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HAPA Grant
Final Evaluation Report
"Training of Trainers for AIDS Education"
Save the Children/Zimbabwe Field Office
September 1, 1989 - August 31, 1991

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GLOSSARY

AHC	Area Health Coordinator
AID	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AmFAR	American Foundation for AIDS Research
CL	Community Leader
CS	Child Survival
DIP	Detailed Implementation Plan
DMO	District Medical Officer
DNO	District Nursing Officer
EHT	Environmental Health Technician
EOP	End of Project
FE	Final Evaluation
FHW	Farm Health Worker
HAPA	HIV and AIDS Prevention in Africa
HGSP	HAPA Grants Support Program
HIS	Health Information System
IA	Impact Area
MCCD	Ministry of Cooperatives and Community Development
MOH	Ministry of Health
MTE	Midterm Evaluation
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
PMD	Provincial Medical Director
PNO	Provincial Nursing Officer
PWAs	People with AIDS
SC	Save the Children
SCN	State-Certified Nurse
TM	Traditional Midwife
TOT	Training of Trainers
VCW	Village Community Worker

EXECUTIVE SUMMARY

The SC/Zimbabwe HAPA project is a two-year activity, funded at \$90,028, and designed to piggy-back onto the Child Survival activities that were initiated in 1986. The project serves the same three impact areas as the CS grant including two rural areas, Muusha and Mutema, and Mupedzanhamo, a commercial farming area 14 km outside of Harare. The project emphasized a Training of Trainers approach to enable the AIDS messages to reach the families in the communities and endure long beyond the end of the grant period. The evaluation team used results from a 30-cluster household KAP survey conducted in two out of three project areas, focus group discussions, and in-depth interviews to assess effectiveness of project activities.

For the most part, the integration of the AIDS project into the ongoing activities of the CS project has been of great benefit. In a short period of time most of the objectives were accomplished as follows: 97% of rural health centre staff and all three MCCD officers received five days of AIDS prevention training; 95% of VCWs/FHWs attended at least 3 days of TOT workshops, and 93% attended at least one 1-day refresher course. The training of community leaders was particularly remarkable with 526 receiving AIDS education of at least 2 days' duration. The VCWs/FHWs trained 4,640 families, or 76% of the families in the three IAs.

The retention of AIDS information was impressive: 91% of VCWs/FHWs were able to demonstrate the proper use of a condom on a model, 86% were able to name the three main modes of HIV transmission, and 96% were able to give three methods of prevention of HIV transmission. Data from the 30 cluster KAP household survey conducted in two of the three impact areas showed that 87% of men and 85% of women surveyed correctly identified the 3 main modes of AIDS transmission, and an average of 34% of men and 37% of women could state 3 or more ways to prevent transmission. The results from the survey will be further analyzed with the aid of a computer.

Some of the major conclusions of the evaluation and the corresponding recommendations are as follows:

Conclusion:

An AIDS education project of 2 years' duration is insufficient to effect attitude and behavior change.

Recommendations:

AIDS education projects should be of no less than 3, and preferably at least 5, years' duration in order to have sufficient time to begin to affect attitudes and behavior.

Future projects should provide for baseline and end-of-project KAP surveys in both project and control areas. This will allow more reliable conclusions to be reached about effectiveness of project interventions.

Conclusion:

The effectiveness and sustainability of the HAPA project was enhanced by its high degree of integration into the existing CS health program and MOH structure.

Recommendations:

Rather than standing on its own, AIDS education should be incorporated into Primary Health Care activities.

The MOH nurses seconded to the project should document lessons learned about secondment to share with the MOH and other NGOs interested in their experience.

Conclusion:

VCWs/FHWs and community leaders are the two keys to providing effective community-based AIDS education. The VCWs/FHWs are the direct conduit for AIDS information to families while community leaders play a crucial role in creating awareness of and supporting the efforts of the VCWs/FHWs.

