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Rock Leadership "90" :

Strengthening Capacity of Traditional Leaders to Champion the Community Response to Ending AIDS in Africa

Endline Evaluation Assessment for Pilot Phase in Seke District

December 2015

ACKNOWLEDGEMENTS

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A special thank you to the following SAfAIDS staff members for providing overall co-ordination and supervision of the evaluation: Jabulani Mavudze (Team Leader- Research Monitoring and Evaluation), Ngoni Chibukire (Team Leader- Gender, Human Rights& Leadership), Chido Musiya, Gamuchirai Mbetu and Leon-Say Mudadi. Technical guidance and review was provided by Lois Chingandu (SAfAIDS Executive Director) and Rouzeh Eghtessadi (SAfAIDS Deputy Director).

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti Retroviral Therapy
BCF	Behavior Change Facilitator
CBO	Community Based Organization
CSO	Civil Society Organization
EID	Early Infant Diagnosis
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
MOHCC	Ministry Of Health and Child Care
NGO	Non Governmental Organization
PMTCT	Prevention of Mother To Child Transmission
PSI	Population Services International
SRHBC	Seke Rural Home Based Care
VHW	Village Health Worker
V2V	Village to Village

EXECUTIVE SUMMARY

Pilot phase overview

The Rock Leadership '90' project kick started with a 3 month pilot that was implemented in Seke district in Zimbabwe covering four wards namely 2, 3, 7 and 8. These four wards were selected through a consultative approach where district stakeholders and representatives of community leadership were engaged during the Project Inception Meeting. SAfAIDS in partnership with Seke Rural Home Based Care piloted the project for 3 months which ended on October 30; 2015.

Specific project goal, outcome and objectives for the pilot phase (3 months period) were as follows:

Overall goal: To contribute towards increased uptake of HTC, PMTCT, ART and EID services by adult men, women and infants in three wards of Seke district by October 2015.

Outcome: Increased uptake of HTC and access to ART by community members (women, adolescents and men) in Seke district.

Methodology

Data was collected from the four (4) intervention wards (Ward 2, Ward 3, Ward 7 and Ward 8) and one (1) control site (Ward 18). A combination of qualitative and quantitative data collection techniques within a participatory framework were employed for this assessment. Within this framework, data was collected through separate focus group discussions with; 1) traditional leaders ; 2) religious leaders; 3) men aged 25 – 49 years ; 4) women aged 25 – 49 years; 5) boys aged 15 - 24 years; and 6) girls aged 15 - 24 years in the intervention wards. Additional focus group discussions were conducted in ward 18, the control site with; 1) traditional leaders, 2) men aged 25- 49 years and, 3) women aged 25-49 years. Quantitative data was collected using a household survey questionnaire as well as a desk review of health facility registers.

Key findings

Relevance and effectiveness of the project

- Overall, 72% of respondents attended the V2V campaigns, of which 48% were females and 24% were males. 49% of the respondents were in the age group 50+ years, and more respondents were from ward 7 (42%).
- For those who participated in the campaigns, 74% of them reported that the project was very relevant as it helped them to know their HIV status without having to walk for long distances to health centers.
- Having the chief and his wife to be tested for HIV publicly was cited by most FGD participants as the most effective way of encouraging community members to get tested. The chief led by example, hence his subordinates were inspired to get tested for HIV. Similarly, the gesture by the chief and his wife was noted by FGD participants as an effective way to get couples tested together.

Relevance, acceptability and effectiveness of traditional and religious leaders in mobilizing community members for the uptake of HIV services

- Overall, 86% of the respondents, (up from 81% at baseline) concurred that traditional leaders are critical in HIV response in the community, while 13% of the respondents did not agree to this line of thought and 1% of the respondents were not sure if indeed traditional leaders are critical or not. The majority of respondents who reported that traditional leaders are critical were females (57%) while 43% were males.
- The majority of respondents (95%) reported that they feel comfortable talking to some community leaders about HIV issues, while 2% were not sure and only 3% said they were not comfortable talking to community leaders about HIV issues. Most respondents who felt comfortable talking to community leaders about HIV issues were in the 25-49 years age group (46%), while 37% were in the 50+ years age group and only 12% were in the less than 25 years age group. This was a significant increase from baseline findings whereby 87% reported that they were comfortable talking to some community leaders.
- Overall, 80% of the respondents at end-line compared to 69% at baseline reported that they were influenced by community leaders to change their attitudes or perception towards uptake of HIV services
- A considerable proportion of respondents (33%) reported that they had changed their perception and attitudes towards uptake of HIV services due to positive influence from a chief within the past 3 months, up from 14% at baseline. Disaggregating by sex, more females (34%) than males (31%) reported that they had changed their perception and attitude towards HIV services within the past 3 months as a result of positive influence from the chief. With respect to age, 36% of respondents in the 25-49 years age group, 31% in the less than 25 years age group and 11% in the 50+ years age group reported that they had changed as a result of positive influence from the chief.

Evidence of change at immediate outcome level

- Compared to baseline findings, knowledge levels around HTC, PMTCT, ART and EID have significantly improved amongst traditional leaders, religious leaders as well as community members. At baseline, the phrase *"zvitsva kwatiri"* (its new to us) was common in reference to the acronyms during focus group discussions. During the endline evaluation, almost all FGD participants could easily articulate the meaning of the acronyms.
- With reference to baseline findings, there was a sharp rise in the proportion of people self-reporting access to HTC services, from 31% at baseline to 57% after the implementation of the pilot phase. Overall, 54% of respondents who got tested during the pilot phase reportedly did so as a result of positive influence from the chief.
- A review of health facility registers also showed a significant increase in number of people accessing HTC services during the three months of the pilot phase. During the baseline period (March to May 2015) a total of 656 people accessed HTC services at Kunaka hospital and Jonasi clinic. For a similar period of three months (August to October 2015) a total of 1,583 people accessed HTC services (representing141% increase) at the same institutions.
- The cumulative number of people on ART at the intervention institutions rose from 2,323 at the end of May to 4,878 by 31 October 2015.

- Some respondents of the V2V campaigns chose not to be tested for HIV during the campaigns. A greater proportion of these respondents (38%) reported that they already knew their status hence it was not important for them to get tested. However, 16% of the respondents reported that they were not prepared to know their status while 6% cited traditional beliefs and norms as the reason for not being tested.
- During focus group discussions, members of the community concurred that the capacity (knowledge, skills and competences) of traditional, religious, political and wives of community leaders has improved as a direct result of the leaders being involved in the Rock 90 program.

Recommendations

Based on the findings, the following recommendations are presented;

- Demand for HTC services was overwhelming during the campaign days. In view of this, scaling up of the project to include all the wards will go a long way in achieving the first 90 of the 90-90-90 targets.
- During project scale up, it is important to include young leaders who can easily relate with adolescents as they reported being uncomfortable talking to older leaders on issues surrounding HIV.
- To reduce HIV related stigma during campaign days, it is important to couple HTC services with other health services like blood pressure checkup, cancer screening and glucose tests.
- It is also important to target hot spots like bars, since these are places where HIV transmission rates are likely to be higher than in the general population.
- Schools should also be targeted during the scale up of the project since it is important for adolescents to know their HIV status as well as to improve their knowledge on HIV issues in order for them to make informed choices.

Conclusion

Results of the endline evaluation have shown that indeed ***community leaders can influence changes in perception, attitude and behavior of men and women towards uptake of HIV services***. Uptake of HIV services in the intervention wards significantly increased during the pilot phase as compared to baseline findings, and most of this credit goes to the influence of community leaders. It has been shown that a greater proportion of people who accessed HIV services during the pilot phase did so as a result of the positive influence from the chief. The results of this endline evaluation clearly shows that there was significant improvement on the first 90 during the 3 month months pilot phase while the second 90 marginally improved and information for the third 90 was not available. It could be then concluded that achieving meaningful improvement on the second and third 90s requires longer interventions with a minimum span of 12 months.

1. Background

1.1 Project Overview

Supported by UNAIDS, SAfAIDS will implement The Rock Leadership "90": Strengthening Capacity of Traditional Leaders to Champion the Community Response to Ending AIDS in Africa Project in five countries namely Malawi, South Africa, Swaziland, Zambia and Zimbabwe. The project is aimed at strengthening community led responses to address community level factors affecting uptake and access to HIV services in selected districts in five (5) countries in Southern Africa. The program will be implemented over a period of 12 months (1 year). The overall goal of this intervention is to strengthen the community response towards the achievement of Fast Track targets for Ending AIDS; through capacitating community leadership to Champion the End of AIDS, in Southern Africa, by 2016.

1.2 Pilot Phase Overview

The Rock Leadership '90' project kick started with a 3 month pilot that was implemented in Seke district in Zimbabwe covering three wards namely 2, 3, 7and 8. These four wards were selected through a consultative approach where district stakeholders and representatives of community leadership were engaged during the Project Inception Meeting. SAfAIDS in partnership with Seke Rural Home Based Care piloted the project for 3 months which ended on October 30; 2015.

Specific project goal, outcome and objectives for the pilot phase (3 months period) were as follows:

Overall Goal: To contribute towards increased uptake of HTC, PMTCT, ART and EID services by adult men, women and infants in three wards of Seke district by October 2015.

Project Objectives:

1. Strengthened capacity (knowledge, skills, and competences) of 15 traditional and religious leaders on HIV services (HTC, PMTCT, ART and EID) in three wards of Seke district
2. Improved positive attitude towards accessing HIV services (HTC, PMTCT, ART and EID) by 200 men and 200 women through actions of 15 supported community leaders in three wards of Seke district by October 2015
3. Increased uptake of HIV services (HTC, PMTCT, ART and EID) by men, women and children through actions of 15 supported community leaders
4. Generated evidence utilized to inform project scale-up phase by October 2015.

