………01 NO…………….. 02	YES………………01 NO…………….. 02	YES………………01 NO…………….. 02
1920	Did the result of the test show that the person had the HIV virus?	YES………………01 NO…………….. 02 NO RESPONSE….03	YES………………01 NO…………….. 02 NO RESPONSE….03	YES………………01 NO…………….. 02 NO RESPONSE….03
1921	Did you share the results of your AIDS test with this partner?	YES………………01 NO…………….. 02 NEVER BEEN TESTED….03	YES………………01 NO…………….. 02 NEVER BEEN TESTED….03	YES………………01 NO…………….. 02 NEVER BEEN TESTED….03
1922	Is this person older than you, younger than you, or about the same age as you?	OLDER…………………….. 1 YOUNGER………………… 2 ABOUT THE SAME AGE…. 3 DON'T KNOW…………….. 4	OLDER…………………….. 1 YOUNGER………………… 2 ABOUT THE SAME AGE…. 3 DON'T KNOW…………….. 4	OLDER…………………….. 1 YOUNGER………………… 2 ABOUT THE SAME AGE…. 3 DON'T KNOW…………….. 4
1923	Would you say this person is ten or more years older /younger than you or less than ten years older / younger than you?	TEN OR MORE YEARS OLDER............ 1 LESS THAN TEN YRS OLDER…......... 2 TEN OR MORE YEARS YOUNGER............. 3 LESS THAN TEN YRS YOUNGER…......... 4 UNSURE HOW MUCH…… 5	TEN OR MORE YEARS OLDER............ 1 LESS THAN TEN YRS OLDER…......... 2 TEN OR MORE YEARS YOUNGER............. 3 LESS THAN TEN YRS YOUNGER…......... 4 UNSURE HOW MUCH…… 5	TEN OR MORE YEARS OLDER............ 1 LESS THAN TEN YRS OLDER…......... 2 TEN OR MORE YEARS YOUNGER............. 3 LESS THAN TEN YRS YOUNGER…......... 4 UNSURE HOW MUCH…… 5
1924	Do you and your partner drink any alcohol?	YES………………01 NO…………….. 02	YES………………01 NO…………….. 02	YES………………01 NO…………….. 02
1925	The last time you had sexual intercourse with this person, did you or this person drink alcohol?	YES………………01 NO…………….. 02 **IF NO SKIP TO 2001**	YES………………01 NO…………….. 02 **IF NO SKIP TO 2001**	YES………………01 NO…………….. 02 **IF NO SKIP TO 2001**
1926	Were you or your partner drunk at the time? If yes, who was drunk?	RESPONDENT ONLY…….. 1 PARTNER ONLY…………. 2 BOTH RESPONDENT AND PARTNER……………. 3 NEITHER…………………… 4	RESPONDENT ONLY…….. 1 PARTNER ONLY…………. 2 BOTH RESPONDENT AND PARTNER……………. 3 NEITHER…………………… 4	RESPONDENT ONLY…….. 1 PARTNER ONLY…………. 2 BOTH RESPONDENT AND PARTNER……………. 3 NEITHER…………………… 4

GO BACK TO 1912 FOR THE NEXT PARTNER OR, IF NO MORE PARTNERS GO TO THE NEXT QUESTION (2001)

Please tell me if you strongly agree , somewhat agree, somewhat disagree , strongly disagree with the following statements.

		strongly agree	somewhat agree	somewhat disagree	strongly disagree
2001	a. It is ok for girls to initiate sexual activity 1 2 3 4	1	2	3	4
	b. Once you have sex with a partner it's difficult to say no in the future 1 2 3 4	1	2	3	4
	c. Parents have different expectations from girls vs. boys 1 2 3 4	1	2	3	4
	d. In general, boys and girls want the same thing out of a relationship 1 2 3 4	1	2	3	4
	e. Boys depend on girls for information about sexual health 1 2 3 4	1	2	3	4
	f. there is a double standard for boys and girls when it comes to sex, that it is ok for boys to have a lot of partners but not for girls 1 2 3 4	1	2	3	4
	g. it is easier for girls to say NO to sex than it is for boys 1 2 3 4	1	2	3	4
	h. Most people have sex before they are really ready 1 2 3 4	1	2	3	4
	i. Oral sex is not as big of a deal as sexual intercourse 1 2 3 4	1	2	3	4
	j. A man can be sexually satisfied with one wife and no other sexual partner 1 2 3 4	1	2	3	4
	k. A woman can be sexually satisfied with one husband and no other sexual partners 1 2 3 4	1	2	3	4
	l. a woman should be a virgin when she marries 1 2 3 4	1	2	3	4
	m. It is acceptable for a man to force a woman to have sex 1 2 3 4	1	2	3	4
	n. A man feels proud if he has multiple sex partners 1 2 3 4	1	2	3	4
	o. Usually people do not plan to have sex, it just happens 1 2 3 4	1	2	3	4
	p. It is acceptable for a married man to have sexual relations outside marriage 1 2 3 4	1	2	3	4
	q. It is acceptable for a married woman to have sexual relations outside marriage 1 2 3 4	1	2	3	4