Recommendations:

MOH should continue to provide updates and refresher courses on AIDS for community-based workers, both those previously trained and new personnel.

MOH should continue to provide AIDS education to community leaders both inside and outside the project areas.

MOH and MCCD staff should continue to supervise the activities of the VCWs/FHWs.

Conclusion:

Until more acceptable methods are developed, condoms remain the best method to prevent sexual transmission of HIV. While condom use and acceptance has grown over the past 2 years, their promotion presents significant challenges for an AIDS education program.

Recommendations:

With MOH, develop a strategy for ensuring that sufficient supplies of condoms reach the rural clinics. Condom availability must be guaranteed to support behavior changes expected to stem from educational programs.

More focus should be given to issues related to women's relative lack of power in their relationships with men and their difficulty in convincing men to use condoms. Education which can help women to communicate more assertively with their sexual partners should be stressed.

Simple, pictorial instructions on condom use should be developed and made available for non-literate people.

Condom distribution should be monitored so that increased demand can be documented, supplies can be adequately maintained, and project effectiveness can be better tracked.

I. INTRODUCTION

Save the Children Federation/USA (SC) has participated in rural development programs in Zimbabwe since 1981. Child Survival (CS) activities began in 1986 in three impact areas (IAs). Mutema and Muusha IAs are located in Chipinge and Chimanimani Districts of the Eastern Highlands, Manicaland Province. The Mutema IA currently covers a population of 26,538, while in Muusha, where the terrain is more mountainous and less densely populated, the population served totals 16,641.

Small-scale subsistence farming is the primary economic activity. The third IA, Mupedzanhamo, is a commercial farming area in Mashonaland East Province, 8 miles south from the city limits of Harare. The population of this area - mostly migrant farm workers - is highly transitory and the total population served in this area has decreased to 8,056. Migrant farm workers represent one of the most seriously disadvantaged segments of the population in Zimbabwe as most live on private commercial farms which are often poorly served by government services.

In April 1989, SC/Zimbabwe was awarded one of the HAPA grants (HIV and AIDS Prevention in Africa) and activities were begun in October 1989 using the already existing CS infrastructure in all three IAs. The program, titled "Training of Trainers for AIDS Education", targeted three specific groups for AIDS prevention training and awareness-raising workshops in Year 1: Rural Health Clinic Staff (MOH) and Ministry of Cooperatives and Community Development (MCCD) Officers, Community Leaders, and Village Community Workers/Farm Health Workers (VCWs/FHWS). In the second year, the VCWs and FHWS with support and encouragement from clinic staff, MCCD officers, and community leaders targeted families for training in the three IAs.

II. EVALUATION METHODOLOGY

This report summarizes the methods, findings, and recommendations of the final evaluation (FE) for the SC HAPA project in Zimbabwe. The project was evaluated according to the Detailed Guidelines for HAPA Grants Project Final Evaluations prepared by HGSP. The purpose of this evaluation, the FE team, and their activities during the three-week evaluation are described below.

A. Purpose of the Evaluation

The main purpose of this end-of-project evaluation is to assess the effectiveness of the project's key interventions and approaches to determine how well the 2-year project has met its stated objectives. As this project (and its objectives) have focused almost exclusively on training, the evaluation will attempt to assess the effectiveness of the training received by different groups in terms of outputs (numbers of training sessions and people trained), outcomes (changes in the knowledge and/or skills due to training), process (the quality of the training), and, finally, whether this training program can and will be sustained after the end-of-project.

A second, but equally important purpose of the evaluation is to reflect back on the experiences of the SC HAPA project to highlight lessons learned which can be documented and shared with others doing AIDS prevention both in Zimbabwe and elsewhere.