Intermediate Outcome: Increased uptake of HIV services (HTC, PMTCT, ART and EID) by men, women and children in Seke district by October 2015

Immediate Outcome:

1. Improved participation by15 community leaders in promoting access and uptake of HIV services (HTC, PMTCT, ART and EID) by men, women and children in Seke

2. Increased positive attitude towards HIV services (PMTCT, HTC, ART and EID) by men, women and children in Seke

3. Restrictive traditional and religious norms and practices addressed to enable access to HIV services

Main Project Indicators for the Pilot Phase

- % of surveyed men and women self-reporting that traditional and religious leaders have influenced their attitude and behavior towards uptake of HTC, PMTCT and ART services

- % of surveyed men and women self-reporting that traditional and religious leaders have the capacity to mobilize and influence communities for HTC, PMTCT and ART services uptake

- Number of individuals (men, women and children) who received HIV Testing and Counseling (HTC) services for HIV and received their test results during the reporting period (disaggregated by age and sex)

- Number of community leaders speaking out to promote uptake of HIV services by men, women, children in their communities

Target Groups

- Primary project target group will include traditional Leaders who include chiefs, headmen, village heads and traditional healers and religious leaders. The pilot phase aimed to reach out to 200 men and 200 women with HIV prevention information and 200 community members with HTC and/or ART services.

1.3 Purpose and Specific Objectives of the Endline Evaluation

SAfAIDS carried out an endline evaluation covering 3 months project pilot phase ended October 30, 2015. The assessment was fundamental in evaluating and establishing whether the outcomes of the pilot phase were achieved and to find out if using traditional and religious leaders is an effective way of achieving 90-90-90 fast track results at community level. This was also the time to generate information to test the hypothesis: ***Community leaders can influence change in perception, attitude and behaviour of men and women towards uptake of HIV services***.

The specific objectives of the assessment were to:

- Determine relevance and effectiveness of the project focusing on project outputs/deliverables
- Determine the relevance, acceptability, and effectiveness of traditional and religious leaders' participation as key players in mobilizing community members for uptake of HIV services to achieve 90-90-90 Fast Track targets at community level.
- Establish evidence of changes at immediate outcome level focusing on:

i. Capacity of traditional and religious leaders to influence uptake of HIV services (HTC, PMTCT, ART and EID) to achieve the 90-90-90 fast track targets

ii. changes in knowledge on HIV services (HTC, PMTCT, ART and EID) including the 90-90-90 Fast Track Targets by community leaders and community members

iii. change in uptake of HIV services (HTC, PMTCT, ART and EID) by community members

- Generate evidence (lessons learnt and best practices) to inform enhanced programming during the scale up phase

2. Methodology

2.1. Sampling Design

A mixed method study design using concurrent triangulation was used for this study. This was the same design that was used during the baseline assessment, hence this makes the results obtained during the endline evaluation be compared against baseline findings. Thus focus group discussions, one on one interviews and review of health facility registers were the data collection methods used. In addition, key informant interviews and recording of success stories was also done to determine the immediate impact of the pilot phase.

Data was collected from the four intervention wards (2, 3, 7 and 8) as well as the control site (ward 18). Health facilities in these same wards were also included in the evaluation so as to review the health facility registers, and these were Kunaka hospital (ward 2, 3, 7), Jonasi clinic (ward 7, 8) and Masasa clinic (ward 18). Purposive sampling was used to recruit respondents so as to ensure that data was collected from individuals who participated in project interventions and also from those who did not participate. Targeted groups were traditional leaders, religious leaders, adolescents aged 15-24 years, men aged 25-49 years and women aged 25-49 years.

2.2. Data Collection Techniques

Quantitative data collection methods

A structured questionnaire was administered orally to adolescents, adult males and females to capture quantitative information on individual demographics, perceptions on the capacity and influence of community leaders to lead community level HIV responses, factors influencing access and uptake of HIV services by men, women and children. In addition, the questionnaire was also set to determine the effectiveness, relevance and acceptability of traditional and religious leaders in mobilizing community members for the uptake of HIV services.Additional quantitative data was collected from health facility registers. The health facility registers that were reviewed were: HTC register, ART register, ANC register, and Pediatric ART register (Infant ART register). Pilot phase project progress and activity reports were also evaluated to determine the number of people reached, referred and accessing services during the V2V- I know my status campaigns.

Qualitative data collection methods

Focus group discussions

Qualitative data during this evaluation was collected through the use of focus group discussions with community leaders (traditional and religious leaders), adolescents (15-24 years), adult men aged 25-49 years and adult women aged 25-49 years. People living with HIV were also included in these focus group discussions. Additional qualitative data was collected through key informant interviews with nurses, community leaders and other HIV services providers. Success stories, testimonials and case studies were also collected and documented.

3. Findings

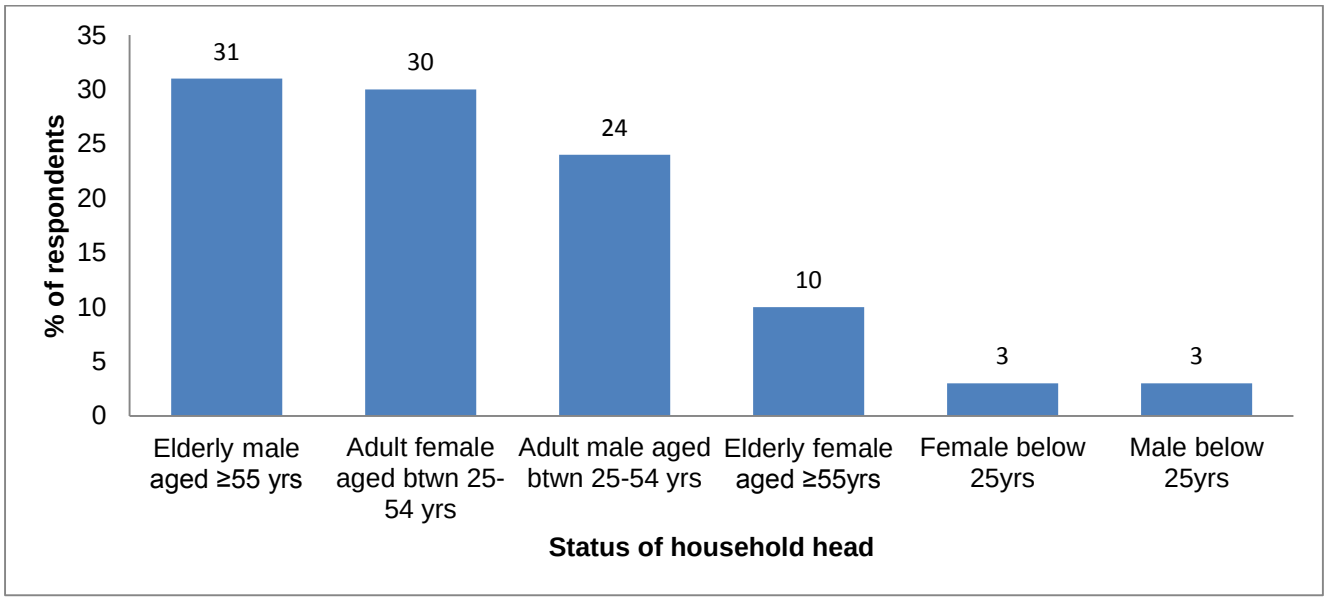
This section presents results from administered questionnaires as well as health facility records i.e. ART registers, HTC registers and PMTCT registers for the four intervention sites and one control site. Also included in this section are findings from the FGDs as well as findings from key informants.

Demographics

A total of 121 people participated in the endline evaluation through one on one interviews. The mean (SD) age was 43 (16.4) years. Females constituted 58% of the respondents while men made up the remaining 42%. A greater proportion of respondents who took part in the one on one interview during the endline survey were from ward 7 (41%) while ward 18 had the least number of respondents (7%). The majority of the respondents (59%) were married, 22% were widows/widowers, 12% were divorced or separated and 7% were single/never married.

Most households were headed by elderly males aged 55 years and above (31%). Only small proportions of households are headed by males and females aged 25 years and below (3% respectively).

Figure 1: Status of household head (n= 121)



Religion and education status

The majority of the respondents reported that they were Christians (90%), while Muslims constituted 0.8%. About 4% of the respondents reported that they had no religious affiliation, while another 4% reported that they follow the African traditional religion. Amongst the Christians; 44% reported that they attend Protestant churches, 22% go to the Roman Catholic Church, 21% attend Apostolic sect/white garment churches and 13% attend Pentecostal churches.

In terms of educational qualifications, the majority of the respondents (66%) had a secondary level qualification, 27% had a primary level qualification, and 1% had no educational qualification. Only 6% of the respondents had a tertiary level qualification.