	r. Sex before marriage is acceptable if the couple loves each other 1 2 3 4	1	2	3	4
	s. Men need sex more frequently than women do	1	2	3	4

CONCLUDING REMARKS

TREATMENT SITE PARTICIPANTS COMPLETE (1201); COMPARISON SITE PARTICIPANTS COMPLETE (1202)

2101a	**ONLY FOR TREATMENT SITES (TZANEEN, TONGA AND DRIEKOPPIES)** **NOTE TO INTERVIEWER: This question will assist you to determine whether the participant is suitable for a Focus Group interview** Do you have any comments about TCE or the people with the red t-shirts and barrettes that you would like to share?	Capture comments made…	IS THIS A GOOD CANDIDATE? A good candidate is someone who is talkative and wants to share more about TCE or about his/her/community challenges or successes around HIV and AIDS YES……01 NO…….. 02
2101b	**ONLY FOR TREATMENT SITES (TZANEEN, TONGA AND DRIEKOPPIES)** A group discussion will be held after all the surveys are completed. I am not saying that someone will call you, but should there be an opportunity for you to be part of a group discussion where you can talk about HIV in your community and programs that have helped you deal with HIV related matters, would you be willing to participate?	YES……01 CONTACT NUMBER:_____ NO…….. 02	
2102a	**ONLY FOR COMPARISON SITES (MANKWENG, MATSULU A & MATSULU B)** **NOTE TO INTERVIEWER: This question will assist you to determine whether the participant is suitable for a Focus Group interview** Do you have any comments about HIV in your community and programs that have helped you deal with HIV related matters?	Capture comments made…	IS THIS A GOOD CANDIDATE? A good candidate is someone who is talkative and wants to share more about relevant programs and/or about his/her/ community challenges/successes around HIV and AIDS YES……01 NO…….. 02
2102b	**ONLY FOR COMPARISON SITES (MANKWENG, MATSULU A & MATSULU B)** A group discussion will be held after all the surveys are completed. I am not saying that someone will call you, but should there be an opportunity for you to be part of a group discussion where you can talk about HIV in your community and programs that have helped you deal with HIV related matters, would you be willing to participate?	YES……01 CONTACT NUMBER:_____ NO…….. 02	

2102	Thank you for your time… R10 voucher provided to interviewee?	YES……01 NO…….. 02	

INTERVIEWER'S OBSERVATIONS
TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:	
COMMENTS ON SPECIFIC QUESTIONS:	
ANY OTHER COMMENTS:	

SUPERVISOR'S OBSERVATIONS

NAME OF THE SUPERVISOR:	
DATE:	
COMMENTS:	

ANNEXURE D: Weighting of samples to ensure equivalence

		Categories	
		Comparison	Treatment
Languages spoken	Afrikaans		.6%
	English	.5%	
	Sepedi	37%	4%
	Sepedi, Tsonga		1%
	Southern Sotho		1%
	Swazi	61%	71%
	Tonga	1%	
	Tsonga		22%
	Zulu	1%	
	Zulu, Tsonga		1%
Age (grouped)	<= 29.0	36%	16%
	30.0 - 38.0	24%	26%
	39.0 - 50.0	23%	25%
	51.0+	17%	33%
Age	Mean	37.1	44.3
Gender	Female	59%	80%
	Male	41%	20%
People over 18 in household	Mean	3.3	3.6
Number of males	Mean	2	2
Number of females	Mean	2.0	2.1
Urbanised or rural	Deep rural	.5%	15.9%
	Rural	58%	61%
	Semi-urban	36%	19%
	Urban	5%	4%