B. Team Composition

The final evaluation of the HAPA program was conducted jointly with the final evaluation for the Child Survival program being implemented in the same project areas. The evaluation team, with some members focusing on AIDS while others were more responsible for CS, included the following members:

Stanley Jere	Health Programmes Administrator SC/USA, Malawi
Ellen Tagwireyi	Area Health Coordinator World Vision Int'l, Zimbabwe
Theresa Ndikudze	District Nursing Officer (elect) Chimanimani, Manicaland
Thokozile L. Ngwenya	Senior Staff and Development Officer for Health Agricultural Finance Corp. Harare

Nicola Gates	AIDS Coordinator SC/USA, Westport
Dr. Louis Fazen	Visiting Lecturer University of Zimbabwe School of Medicine
Dr. N. Lynn Eckhert	Visiting Lecturer University of Zimbabwe School of Medicine

The AIDS/Child Survival Coordinator for SC/USA, Zimbabwe, Linile Malunga, served as a resource person for the team.

C. Evaluation Methodology

The FE team had initial planning meetings to determine the purpose of the evaluation, to define questions to be answered during the evaluation, to determine data needs and how such data would be collected, recorded, and analyzed, to determine how recommendations would be formed, and, finally, to plan how findings, lessons learned, and recommendations would be shared with all the parties involved, including SC staff in Zimbabwe and the Westport Home Office, MOH, MCCD, the communities, HGSP, and A.I.D..

Prior to developing the evaluation instruments, the report of the 30-cluster household KAP survey conducted during the three week period prior to the start of the evaluation was reviewed. The initial survey report is included in this report as Appendix A. Further analysis of the data will be done using the Epi-Info software package.

Questionnaires were developed for in-depth interviews with the following categories of informants:

- Village Community Workers/Farm Health Workers
(including a 50% randomly selected sample of VCWs from Muusha (n=20) and Mutema (n=16) and all of the FHWs from Mupedzanhamo (n=13))
- Farm owners/farm managers in Mupedzanhamo
- Rural Council in Mupedzanhamo
- Impact Area Manager for Muusha/Mutema
- Area Health Coordinators (3)
- AIDS/CS Coordinator
- DNOs/DMOs from each of the three districts
- PNOs/PMDs from each of the two provinces
- Rural Clinic staff (nurses and EHTs) from Muusha and Mutema
- Director, SC/USA in Zimbabwe
- AIDS Coordinator, SC/USA, Westport, Connecticut

Included in the questionnaire for VCWs/FHWs was a section evaluating their retention of the modes of HIV/AIDS transmission, methods of prevention, and a demonstration of the proper use and disposal of a condom.

In addition, focus group discussions were held with the following groups:

VCWs/FHWs (including a random 50% sample of the previously selected VCWs in Muusha (n=8), Mutema (n=8) and 7 out of the 13 FHWs in Mupedzanhamo)

Community Leaders (a random sample of 10 from each of the 3 IAs)

Headmasters in the Mutema IA

Adult males in the community (10 men randomly selected from areas adjacent to the focus group locale in each of the three IAs)

Adult females in the community (10 women randomly selected from areas adjacent to the focus group locale in each of the three IAs)

All of the questionnaires developed and used for the various focus group discussions are included in Appendix B; a schedule of evaluation activities is provided in Appendix C. A list of contacts for the evaluation is included as Appendix D.

Data was collected from individual in-depth interviews and focus group discussions as stated above as well as project records documenting training attendance, curricula and activity reports, and numbers of families trained by the VCWs/FHWs.

After data were reviewed by the group individually, a group discussion was held to determine the findings, conclusions, recommendations, and lessons learned.

Evaluation results and recommendations were written up in summary form and presented for feedback at a group meeting of the evaluation team, SC/Zimbabwe staff, and a representative of the MOH from Chimanimani District. The draft of the evaluation report was amended to address the group's comments and finalized. A feedback meeting was also held with the Director of the A.I.D. Mission in Harare, Mr. Ted Morse, and other members of his staff.

Copies of the final report will be sent to the MOH (national, provincial, and district levels), the MCCD (national, provincial, and district levels), the Commercial Farmers Union (Harare), the Rural Council in Mupedzanhamo, Save the Children/Zimbabwe Field Office, Save the Children/Home Office, the HAPA Support Program, and USAID, both to the Mission in Harare and to the Africa Bureau in Washington, DC.