3.1. Relevance and Effectiveness of the Project

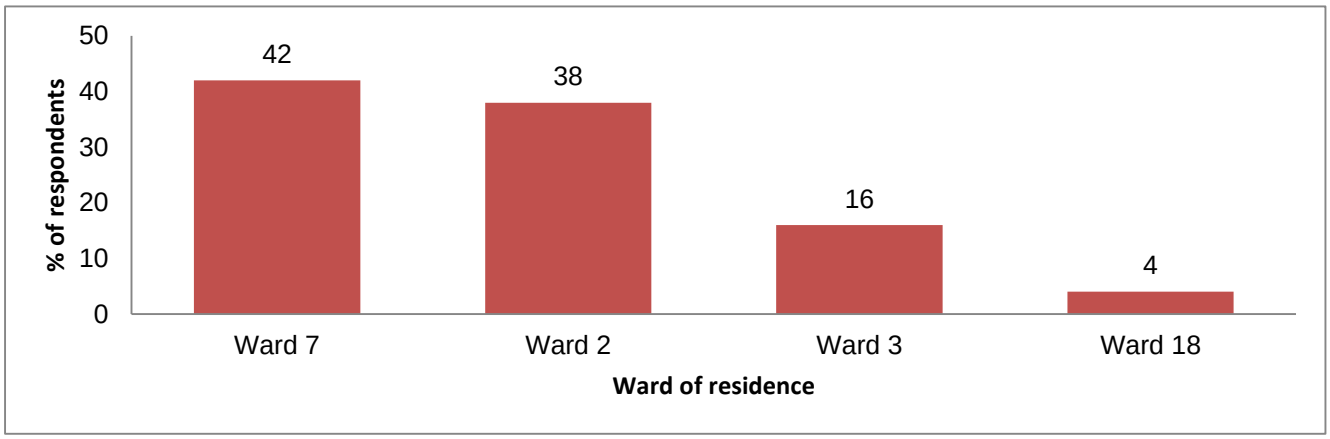
Participation in demand creation events

The village to village events that were supported by SAfAIDS were well attended by people. Overall, 72% of the respondents reported that they attended the V2V- I know my status campaign that were conducted in their wards. Only 28% of the respondents reported that they did not attend these campaigns. The major reason cited for not attending the V2V campaigns was that such individuals were not in their respective wards when campaigns were conducted. Others pointed out that they were busy with other chores during the campaign days, while a small proportion reported that they didn't know what the campaigns were all about. One adolescent said *"Tainge tisingambozive kuti chirongwa chema 90 matatu ndechei saka hatina kuda kumbopinda mazviri"* (We didn't know anything about 90-90-90 targets thus we never bothered to attend the campaigns). A review of the project narrative reports confirmed that the events were well attended, as they managed to reach out to 1,071 people during the community dialogues.

Disaggregated by age, it emerged that most respondents who participated in the V2V were in the age group 50+ years (49%), while those aged between 25 – 49 years made up 43% of the respondents and those aged less than 25 years constituted 8% of the respondents.

Stratifying by sex, more women (66%) participated in the campaigns than men (34%). Most of those who participated were from ward 7(42%).

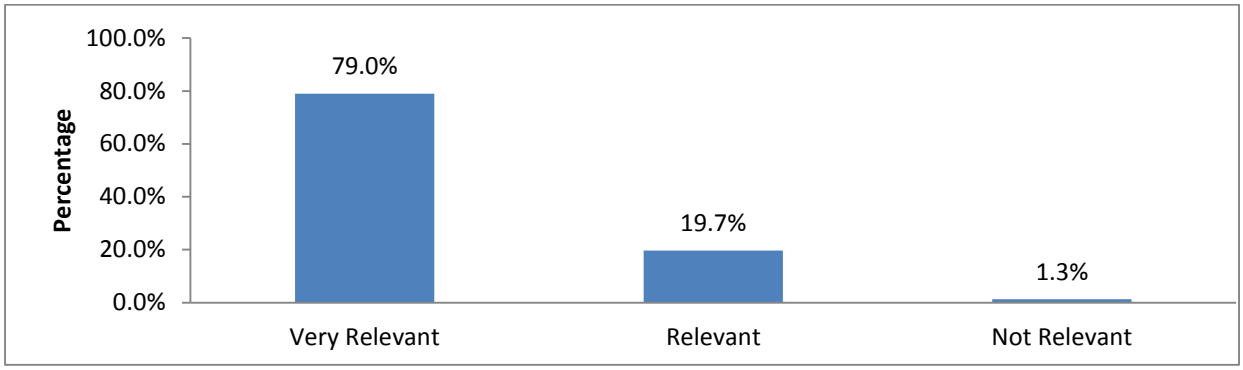
Figure 2: Participation in the V2V campaigns disaggregated by ward



Project relevance

With reference to the relevance of the project in the community, the majority of those who participated in the V2V- I know my status campaign concurred that the project was very relevant (79%), 19.7% felt that it was relevant while only 1.3% of the respondents felt the project was not relevant.

Figure 3: Respondents' Perceptions on Project Relevance



According to most FGD respondents, the project was very relevant in that it gave people in the community an opportunity to know their HIV status since it brought HIV services to the people. In addition, the project helped to enlighten people as well as educate traditional and religious leaders about HIV and how it is transmitted. One traditional leader from ward 8 said: *"Chirongwa che 90-90-90 chakatibatsira kuti tizive dzimwe nzira dzinotapuriranwa nadzo utachiona hwe HIV nekuti isu taingofunga kuti chirwere chinowanikwa pabonde chete"* (the project made us know other HIV transmission methods since we only thought HIV could only be transmitted sexually). In addition, the project also helped those people who had defaulted on their medication to understand the implications of such actions and in a way encouraged them to adhere to treatment.

Adolescents felt the project was very relevant since it helped them to know their HIV status at a young age, thus it helped them plan their future appropriately. Also, the project helped to improve knowledge levels on HIV among the youths.

Project effectiveness

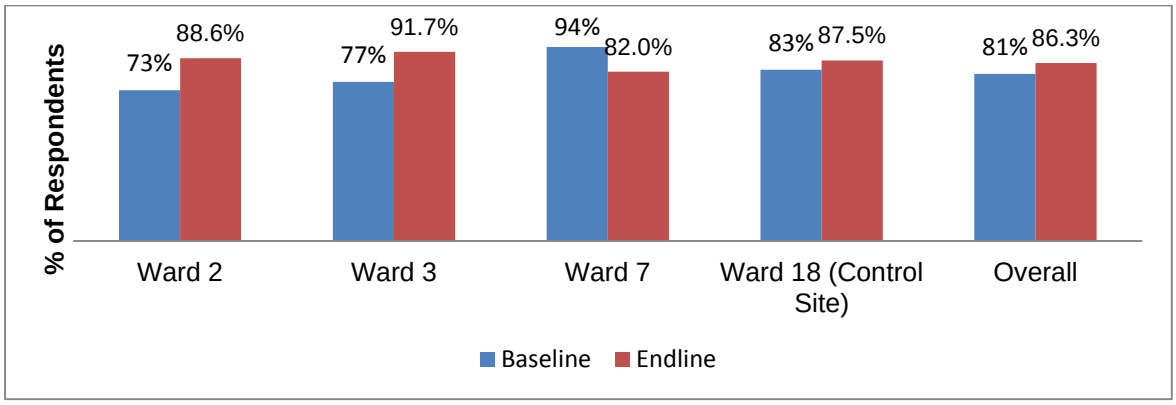
The strategy of using traditional and religious leaders was very effective in encouraging people to come out to get tested. The idea of having Chief Seke and his wife to spearhead the V2V campaigns was pointed out by many people as the most effective way of getting people to get tested. The move was seen by many people in the community as breaking those traditional and cultural norms that prevent people from accessing HIV services. Also, due to the mature age and ascribed authority of the chief and his wife, most elderly people went out to get tested because by their gesture, the chief and his wife showed that knowing one's status is important regardless of age. A certain man in ward 7 said *"Pandakaona Chief Seke nemudzimai wavo pa TV vachiongororwa ropa ravo ndakabva ndazvipira kuti ndichaendawo navadzimai vangu kuti tindoongororwa ropa sezvaitwa na mambo vedu"* (when I saw Chief Seke and his wife being tested on TV during the V2V launch, I vowed to go with my wife to get tested as well). Actions and words of traditional and religious leaders have a huge bearing on actions of community members, who are compelled to follow what their leaders have said or done. Thus using traditional and religious leaders is an effective way of getting HIV messages across to community members.

3.2 Roles and Capacities of Community Leaders in HIV Interventions

3.2.1 Relevance of Community Leaders

Overall, 86% (up from 81% at baseline) of the respondents concurred that traditional leaders are critical in HIV response in the community, while 13% of the respondents did not agree to this line of thought and 1% of the respondents were not sure if indeed traditional leaders are critical or not. The majority of respondents who reported that traditional leaders are critical were females (57%) while 43% were males. In addition, most of these respondents were in the age group 25-49 years (51%), 37% were in the 50+ years age group and 12% were in the less than 25 years age group. Stratified by wards, 35% of the respondents who agreed that traditional leaders are critical were from ward 7 while only 6% were from ward 18.

Figure 4: Respondents who felt that Traditional leaders are Critical in the HIV Response Stratified by Ward



During focus group discussions, it emerged that most people respect the post as well as the power of traditional leaders, thus they are compelled to listen to their leaders. This puts leaders in the right position to tackle issues pertaining to HIV arising in the community. The leaders themselves pointed out that they are the focal persons when it comes to mobilizing people and disseminating information to community members.

Furthermore, community leaders reported that they are willing to engage community members so that they change their attitude and behavior towards uptake of HIV services. The leaders feel they are the custodians of the community they lead and hence they should always be giving guidance and direction to community members to ensure that they have better livelihoods. To quote, one leader from ward 2 said; *"Chirongwa ichi chabetsera kuwedzera ruzivo rwedu isu vatungamiri maererano nezve* HIV *zvekuti tave kukwanisawo kutsiura uye kuraira vatinotungamira nezvechirwere ichi"* (The Rock 90 program improved our knowledge levels on HIV, now we can competently advise and guide members of the community on issues pertaining to HIV). Thus the project has helped leaders become relevant in their communities especially where HIV is concerned.

However, adolescents had a different opinion when it comes to the relevance of traditional leaders. One boy from ward 7 said; *"Sabhuku vedu vave munhu mukuru zvekuti zvinotiremera isu vechidiki kuti titaure naye zvikuru sei pane nyaya dze HIV, nekuti anenge ave kutofunga kuti tave nemisikanzwa"* (Our village head is old, hence it is difficult to approach him on issues pertaining to HIV because he will think we are up to no good). Thus

for adolescents, they would prefer a situation where the leader is partnered with someone younger whom they could easily relate to.