Profile before weighting (Unweighted data)

		Categories	
		Comparison	Treatment
Languages_spoken	Swazi	54%	65%
	Sepedi	44%	5%
	Zulu	1%	0%
	English	1%	0%
	Tonga	0%	0%
	Afrikaans	0%	0%
	Sepedi, Tsonga	0%	0%
	Southern Sotho	0%	1%
	Tsonga	0%	28%
	Zulu, Tsonga	0%	0%
Age_2	Under 30	27%	35%
	30 - 44	35%	33%
	45 - 59	27%	26%
	60+	11%	7%
@207_Participantage	Mean	39.9	38.0
@101_Howmanypeopleabove 18yearsliveinhousehold	Mean	3	3
@103_Capturenumberofpeop leinthehousehold	Mean	3	2
@102_Numberofmales	Mean	2	2
@102_Numberoffemales	Mean	2.1	2.1
Gender	Female	69%	59%
	Male	31%	41%
Urbanised_or_rural	Rural	67%	60%
	Urban	33%	40%

Profile after weighting (Weighted data)

Categories: Total

			Gender	
			Female	Male
			Count	Count
Age_2	Under 30	Rural	41	24
		Urban	12	15
	Between 30 - 44	Rural	57	23
		Urban	31	12
	Between 45 - 59	Rural	49	12
		Urban	19	13
	60+	Rural	22	6
		Urban	8	3

Categories Total

			Gender			
			Female		Male	
			Count	Unweighted Count	Count	Unweighted Count
Age_2	Under 30	Rural	65	41	41	24
		Urban	21	12	29	15
	Between 30 - 44	Rural	76	57	39	23
		Urban	44	31	23	12
	Between 45 - 59	Rural	71	49	17	12
		Urban	29	19	23	13
	60+	Rural	27	22	7	6
		Urban	13	8	4	3

Categories: Comparison

			Gender			
			Female	Male		
			1	2	Weights to overall	
Age_2	Under 30 (1-2)	Rural (1-2)	23	18	1.8	1.3
		Urban (3-4)	9	14	1.3	1.1
	Between 30 - 44 (3 - 5)	Rural (1-2)	19	16	3.0	1.4
		Urban (3-4)	14	11	2.2	1.1
	Between 45 - 59 (6-7)	Rural (1-2)	21	5	2.3	2.4
		Urban (3-4)	10	10	1.9	1.3
	60+ (8)	Rural (1-2)	5	1	4.4	6.0
		Urban (3-4)	5	1	1.6	3.0

Categories Comparison

			Gender			
			Female		Male	
			Count	Unweighted Count	Count	Unweighted Count
Age_2	Under 30	Rural	41	23	23	18
		Urban	12	9	15	14
	Between 30 - 44	Rural	57	19	22	16
		Urban	31	14	12	11
	Between 45 - 59	Rural	48	21	12	5
		Urban	19	10	13	10
	60+	Rural	22	5	6	1
		Urban	8	5	3	1

Categories: Treatment

			Gender			
			Female	Male		
			1	2	Weights to overall	
Age_2	Under 30 (1-2)	Rural (1-2)	18	6	1.3	3.0
		Urban (3-4)	3	1	3.0	14.0
	Between 30 - 44 (3 - 5)	Rural (1-2)	38	7	0.5	2.3
		Urban (3-4)	17	1	0.8	11.0
	Between 45 - 59 (6-7)	Rural (1-2)	28	7	0.8	0.7
		Urban (3-4)	9	3	1.1	3.3
	60+ (8)	Rural (1-2)	17	5	0.3	0.2
		Urban (3-4)	3	2	1.7	0.5

Categories Treatment

			Gender			
			Female		Male	
			Count	Unweighted Count	Count	Unweighted Count
Age_2	Under 30	Rural	23	18	18	6
		Urban	9	3	14	1
	Between 30 - 44	Rural	19	38	16	7
		Urban	14	17	11	1
	Between 45 - 59	Rural	22	28	5	7
		Urban	10	9	10	3
	60+	Rural	5	17	1	5
		Urban	5	3	1	2