III. FINDINGS OF THE EVALUATION

A. DESIGN

The SC/Zimbabwe HAPA project uses a Training of Trainers approach to train a cadre of community-based workers in AIDS and adult education techniques who, in turn, are responsible for sharing the AIDS education messages with members of their communities. Under the program, Village Community Workers (VCWs) and Farm Health Workers (FHWs) who were already operating in the project areas received training to be trainers in AIDS education. The VCWs and FHWs have gone on to educate members of their communities about AIDS through regular family visits and contact, such as at outreach sessions and other community gatherings and events. Three other groups - MOH staff (nurses and Environmental Health Technicians (EHTs)) from the rural clinics, MCCD ward officers, and community leaders - also received AIDS training in order to better support the efforts of the VCWs/FHWs.

The project's Detailed Implementation Plan (DIP) set five key interventions to be accomplished over the 2-year grant period:

Key interventions	Number and Target Populations
1. Conduct KAP baseline survey	1. Survey to be carried out in Muusha, Mutema, and Mupedzanhamo.
2. Training of Trainers in AIDS Education	2. 20 health professionals, 3 MCCD officers
3. Training in motivation and education for the prevention of HIV	3. 100 Community leaders headmasters, church leaders
4. Training in techniques for family training in the prevention of HIV transmission	4. 111 VCWs/FHWs
5. Training in behaviors for the prevention of HIV/AIDS transmission	5. 8,866 families

Four measurable objectives were defined in the DIP which were refined and added to in the Midterm Progress Report in September 1990 for a total of 6 objectives. The original objectives and their refinements as well as the newer objectives are listed below. (Reasons for the changes have been outlined in the Midterm Progress Report and will not be repeated here.)

1) 85% of rural health center staff working with AIDS and Ministry of Cooperative and Development (MCCD) Officers in the 3 IAs will attend 2 days of AIDS prevention training by June 1990.

Modification: By August 1991, 85% of these personnel in the 3 IAs will attend 5 days of AIDS prevention training.

2) All VCW's/FHW's (111) in the 3 IA's will attend a 2-day AIDS prevention Training of Trainers by March 1990.

Modification: By August 1991, 90% (rather than all) of the VCWs/FHWs in the 3 IAs will attend a 3-day AIDS prevention Training of Trainers with at least one 1-day refresher course attended.

Objectives 3 and 4 were added during the Midterm Review on the recommendation of the TAG review team.

3) By August 1991, 90% of the trained VCWs/FHWs will be able to demonstrate the proper use of a condom on a model.

4) By August 1991, 90% of the trained VCWs/FHWs will be able to name the three main modes of HIV transmission and three ways transmission can be prevented.

5) 100 community representatives and all government extension workers in the three IAs will attend 2 days of AIDS prevention training by June 1990.

Modification: By December 1990, 120-150 community leaders and all ward coordinators in the three IAs will attend a 2-day AIDS awareness workshop.

6) Eighty percent of families trained in the three IAs will be able to identify the 3 major modes of HIV/AIDS transmission and will be able to identify 3 behaviors that prevent HIV/AIDS transmission.

Modification: By August 1991, 65% (revised downward from 80%) of the families trained in the three IAs will be able to identify the 3 major modes of AIDS transmission and 3 behaviors that prevent transmission.

The SC/HAPA program was set up to "piggy-back" onto the pre-existing Child Survival (CS) program which had been

operating in three project areas since 1986. The CS program had also been using the VCWs and FHWS to motivate behavior change at the family level. Thus, under the HAPA project, these same VCWs and FHWS received training in AIDS Training and Prevention and essentially folded the AIDS prevention message into the mix of health protective behaviors they were already promoting under the CS program. The "piggy-backing" meant that the HAPA project was implemented in the same three geographic areas as the CS program, using the same personnel, supervisory systems, vehicles, etc..