3.2.2 Capacity of Community Leaders on HIV Services

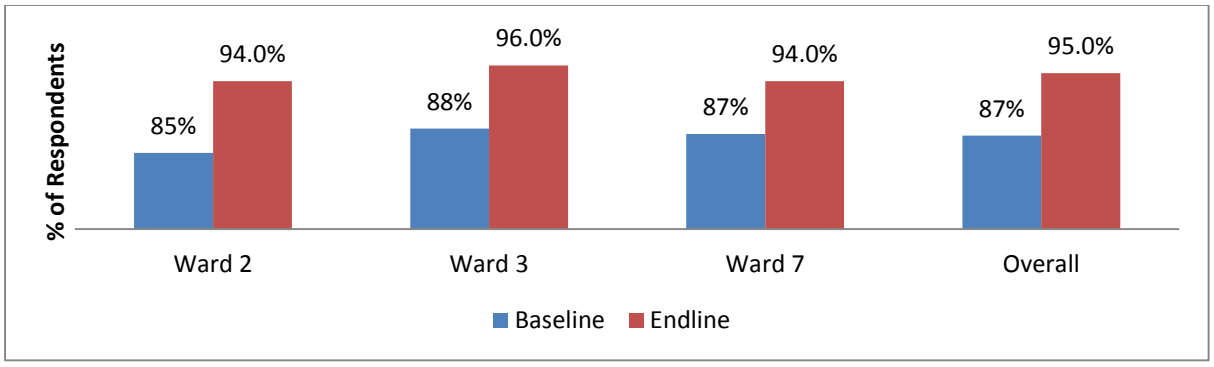
The capacity (knowledge, skills and competences) of traditional, religious, political and wives of community leaders was reported to have improved as a direct result of the leaders being involved in the program. Most FGD participants concurred that the training given to the leaders was comprehensive enough since they could now speak with confidence on issues surrounding HIV and the 90-90-90 targets, a feat which was mainly unheard of before the pilot phase. The leaders themselves agreed that the program played a huge part in building their capacity on issues of HIV as well as the 90-90-90 targets.

The same sentiments were echoed by religious leaders who were involved in the program. One religious leader from ward 2 said as a result of the program, he has coined a new slogan in his church; *"Miteuro yedu kumashure, mapiritsi kumberi"* (Adhere to medication, don't default due to prayer). This slogan, he said, is meant to address the escalating trend of people defaulting medication after visiting some churches where they are told they are cured of HIV through prayer.

3.2.3 Acceptability of Community Leaders

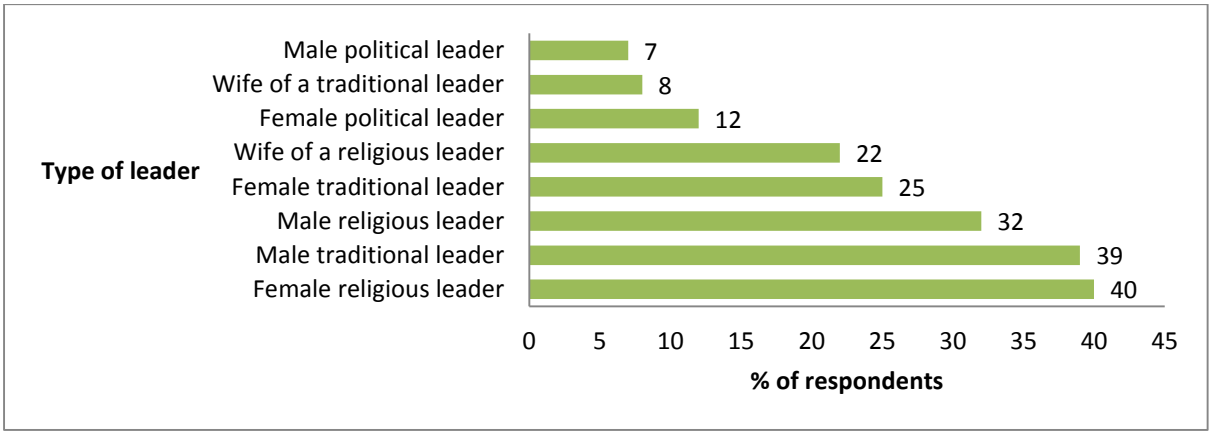
The majority of respondents (95%) reported that they feel comfortable talking to some community leaders about HIV issues (an increase from 87% at baseline), while 2% were not sure and only 3% said they were not comfortable talking to community leaders about HIV issues. Stratified by sex, more females (57%) than males (43%) were inclined to speak to community leaders on HIV issues. With respect to age, most respondents who felt comfortable talking to community leaders about HIV issues were in the 25-49 years age group (46%), while 37% were in the 50+ years age group and only 12% were in the less than 25 years age group. Disaggregated by ward, respondents from ward 7 contributed a higher proportion (40%) of people who reported that they are comfortable talking to community leaders about HIV issues while only 8% of respondents from the control site reported being comfortable talking to leaders about HIV. However, the observed difference between intervention wards and control ward was not statistically significant (p = 0.66).

Figure 5: Respondents who felt Comfortable Talking to Leaders about by Ward



Overall, 40% of respondents reported being comfortable talking to a female religious leader about issues on HIV; while 39% reported that they are comfortable talking to male traditional leaders.

Figure 6: Types of leaders respondents were comfortable talking to



Disaggregating by age, adolescents below the age of 25 reported being more comfortable talking to female political leaders (29%), while respondents in the 25-49 years age group were more comfortable talking to male traditional leaders (46%) and respondents in the 50+ years age group were more comfortable talking to female religious leaders (49%). These findings deviate from baseline findings whereby most respondents in the 25-49 and 50+ years' age groups reported being comfortable talking to male traditional leaders (52% and 69% respectively) while those less than 25 years old reported being comfortable talking to female religious leaders (60%).

Stratifying by sex, a greater proportion of females (55%) reported being comfortable talking to female religious leaders about issues on HIV while a greater proportion of males (52%) were more comfortable talking to male traditional leaders. Compared to baseline findings, females' preferences have changed while for men they remained the same. At baseline females were more comfortable talking to female traditional leaders (66%) while men were more comfortable talking to male traditional leaders (57%).Within the wards, most respondents in ward 7 reported that they were comfortable talking to male religious leaders (47%) whilst for respondents from ward 2, a considerable proportion reported being comfortable talking to female religious leaders (33%).

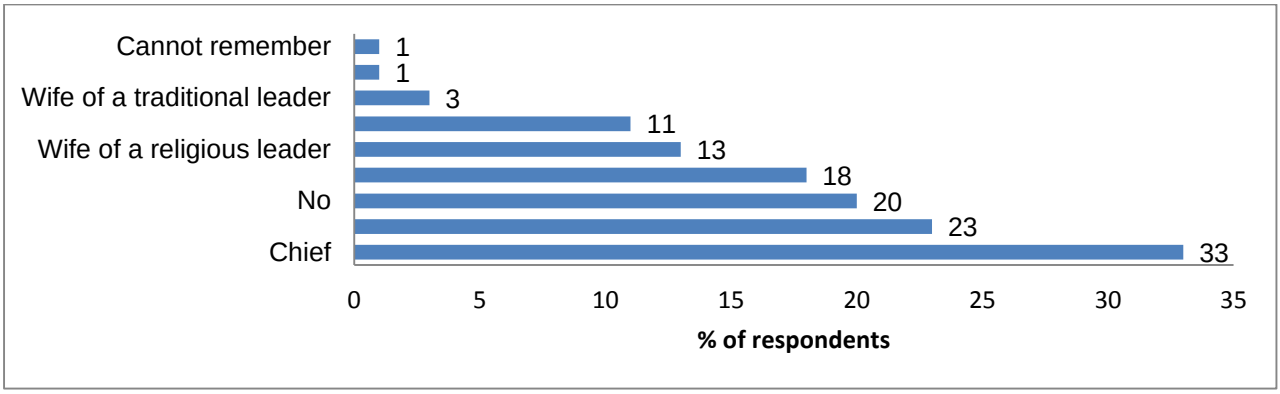
Table 1: Leaders People Feel Free to Talk to on HIV Issues

Type of leader	Ward 2 n (%)	Ward 7 n (%)	Ward 3 n (%)	Ward 18 n (%)	Overall n (%)
Male traditional leader	11 (26)	21 (49)	8 (19)	3 (7)	43 (39)
Female traditional leader	9 (32)	11 (39)	8 (29)	0 (0)	28 (25)
Male religious leader	10 (28)	17 (47)	7 (19)	2 (6)	36 (32)
Female religious leader	15 (33)	19 (42)	10 (22)	1 (2)	45 (41)
Male political leader	0 (0)	4 (9)	2 (8)	2 (25)	8 (7)
Female political leader	4(12)	7 (15)	2 (8)	0 (0)	13 (12)
Wife of a religious leader	13 (39)	7 (15)	3 (13)	1 (14)	24 (22)
Wife of a traditional leader	4 (12)	3 (6)	2 (8)	0 (0)	9 (8)

3.2.4 Perceived Influence of Community Leaders by Respondents

Overall, 80% of the respondents at end-line compared to 69% at baseline reported that they were influenced by community leaders to change their attitudes or perception towards uptake of HIV services. A greater proportion of respondents (33%, up from 10% at baseline) reported that they had changed their perception and attitudes towards uptake of HIV services due to positive influence from a chief within the past 3 months. Other leaders with influence were religious leaders (18%) and wife of a religious leader (13%). However, 20% of the respondents reported that they had not been influenced by any type of leader within the past 3 months.