This integration of HAPA into CS activities has made implementation of the HAPA program far easier since infrastructure, staff, and relationships with the MOH and MCCD were already in place. In addition, VCWs and FHWS had already built positive relationships with the families in their areas and had experience talking to community members about more sensitive topics such as family planning. In short, "piggy-backing" the HAPA program onto the pre-existing CS activities has enabled the program to meet the project objectives in a shorter period of time than might otherwise have been the case if the HAPA project had been implemented in an area with no other health program. On the other hand, the combination of the HAPA and CS projects resulted in an increased workload for all project staff. This will be discussed further, below.

Staffing and supervision. Coordination of the HAPA activities is the responsibility of the AIDS/CS Coordinator, Mrs. Linile Malunga, who is based in Harare but who spends a considerable amount of her time visiting and supporting project activities in the three impact areas. On average, Mrs. Malunga spends three weeks a month in the field (one per Impact Area), with one week a month spent in Harare doing administrative tasks and networking. While originally the HAPA project was to have had its own coordinator separate from CS, the resignation of the CS Coordinator and difficulty in finding a replacement led to the decision to combine the two positions. Thus, Mrs. Malunga has had responsibility for overseeing both CS and HAPA. This dual role has been both a strength and weakness for the HAPA project. On one hand, having one person in charge of both projects has led to even closer integration and coordination of CS and HAPA project activities. On the other hand, the workload involved has been too much for one person. While Mrs. Malunga has done a commendable job meeting training objectives and ensuring progress at the field level, it is clear that networking and documentation have suffered.

Staffing and workloads have also been on-going issues at the field level where the project is staffed by three seconded MOH nurses, one based in each IA (except for Mupedzanhamo, where the seconded nurse is based in Harare). Again, these seconded nurses, called Area Health Coordinators (AHCs), are

responsible for both HAPA and CS project activities and supervise the efforts of the VCWs and FHWs. While enthusiastic and highly motivated, all AHCs report feeling overstretched. The AHC for Mupedzanhamo experienced special difficulties since, unlike her other two colleagues in Muusha and Mutema, she was seconded only part-time to the project, spending two weeks with Save the Children and then two weeks based at an MOH clinic near the commercial farming area. This part-time secondment did not seem to be satisfactory and resulted in conflicting schedules and insufficient communication. The reasons for the difficulties in communication are unclear but may stem in part from misunderstandings which arose between Save the Children staff and MOH District-level staff when the first CS grant was begun in Mupedzanhamo in 1986.

VCWs also shoulder a heavy load since they are responsible for village development activities in addition to primary health care and AIDS education. However, when asked during focus group discussions how becoming a multi-cadre worker had affected their ability and effectiveness in promoting health messages, most VCWs reported that they do not feel overworked and feel they are still effective health promoters. Some even felt that becoming multi-cadre workers had actually increased their effectiveness as they now have more opportunity for contact with community members and can talk about health matters even in traditionally "non-health" settings, such as at development meetings and other gatherings. While hiring additional VCWs was discussed, it was not considered a viable option for budgetary and sustainability reasons.

There are currently 40 and 32 VCWs in Muusha and Mutema, respectively, and 13 FHWs in Mupedzanhamo. On average, each VCW/FHW is responsible for 50 to 60 families. VCWs and FHWs are paid, though the pay scale varies. In Muusha, where all 40 VCWs have been absorbed by MCCD and thus are government employees, a VCW is paid 70 Zim dollars per month. In Mutema, only 9 of the 32 VCWs have been/will be absorbed by the MCCD and therefore receive Z70 per month. The remaining 23 VCWs have been paid by the project and receive Z50 per month. (This was increased a year ago from Z36 per month). This pay differential has undoubtedly affected motivation levels of those VCWs receiving the lesser amount; the problem was discussed thoroughly during the midterm review but the project could not afford to pay the VCWs more than Z50 per month. Another problem leading to lower morale among VCWs in Mutema is that none of the 23 VCWs currently being paid by the project will be absorbed by the MCCD. These workers will lose their jobs once the project ends in August 1991 and their performance, especially during the last few months, has deteriorated somewhat. Of the 13 FHWs in the commercial farming area, all but one are now being paid by the farm owners. Their

pay varies widely, from Z36 to Z70 per month. Project staff should be commended for their success in convincing farm owners to pick up the FHW salaries; efforts to establish more standard remuneration of FHWs are ongoing.