Figure 7: Percentage of Individuals Influenced by Community Leaders during 3 Months Ended 31 October 2015



Stratifying by ward, the chief's influence was pronounced in all the wards whilst political leaders had the least influence in all the wards. Of note however is the significant proportion of respondents who reported that within the three months of the pilot phase they had not changed their perception towards HIV services as a direct result of influence of community leaders (15% in ward 2, 32% in ward 3, 17% in ward 7 and 17% in ward 18).

Table 2: Influence of Community Leaders by Ward

Type of leader	Ward 2 n(%)	Ward 3 n(%)	Ward 7 n(%)	Ward 18 n(%)	Overall n(%)
Chief	10 (29)	9 (36)	16 (34)	2 (33)	37 (33)
Other traditional leaders	8 (24)	6 (24)	11 (23)	1 (17)	26 (23)
Religious leader	7 (21)	1 (4)	11 (23)	1 (17)	20 (18)
Wife of a traditional leader	1 (3)	1 (4)	1 (2)	0 (0)	3 (3)
Wife of a religious leader	7 (21)	3 (12)	4 (9)	1 (17)	15 (13)
Political leader	0 (0)	0 (0)	1 (2)	0 (0)	1 (1)
Other leaders	5 (15)	0 (0)	6 (13)	1 (17)	12 (11)
Cannot remember	0 (0)	1 (4)	0 (0)	0 (0)	1 (1)
No	5 (15)	8 (32)	8 (17)	1 (17)	22 (20)

Disaggregating by sex, more females (34%) than males (31%) reported that they had changed their perception and attitude towards HIV services within the past 3 months as a result of positive influence from the chief. With respect to age, 36% of respondents in the 25-49 years age group, 31% in the less than 25 years age group and 11% in the 50+ years age group reported that they had changed as a result of positive influence from the chief.

These findings were further confirmed during focus group discussions as most people agreed that the chief was the most influential leader in the community, and hence the most effective. However, since the chief is always busy with other commitments, other traditional leaders were also endorsed as effective in mobilizing community members for the uptake of HIV services to achieve 90-90-90 fast track targets at community level. The leaders themselves felt they are effective as well given the training they received during the pilot phase. Hence, they can now mobilize people for the uptake of HIV services.

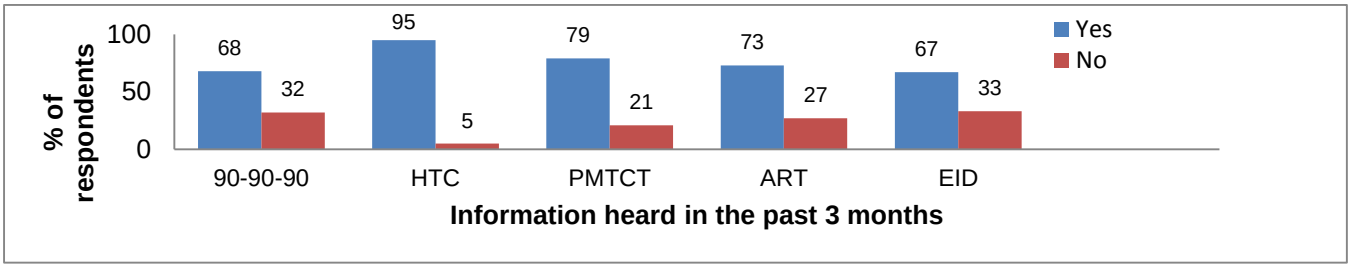
With respect to the effectiveness of the strategy that was used during the pilot phase, most people concurred that the strategy was a good approach as it targeted everyone in the community. Henceforth, the majority of respondents (73%) strongly agreed that working with community leaders to mobilize community members should be scales up for communities to achieve 90-90-90 targets. 22% of respondents also agreed to this, while only 4% did not agree and 1% was not sure if the project should be scaled up.

3.3 Project Results at Immediate Outcome Level

3.3.1 HIV Knowledge Level

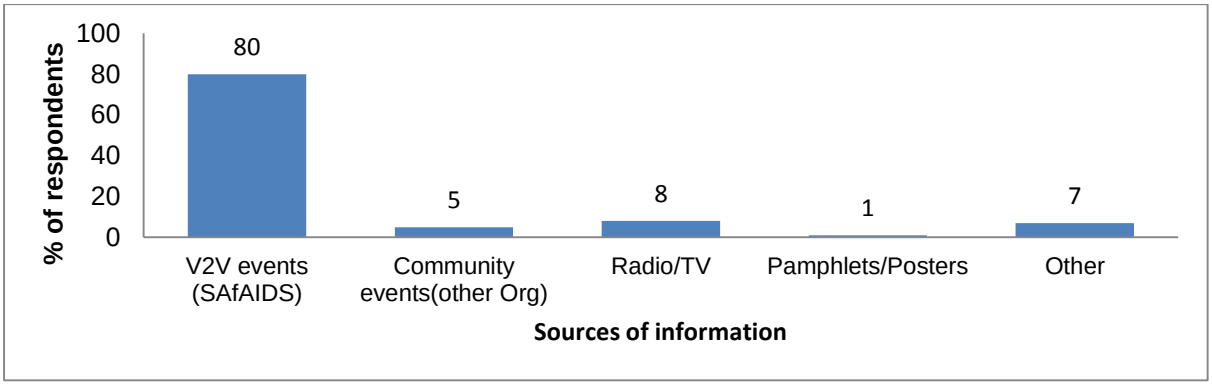
Compared to baseline findings, knowledge levels around HTC, PMTCT, ART and EID significantly improved amongst traditional leaders, religious leaders as well as community members. The majority of FGD respondents could easily comprehend what the acronyms stand for and what they mean with respect to HIV. However, a sizeable proportion of respondents had difficulties articulating the 90-90-90 targets. Those who could speak out comprehensively on the 90-90-90 targets were mainly traditional leaders, religious leaders, village health workers and those community members who had participated in the V2V campaigns. It emerged through one on one interview that during the three months of the pilot phase the majority of people (95%) had heard information pertaining to HTC, while 79% had heard information pertaining to PMTCT and 68% had heard information pertaining to the 90-90-90 targets.

Figure 8: Information heard in the past 3 months Ended 31 October 2015



The major source of information on HIV services like HTC, ART, PMTCT and 90-90-90 targets within the past 3 months was V2V events that were organized by SAfAIDS and SRHBC (80%). Other sources of information like VHWs were mentioned by 7% of the respondents.

Figure 9: Source of information in the past 3 months Ended 31 October 2015

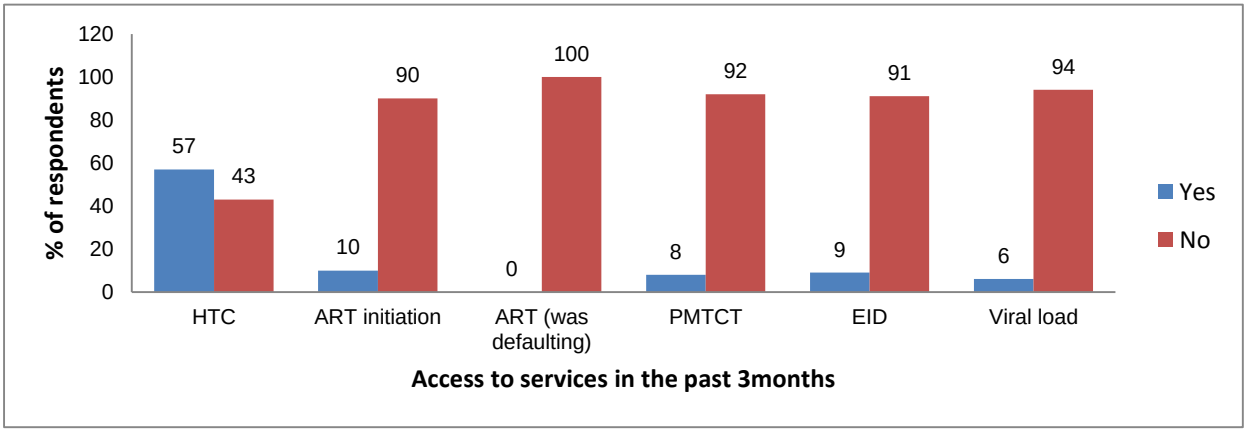


3.3.2 Access to HIV Services

Compared to baseline findings, there was a sharp rise in the proportion of people self-reporting access to HTC services, from 31% at baseline to 57% after the implementation of the pilot phase. Access to other HIV services was low, however no comparison could be made to baseline findings since data was not collected in respect to these other services at baseline. The results presented in Figure 6 below shows that the 3 months pilot period was not enough to significantly contribute to the second and third 90s for the UNAIDS fast track targets. Further analysis showed that of the individuals who accessed HTC services during the three months ended 31 October 2015, 83% participated in the V2V campaigns while 17% did not participate in such campaigns; p-value = 0.005. 100% of the people who reported that they were initiated on ART during the same period had participated in the V2V campaigns. A similar trend was observed among individuals who accessed other services such as PMTCT, EID and viral load where 89%, 90% and 100% respectively had attended the V2V campaigns. However, there was no significant statistical difference due to small number of individuals who accessed these services.

During focus group discussions, respondents pointed out that not all people accessed HTC services during V2V events because PSI ran out of testing kits as confirmed in the project narrative report. However, a review of HTC registers for the period August to October 2015 showed a sharp rise in the number of people being tested for HIV as compared to baseline findings of the same register.