Finally, project activities in Muusha and Mutema were enhanced by the on-going support offered by the Impact Area Manager. The Impact Area Manager is an SC senior staff member (not paid under the project), who is responsible for the oversight of all projects in his IA. While there has been some shifting of managers between impact areas depending on the needs of certain programs, the most recent manager, covering both Muusha and Mutema, has provided excellent support as well as taking a real interest in the health activities. There has been no IA manager for Mupedzanhamo for over one year.

Integration with other local institutions. The project has succeeded in achieving a high degree of collaboration with the MOH. At the national level, the CS/AIDS Coordinator is invited by the NACP/NGO Coordinator to participate in AIDS prevention program meetings attended by other NGO and MOH staff. Such meetings help ensure that there is neither waste of resources nor duplication of effort. The CS/AIDS Coordinator has also met with the Director of the NACP and the National Liaison Officer of the NACP on several occasions to discuss the program.

At the Provincial level, the AIDS/CS Coordinator is in contact with the PMD and PNO of both Manicaland and Mashonaland East Provinces. The relationship with the Provincial Medical Office of Manicaland seems especially strong; the office has lent staff to serve as members of both the mid-term and final evaluation teams.

Collaboration with the MOH is most impressive, however, at the District level where all planning, organization, and facilitation of trainings is done jointly with the MOH. Quarterly meetings are held between SC project staff and MOH staff from the District where project progress is discussed and plans made for the next quarter. The relationship and resulting communication between SC and the District Medical Office in Seke, where Mupedzanhamo is located, seems less strong than between SC and the DMO in both Chimanimani and Chipinge districts. As stated earlier, the reasons for this situation are not entirely clear, though it is the opinion of the evaluation team that the relationship would need to be strengthened if SC were to undertake any future programs in the district.

As discussed above, under staffing, the project is staffed at the field level by 3 seconded nurses (the AHCs) from the MOH who facilitate the training of community leaders and VCWs/FHWs and are themselves trained by both MOH and

SC/Zimbabwe. Not only have these MOH staff ensured a closer collaboration between SC and the MOH, but through the training and experience they have gained from the project, these nurses have become a real resource to the MOH which it could potentially use in future AIDS education efforts. Unfortunately, it appears that none of the three nurses will be directly involved in AIDS programs when they return to the Ministry after August 1991.

SC has also maintained a collaborative relationship with the MCCD. Whereas the MOH trains and provides technical supervision of the VCWs, administratively, their supervision and payment falls under the purview of MCCD. The project has trained all MCCD ward coordinators in AIDS and it is clear this training has made quite an impression on certain coordinators.

One area where collaboration has been less than ideal is with the Rural Council in Mupedzanhamo. It is interesting that while the Rural Council coordinates its health activities with the District Medical Office, as does SC, the Rural Council and SC were not always aware of each other's health activities in the commercial farming areas. One could argue that the District Medical Office could have done more to coordinate health activities on the farms, but in the absence of such coordination SC should work to strengthen its relationship with the Rural Council. The Director, a nurse, recognizes the importance of promoting health issues and could be a strong advocate with the farmers. The Rural Council seems to be the key local administrative body for communicating with the farmers.

SC's relationship with the other HAPA grantee in Zimbabwe, World Vision, is excellent. World Vision staff participated in both the midterm and final evaluations of SC's HAPA project and the two project coordinators share program ideas and experiences on an on-going basis. SC's AIDS/CS Coordinator will be a member of the final evaluation team for World Vision's HAPA project in October 1991.