Figure 10: Individuals Self-reporting access to Services in the Past 3 months Ended 31 October 2015



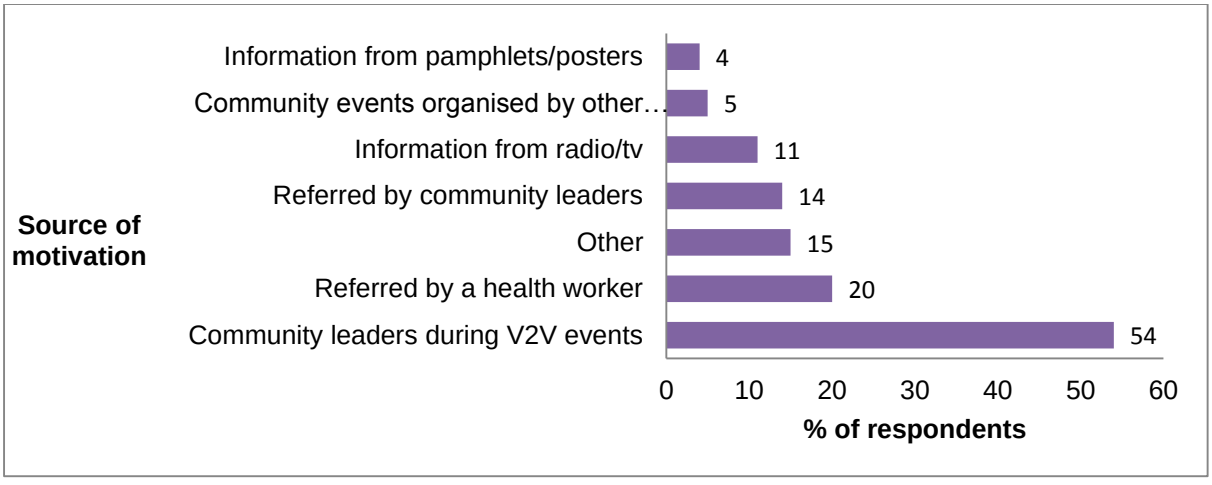
Access to services by family members was generally low with only 41% of respondents reporting that their family members had accessed HTC services within the past 3 months. However, no comparison could be made to baseline findings since this was not assessed at baseline.

Table 3: Number of Individuals ≥ 5 years who Accessed HTC for the period August to October 2015 According to Facility Records

Health Facilities	5-9 years	10-14 years	15-19 years	20-24 years	25-49 years	≥50 years	Total	Monthly Average	Males	Females	HIV positive	Positivity Rate
Jonasi	1	4	49	102	232	81	469	156	160	309	44	9.4%
Kunaka	24	55	170	317	459	89	1114	371	564	550	89	8.0%
Totals for Intervention Sites	25	59	219	419	691	170	1583	528	724	859	133	8.4%
Masasa (Control)	2	0	6	15	54	4	81	27	30	51	8	9.9%

Table 3 above shows the number of individuals aged 5 years and above who accessed HTC according to intervention health facilities records review for this evaluation. For the three months that were under review during the baseline, a total of 656 people were tested for HIV at the 2 health facilities in the intervention wards. During the project pilot phase, a total of 1,583 people were tested for HIV at the same health facilities. This shows that even though most people failed to get tested during the V2V campaigns, they went on to access HTC services from local health facilities as a result of information they received during the campaigns as well as influence and motivation from the community leaders during V2V events as reported by 54% of the respondents shown in figure 11 below. For the control site, a total of 81 people accessed HTC services during the pilot phase. This shows a decrease in the number of people accessing HTC services as 105 people had accessed HTC services during the baseline.

Figure 11: Source of Motivation to Seek HIV services in the Past 3 months



For those under five years of age, access to HTC services also increased from 43 at baseline to 99 during the pilot phase (130% increase) for the two intervention sites. There was no significant increase in access to HTC for the control site as only 6 people accessed HTC services during the period August to October against 5 infants at baseline.

Table 4: Number of Individuals < 5 years who Accessed HTC for the period August to October 2015 According to Facility Records

Health Facilities	<1 year	1-4 years	Total	Monthly Average	Males	Females	HIV positive	Positivity Rate
Jonasi	7	5	12	4	7	5	0	0%
Kunaka	31	56	87	29	34	53	5	5.7%
Totals for Intervention Sites	38	61	99	33	41	58	5	5.1%
Masasa (Control Site)	5	1	6	2	2	4	0	0%

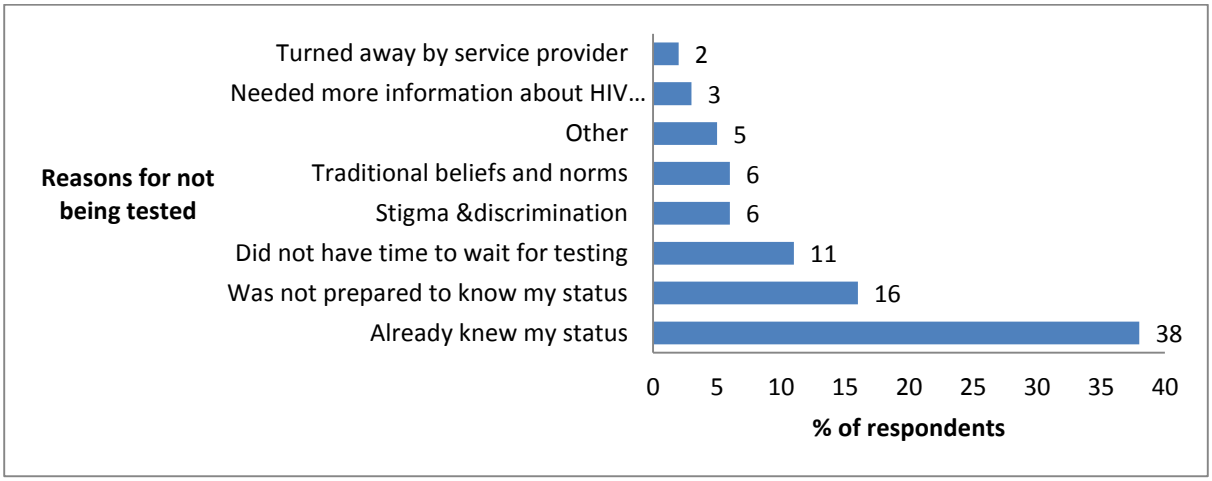
With respect to ART initiation, 96 people were newly initiated on ART during the pilot phase while only 95 were initiated at baseline for the two intervention sites (Kunaka hospital and Jonasi clinic). For the control site (Masasa clinic), there was a decline in the number of people newly initiated on ART from 9 at baseline to 3 people during the period of the pilot phase.

Table 5: Individuals newly initiated on ART from August to October 2015 According to Health Facilities Records

Health Facility	<1 year	1-4 years	5-9 years	10-14 years	15-19 years	20-24 years	25-49 years	≥ 50 years	Total	Monthly Average	Males	Females
Jonasi	0	0	0	0	0	4	13	2	19	6	5	14
Kunaka	1	3	0	0	1	14	54	4	77	26	23	54
Totals for Intervention Sites	1	3	0	0	1	18	67	6	96	32	28	68
Masasa (Control site)	0	0	0	0	0	1	2	0	3	1	2	1

Some respondents of the V2V campaigns chose not to be tested for HIV during the campaigns. A greater proportion of these respondents (38%) reported that they already knew their status hence it was not important to them to get tested. However, 16% of the respondents reported that they were not prepared to know their status while 6% cited traditional beliefs and norms as the reason for not being tested.

Figure 12: Reasons for not being tested during the V2V campaigns (n= 68)



4. Discussion

4.1. Relevance and effectiveness of the project

Community based testing models have high rates of acceptability, are important for increasing early diagnosis, reaching first-time testers and for people who otherwise seldom attend clinical services such as men and adolescents. In the context of the pilot phase, HTC services were brought to the community, in a bid to counter the distance barrier that was pointed out during the baseline as the major factor hindering access to HIV services in the communities. Most people responded positively to this noble initiative and came out in their numbers to get tested. Out of the 1071 people reached during the pilot phase, 480 (45%) managed to access HTC services.

A study in Uganda performed between 2003 and 2005 comparing stand alone, hospital based provider initiated testing and counseling (PITC), household index client home testing and door to door HTC demonstrated that household member and door to door strategies reached the largest proportion of untested clients whilst hospital based PITC yielded the highest positivity rates. According to the project narrative report, the positivity rate during the campaigns was 7.6%. A review of facility registers revealed a positivity rate of 8.4%. These positivity rates are not significantly different, thus in the context of the pilot phase, the cost effectiveness of the project is high since it almost equates the yield of health facilities, with a superior edge of a greater reach.

4.2 Roles and Capacities of Community Leaders in HIV Interventions

Results of the pilot phase have shown that using community leaders to mobilize community members for the uptake of HIV services is an effective model as it managed to receive an overwhelming response. Most people who attended the V2V campaigns did so because of the influence of the chief (33%) as well as other leaders. This was a significant increase from baseline findings where only 10% of respondents had been influenced by the chief. A greater proportion of males (31%) who accessed HTC services reportedly did so as a result of the chief's influence. The Chief is seen as the custodian of culture and tradition and importantly, of customary law; his power and influence has been shown to enhance local HIV responses including increasing uptake of HIV services such as HTC by men. The chief set an example that many men felt was good and hence it was to be replicated.

At baseline, only 81% of the participants reported that community leaders are critical in the HIV response in the community and at the end of the pilot phase this proportion had increased to 86%. This shows that community members are now more inclined to listen to their leaders especially on issues of HIV in the community. Hence, it is important therefore to continue using community leaders to mobilize their communities for the uptake of HIV services so as to achieve 90-90-90 targets.

Studies in Zambia have shown that in scenarios where traditional leaders have been meaningfully involved in community programs on health issues, the communities ended up with improved health outcomes such as increased uptake of health services like HTC. The findings of this endline evaluation supports this as shown by the increase in access to HTC services for the intervention wards during the pilot phase, and most people reporting that access to services was influenced by leaders.