As noted earlier, due to demands placed on her time by field activities, the AIDS/CS Coordinator has not had sufficient time to network with other organizations doing AIDS work in Zimbabwe. Collaboration with other NGOs could have been particularly useful in the area of sharing educational approaches and materials, especially in condom promotion and the development of teaching materials to be used with non-literate people. Future SC AIDS projects should ensure adequate staff to make sure this kind of networking can occur.

Involvement of community. SC is committed to working with community people. In its project sites in Muusha and Mutema, SC helps to create and/or strengthen what is called

the "coordinating committee" - a group of community leaders which determines community development priorities and makes decisions about action to be taken. SC "doesn't do anything" without consulting these community leaders. Project staff report that once these leaders were convinced about the dangers AIDS posed to their communities, they were wholehearted in their support for the HAPA program. This commitment on the part of the community leaders was borne out by the comments generated during the focus group discussion held with community leaders in all three project areas. The community leaders all expressed concern that AIDS was a major problem in their communities and spoke positively about the HAPA project and the important role being played by the VCWs/FHWS in educating members of the community about AIDS and how it can be prevented. VCWs confirmed this support, saying that community leaders in their areas had been very helpful in mobilizing village-wide awareness and acceptance of their efforts. Community leaders also played a role in helping to educate members of their communities about AIDS - especially other men - in schools, in the workplace, at meetings, etc.

The VCWs/FHWS, themselves, are another important way the community has been involved in the project. VCWs and FHWS live in and are chosen by their communities. With the support of the community leaders, the VCWs/FHWS form the project's direct link to the community and educate their fellow community members through home visits, group meetings, and more informally at the market or well, for example.

There was some concern among the evaluation team members that, while community leaders were most supportive of the program, they were not always well-informed about the project's plans for phase-out at the end of August 1991. It seems that more regular meetings with the community leaders, perhaps paralleling the quarterly meetings held with MOH district staff, might have helped to avoid some of this confusion. SC could then have worked with the communities to help them decide on concrete steps they could take to best carry on the program once SC leaves the area.

Major uses of project funding. As this project was a Training of Trainers project, most of the funds were used to support training of the various groups targeted by the project. This support included training supplies and materials, per diems for participants, food, transport, and, in some cases, rental for the training space. Funds budgeted under International Travel allowed the AIDS/CS Coordinator to attend an international AIDS conference, to have a month-long orientation in the Home Office in Westport (including visits to HGSP in Baltimore and A.I.D. in Washington, DC), and enabled her, the 3 AHCs, and the 3

District Nursing Officers to attend an AIDS workshop at Chikankata Hospital in Zambia.

A video monitor was purchased with grant funds in Year 2 of the project for a total of USD 941.77, including shipping costs. The monitor will be turned over to the national level of the National AIDS Control Program at the end of the project.

Please see Appendix E for a budget summarizing project expenditures through June 1991.

B. PROCESS

The AIDS educational message promoted by the project is based on a compendium of AIDS facts, skills, and attitudes originally developed by staff at SC's Westport, Connecticut headquarters. This curriculum was pre-tested at a week-long workshop in September 1989 in Westport with representatives from both the Home Office and field participating. The curriculum was further revised in October 1989 at a Training of Trainers workshop held in Cameroon for key project staff from SC's two HAPA Projects in Zimbabwe and Cameroon. In November 1989, the curriculum was analyzed again at a three-day workshop for MOH district and provincial level staff at Chimanimani (Zimbabwe). In order to ensure the appropriateness of the curriculum, SC continued the development of the AIDS curriculum as an on-going process. Project staff doing training were encouraged to make changes to the curriculum as the need arose. Alterations made by project staff to the original list of facts, skills, and attitudes were indicated in the Mid-term Report (p. 8).