In as much as community leaders are effective in mobilizing people, a lot still needs to be done when it comes to mobilizing adolescents. During focus group discussions, most adolescents felt that traditional leaders are too old hence it is difficult for them to be active when it comes to mobilizing people. They would prefer a scenario where other young people are given the platform to mobilize people for the uptake of HIV services in the community.

4.3 Project Results at Immediate Outcome Level

As a direct result of the pilot phase, access to HIV services improved greatly within the communities. During the baseline, only 31% of the respondents self-reported that they had accessed HTC services in the 3 months preceding the baseline survey. After implementation of the pilot phase, 57% of the respondents reported access to HTC services within the 3 months. A review of the HTC registers also showed a sharp increase in the number of people older than 5 years accessing HTC services during the time of the pilot phase. For the period March to May 2015, 656 people were tested for HIV at the two health facilities in the intervention wards. A similar 3 months period during the pilot phase saw 1583 people accessing HTC services at the same health facilities. This shows that the pilot phase was effective in improving access to HTC services within the communities, in line to achieve the first 90 of the 90-90-90 targets. An opposite trend was observed at the control site whereby access to HTC services actually dropped from 105 people accessing HTC between March and May to 85 people accessing HTC between August and October 2015.

With respect to capacity building of community leaders, the project model proved to be effective as the leaders were already knowledgeable of the 90-90-90 targets by the end of the pilot phase. As a result of improved capacity, the leaders were more effective in mobilizing community members towards the uptake of HIV services.

5. Recommendations and conclusion

Based on the findings of the endline evaluation, the following recommendations are presented:

- Demand for HTC services was overwhelming during the campaign days. In view of this, scaling up of the project to include all the wards will go a long way in achieving the first 90 of the 90-90-90 targets.
- During project scale up, it is important to include young leaders who can easily relate with adolescents as they reported being uncomfortable talking to older leaders on issues surrounding HIV.
- To reduce HIV related stigma during campaign days, it is important to couple HTC services with other health services like blood pressure check up, cancer screening and glucose tests.
- It is also important to target hot spots like bars, since these are places where HIV transmission rates are likely to be higher than in the general population.
- Schools should also be targeted during the scale up of the project since it is important for adolescents to know their HIV status as well as to improve their knowledge on HIV issues in order for them to make informed choices.

Conclusion

The results of the endline survey have shown that the pilot phase was successful hence the need to scale up the project to cover all the wards in the district. The strategy of using community leaders should be maintained as they have been shown to be effective with respect to mobilizing communities towards the uptake of HIV services to achieve the 90-90-90 targets. The results of the pilot phase have confirmed to be true the hypothesis: Community leaders can influence change in perception, attitude and behaviour of men and women towards uptake of HIV services.

However, in order for the project to have a greater appeal, there is need to integrate other health services with HIV services during scale up as this will reduce HIV related stigma. Also, there is need to include younger leaders who are easily accessible especially to the adolescents.

Given the timeframe of project implementation, it is important to act swiftly to scale up the project to other wards in the district so that 90% of the people are tested for HIV. Achieving the first 90 with the current model is possible but there will be need for a stronger referral system to link to care those individuals who test positive during the campaigns. This will ensure that the efforts of traditional leaders to mobilize their communities are put to good use and in a way achieving the second 90, whereby 90% of all people who are HIV positive are on anti-retroviral treatment. The third 90 which refers to virus suppression can only be a reality if the first two are achieved in full.

ANNEXE

Data collection tools

Tool 1: Focus Group Discussion Guide for Adults (Men and Women), Adolescents and PLHIV

Ward Name:_____ Group: _____

Number of Participants: _____ Date of Data Collection:_____

A. Relevance and effectiveness of the project focusing on project outputs/deliverables

i. In the past 3 months, did you participate in the Village to Village event that was supported by SAfAIDS and SRHBC? For those who did not participate why?

ii. Was the project relevant in your community? Comment

iii. Did the project target the relevant traditional and religious leaders to spearhead HIV responses in your community? Explain

iv. What changes did you observe among traditional and religious leaders who were targeted by this project? Focus on knowledge and level of participation in mobilizing community members for uptake of HIV services

v. The Village to Village Campaign; was this an appropriate and effective approach for community leaders to reach out to community members? Comment

vi. The project being evaluated focused on reaching communities with HIV services through mobile outreach programmes. Comment on appropriateness and effectiveness of this approach in your community

vii. What can be done better in future for similar interventions to ensure that interventions are carried out in a more effective manner?

B. Establish evidence of changes at immediate outcome level

i. What is your understanding of each of the following 1) HTC; 2) PMTCT; 3) ART; and 4) EID). What is your understanding of 90-90-90 Targets?

ii. Since August 2015 to date, what have been the main sources of HIV services (HTC, PMTCT, ART and EID) in your community? Check for clinic based, mobile services, door to door service provision?

iii. Since August 2015 to date, do you think access to HIV services (HTC, PMTCT, ART and EID) improved in your community? Why?

iv. For those who attended demand creation events (V2V) in the past 3 months, were you tested for HIV? If yes why? If no why? Investigate if it was because of the influence of the community leaders

v. What are some of the things that traditional and religious leaders have influenced you to do in the past 3 months? Probe influence of leaders on attitudes towards and uptake of HIV services (HTC, PMTCT, ART and EID). Explain

vi. Since August 2015, do you think the capacity (knowledge, skills and competences) of traditional, religious, political and wives of community leaders) on HIV services (HTC, PMTCT, ART and EID including promotion of 90-90-90) has improved?. Probe if the project had any contribution to the changes or lack thereof

vii. Since August 2015 to date, what major factors have been hindering access to HTC, PMTCT, ART and EID in your community? (Traditional & religious norms and practices, individual perceptions & attitudes, etc).

C. Relevance, acceptability, and effectiveness of traditional and religious leaders in mobilizing community members for uptake of HIV services to achieve 90-90-90 targets

i. Do you think 1) traditional leaders and 2) religious leaders are critical in HIV response in your community? If yes in what role? If no why?

ii. Who are the most influential community leaders in your community? (Explore on chiefs, headmen, village heads, religious leaders, wives of community leaders) Explain why

iii. What are the qualities of community leaders who can positively influence your attitude and behaviour towards uptake of HIV services (HTC, PMTCT, ART and EID)? (Investigate on attributes (honest, reputation, economic status, role model, gender, type of leader, skills, knowledge etc) Do you have such leaders in your community?

iv. In the past 3 months what activities have traditional and religious leaders been doing to promote access to HIV services (HTC, PMTCT, ART and EID) by community members in your community? Probe if community leaders were talking about the 90-90-90.

v. Are traditional, religious and their wives active in promoting access to HIV services (HTC, PMTCT, ART and EID) by community members in your community? Comment. Do you feel the project contributed to the level of participation by these community leaders?

vi. Was it a good think to work with the chief and his wife in mobilization of the community for HIV services? Explain

vii. What did you like about the approach of working through traditional and religious leaders to mobilize community members for HIV services (HTC, PMTCT, ART and EID including the 90-90-90 targets)?

viii. What did you dislike about the approach of working through traditional and religious leaders to mobilize community members for HIV services (HTC, PMTCT, ART and EID including the 90-90-90 targets)?

ix. Do you think working through traditional and religious leaders to promote uptake of HIV service (HTC, PMTCT, ART and EID) should be continued in your community? Explain

TTool 2: Focus Group Discussion Guide for Community Leaders (Traditional, Religious or Wives of Community leaders)

Ward Name: _____ Group (Traditional/Religious/Wives): _____

Number of Participants: _____ Date of Data Collection:_____

A. Relevance and effectiveness of the project focusing on project outputs/deliverables

i. In the past 3 months, did you participate in the Village to Village event that was supported by SAfAIDS and SRHBC? For those who did not participate why?

ii. Was the project relevant in your community? Comment

iii. Did the project target the relevant traditional and religious leaders to spearhead HIV responses in your community? Explain

iv. What changes did you observe among traditional and religious leaders who were targeted by this project? Focus on knowledge and level of participation in mobilizing community members for uptake of HIV services

v. The Village to Village Campaign; was this an appropriate and effective approach for community leaders to reach out to community members? Comment

vi. The project being evaluated focused on reaching communities with HIV services through mobile outreach programmes. Comment on appropriateness and effectiveness of this approach in your community

vii. What can be done better in future for similar interventions to ensure that interventions are carried out in a more effective manner?

B. Establish evidence of changes at immediate outcome level

i. What is your understanding of each of the following 1) HTC; 2) PMTCT; 3) ART; and 4) EID). What is your understanding of 90-90-90 Targets?

ii. Since August 2015 to date, what have been the main sources of HIV services (HTC, PMTCT, ART and EID) in your community? Check for clinic based, mobile services, door to door service provision?

iii. Since August 2015 to date, do you think access to HIV services (HTC, PMTCT, ART and EID) improved in your community? Why?

iv. For those who attended demand creation events in the past 3 months, were you tested for HIV? If yes why? If no why?

v. What are some of the things as community leaders have you influenced some community members to do in the past 3 months? Probe influence of leaders on attitudes towards and uptake of HIV services (HTC, PMTCT, ART and EID)

vi. Since August 2015, do you think your capacity (knowledge, skills and competences) of traditional, religious, political and wives of community leaders) on HIV services

(HTC, PMTCT, ART and EID including promotion of 90-90-90) has improved?. Probe if the project had any contribution to the changes or lack thereof

vii. Since August 2015 to date, what major factors have been hindering access to HTC, PMTCT, ART and EID in your community? (Traditional & religious norms and practices, individual perceptions & attitudes, etc).

C. Relevance, acceptability, and effectiveness of traditional and religious leaders in mobilizing community members for uptake of HIV services to achieve 90-90-90 targets

i. Do you think as community leaders you are critical in HIV response in your community? If yes in what role? If no why?

ii. Are you willing to engage community members so that their change their attitude and behaviour towards uptake of HTC, PMTCT, ART and EID services? Explain

iii. Since August 2015 to date; what activities have you been doing as community leaders to promote access to HIV services (HTC, PMTCT, ART and EID) by community members in your community? Probe if community leaders were talking about the 90-90-90.

iv. Do feel you have the ability (existing influence) and capacity (knowledge, skills, and competence) to influence community members to change their attitude and behavior towards uptake of HTC, PMTCT, ART and EID services? Explain.

v. Do you feel the training provided by this project adequately equipped you to engage and mobilize communities for uptake of HIV services? Explain

vi. What did you like about the approach of working through traditional and religious leaders to mobilize community members for HIV services (HTC, PMTCT, ART and EID including the 90-90-90 targets)?

vii. What did you dislike about the approach of working through traditional and religious leaders to mobilize community members for HIV services (HTC, PMTCT, ART and EID including the 90-90-90 targets)?

viii. Do you think working through traditional and religious leaders to promote uptake of HIV service (HTC, PMTCT, ART and EID) should be continued in your community? Explain

Thank You

Tool 3: Household Survey Tool

INTERVIEWER

Good morning/afternoon sir/madam. My name is _____ representing SAfAIDS/SRHBC. SAfAIDS is carrying out an end of evaluation assessment for the pilot phase of the Rock Leadership "90" which was implemented in Seke district. The purpose of the evaluation is to assess the impact of the pilot in the district. You have been identified to participate in the evaluation representing your community. Participation in the exercise is voluntary and information that you give will remain strictly confidential and your answers will never be shared with anyone other than our project team. Our discussion will last approximately 20 minutes.

Instructions

All the questions require you to just select an answer from the given options. Please answer ALL questions as it is important for us to have complete information. ***Please CIRCLE the number next to your answer. If you make a mistake, cross out the incorrect answer}***

Section A: Background Characteristics		
Area Details		
District		
Ward Name or Number		
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**
1	Age of respondent	Enter age _____
2	Sex of Respondent	1 = Male 2 = Female 3 = Other (Specify)
3	Marital status of respondent	1 = Married 2 = Widow/Widower 3 = Never married 4 = Divorced/seperated
4	Status of household head	1 = Adult male aged between 25-54 years 2 = Adult female aged between 25-54 years 3 = Elderly female aged ≥ 55 years 4 = Elderly male aged ≥ 55 years 6 = Female below 25 years 7 = Male below 25 years
5	What is your religion?	1 = None 2 = Christian 3 = Muslim 4 = African Traditional Religion 5 = Other (Specify)_____
6	If Christian, please specify which church you attend	1 = Roman Catholic 2 = Protestant(Lutheran, SDA, Methodist,Anglican) 3 = Pentecostal (AFM, ZAOGA, Christ Embassy, ett) 4 = Apostolic Sect/White Garment
7	What is your educational status?	1= None 2= Primary 3= Secondary 4 = Higher

A. Project Relevance and Effectiveness			
8	In the past 3 months, did you ever participate in any activity involving creation of demand and uptake of HIV services supported by SRHBC (V2V)?	1 = Yes through community events organized by SRHBC and/or community leaders 2 = Yes through other organizations 3 = Never	
9	If yes in 8 above; do you think such activities are relevant in your community?	1 = Very relevant 2 = Relevant 3 = Not relevant 4 = Not sure 5 = N/A	
10	If Relevant or very relevant in 9 above why?		
11	If not relevant or not sure in 9 above why?		
B. Evidence of changes at immediate outcome level (Knowledge, Attitude and Uptake of Services)			
12	In the past 3 months, have you ever heard about any of the following?	Yes	No
	90-90-90		
	HIV testing and counseling		
	PMTCT		
	ART		
	EID		
	Other (specify)		
13	If Yes to any in the list in Qn 12 above; state the source(s) of information. *Circle all that apply*	1 = Village to Village events organized by SRHBC and community leaders (SAfAIDS events) 2 = Community events organised by other organizations 3 = Newspapers 4 = Radio and/or TV 5 = Pamphlets/Posters/brochures/booklets 6 =Other (Specify)_____	

14	In the past 3 months, did you and/or any family member receive any of the following services?	**Self**		**Family Member**	
		Yes	**No**	**Yes**	**No**
	HTC				
	ART initiation				
	ART – was defaulting				
	PMTCT				
	EID				
	Viral load				
	Other (specify):				
15	What motivated you to get the services you mentioned in question 14 above? *(Circle all that apply)*	1 = Community leader(s) during V2V events 2 = Referred by a community leaders 3 = Referred by a village health worker 4 = Community events organised by other organizations 5 = information from newspapers 6 = information from radio and/or TV 7 = information from pamphlets/Posters/brochures/booklets 8 =Other (Specify)_____			

16	For those who attended the V2V campaigns, who did not get tested for HIV during the V2V event, what were the reasons? *(Circle all that apply)*	1 = Already knew my status 2 = was not prepared to know my status 3 = Needed more information about HIV testing 4 = Did not have time to wait for testing 5 = Wanted to be tested by service providers turned me away 6 = Stigma and discrimination 7 = Traditional beliefs and norms 8 = Religios beliefs 6 = Other (Specify)_____ 7 = N/a
17	If respondent has never tested for HIV in the past three months why? *(Circle all that apply)*	1 = Traditional beliefs and norms 2 = Religious beliefs and norms 3 = Spouse not allowing me to do so 4 = Do not want to know my HIV status 5 = Negative attitude of health care workers 6 = long distances to the nearest service provider 7 = Stigma and discrimination 8 = Had testing 4 – 6 months ago 9 = Other (Specify)_____
18	Number of children aged ≤ 5 years in your household	1 = 0 2 – 0ne to two 3 = Three to five 5 = Above five
19	Age of the youngest child in the household (Applicable to households with children ≤5 years)	1 = ≤ 2 years 2 = 3 - 4 years 3 = > 4 years
20	Relationship between respondent and the youngest child with 0 -5 years age range *(Applicable to households with children ≤5 years)*	1 = Mother 2 = Father 3 = Grandmother 4 = Grandfather 5 = Other relative 6 = N/a
21	Do you know the HIV status of the youngest child in your household *(Applicable to households with children ≤5 years)*	1 = Yes 2 = No
22	If 'No" in 21 above why? *(Circle all that apply)*	1 = Not important to know it 2 = I do not want to know about it 3 = Traditional practices and beliefs 4 = Religious practices and beliefs 5 = Long distances to the nearest service provider 6 = Negative attitude of service providers 7 = Stigma and discrimination 8 = Spouse not supportive
C. Relevance, acceptability, and effectiveness of traditional and religious leaders in mobilizing community members for uptake of HIV services		
23	Do you think that traditional leaders are	1 = Yes

	critical in addressing HIV challenges in your community?	2 = No 3 = Not sure
24	Do you feel comfortable talking to some community leaders about HIV issues?	1 = Yes 2 = No 3 = Not sure
25	If 'Yes' in 24 above what type(s) of leaders? *(Circle all that apply)*	1 = Male traditional leader 2 = Female traditional leader 3 = Male religious leader 4 = Female religious leader 5 = Male political leader 6 = Female political leader 7 = Wife of a religious leader 8 = Wife of a traditional leader
26	If not 'Yes' in 24 above or for some leaders not selected in 25 above why? *(Circle all that apply)*	1 = I do not trust them 2 = Not of good standing in the community 3 = Lack knowledge and skills on HIV issues 4 = Not sensitive to confidetial matters 5 = Not mature 6 = Because of their sex 7 = They are proud 8 = Abuse their power on community members 9 = Because they are poor
27	In the past 3 months, did you ever change your perception, attitude or actions towards something due to positive influence from a community leader in your community? *(Circle all that apply)*	1 = Yes from a chief 2 = Yes from other traditional leaders 3 = Yes from a religious leader 4 = Yes from wife of a traditional leader 5 = Yes from wife of a religious leader 6 = Yes from a political leader 7 = Yes from other leader(specify)_____ 8 = Cannot remember 9 = No
28	In the past 3 months, did you ever change your perception and attitude towards HIV services due to positive influence from a community leader in your community? *(Circle all that apply)*	1 = Yes from a chief 2 = Yes from other traditional leaders 3 = Yes from a religious leader 4 = Yes from wife of a traditional leader 5 = Yes from wife of a religious leader 6 = Yes from a political leader 7 = Yes from other leader(specify)_____ 8 = Cannot remember 9 = No
29	Are there communities leaders in your community that you feel can mobilize community members for uptake of HIV services in your community? *(Circle all that apply)*	1 = Yes; a chief 2 = Yes; wife of the chief 3 = Yes; other traditional leaders 4 = Yes; religious leaders 5 = Yes; wives of a traditional leader 6 = Yes; wives of a religious leader 7 = Yes; political leaders 8 = Yes; other leaders(specify)_____ 9 = No
30	Reasons for a 'Yes' in 29 above	1 = Because of their ascribed power 2 = Trust worthy

	(Circle all that apply)	2 = Good social standing 4 = They have wealth 5 = They are sensitive to confidential matters 6 =They are mature 7 = Because of their sex 8 = Their knowledge and skills 9 = They respect other people
31	Reasons for 'No' in 29 above or not selecting a particular group of leaders *(Circle all that apply)*	1 = I do not trust them 2 = Not of good standing in the community 3 = Lack knowledge and skills on HIV issues 4 = Not sensitive to confidetial matters 5 = Not mature 6 = Because of their sex 7 = They are proud 8 = Abuse their power on community members 9 = They are poor 10 = Other(Specify)_____
32	Do you agree that working with community leaders to mobilize community members-- should be scaled up for community to achieve 90-90-90 targets?	1 = Strongly agree 2 = Agree 3 = Do not agree 4 = Not sure

THANK YOU