Key project staff trained health professionals and facilitated in the training of community leaders and the VCWs/FHWs. VCWs/FHWs were, in turn, responsible for training the families in their communities. In this way the quality of each major activity undertaken by the project was assured.

Activity I: Training of Trainers in AIDS Education

Realizing that AIDS messages can only be internalized if quality training is given, great emphasis was placed on the training of trainers. 29 (out of 30) health professionals (State Certified Nurses and Environmental Health Technicians) and all 3 MCCD officers underwent training in preparation for their training and supervision roles. To ensure that the quality of the trainer remained high, the latter attended refresher courses once every three months to update knowledge. (See Appendix F for list of training provided.)

Clear and measurable objectives were developed to reflect the specific skills to be acquired by workshop participants. The objectives included the following:

1. To impart knowledge and AIDS facts to the participants on AIDS transmission and prevention
2. To equip rural health center staff with the attitudes necessary for the AIDS education campaign
3. To equip health center staff with skills necessary for effective teaching on AIDS

The training workshop included a pre- and post-test to indicate the degree of knowledge, skills and attitudes possessed by the participants before the training and the levels demonstrated after training. To ensure standardization of the training, the same test was given to the health personnel participants at all training workshops. Positive comments given by the participants were used by the facilitators as an indication of the quality of the education given.

Activity II. Training in motivation and education for prevention of HIV transmission

Those trainers who had attended the TOT workshops further trained the community leaders, including teachers, church leaders, health workers, traditional healers, etc. (See Appendix F for lists of those trained.) SC staff helped with the training or acted as resource people. MOH staff were also used as resource persons. The curriculum was the same as that used for the health workers but simplified for easier understanding by non-health personnel. A variety of methodologies, such as lecture, demonstration, and group discussion, were used to ensure that the AIDS messages were clearly understood. For teaching on use of a condom, a demonstration was given using a banana and a condom. Where possible, all participants were given a chance to practice the skill. Women were educated separately from men because it would have been culturally unacceptable to teach the two sexes together and thus would have interfered with learning. Project staff continuously monitored these activities during their presence at these workshops.

Activity III: Training in techniques for family training in prevention of HIV

FHWs and VCWs were trained in techniques for family training (See Appendix F for numbers trained.) Because this cadre formed an important link between the community and the health system, it was very important that they clearly understood the AIDS facts for effective transfer of this information. Their curriculum was also simplified; the AIDS

facts were straightforward, concise and understandable. The education was given by health professionals in Shona, the language best understood by locals. Evaluation of a random sample of 50% of the VCWs found a standard knowledge base and a common utilization of terminology. 86% of VCWs/FHWs could name three major modes of HIV/AIDS transmissions and 96% could name three methods of prevention. In addition, 91% of the FHWs/VCWs could properly and effectively demonstrate the use of a condom.

This impressive acquisition of knowledge once again indicated the quality of the programme. Once again a variety of methodologies were used to transmit the message to participants. Role plays, lecture, songs, and one-to-one methods were used to teach the participants thereby effectively demonstrating the methods they would use in their education of families. Inappropriate attitudes or misconceptions displayed during role plays were corrected by the trainers following the play. This feedback ensured that fewer of the participants left the workshops with inappropriate attitudes or misconceptions which might have been further disseminated to the families. At the final evaluation, the majority of VCWs/FHWs felt that they had received adequate information on AIDS and what they needed were regular refresher courses to update their knowledge. This was an indication that the training given to these cadres was not only effective in transferring knowledge and teaching skills, but also in motivating the community to learn - which is one of the fundamental objectives in community education.

Activity IV: Training in the behavior of the prevention of HIV/AIDS

Both male and female VCWs/FHWs educated the families in the behavior of prevention of HIV/AIDS by giving the families the knowledge and skills necessary to prevent AIDS. Methods used included discussing HIV/AIDS prevention on a one-to-one basis during home visits as well as group meetings at church gatherings, community meetings, clubs, outreach centers, and even beer halls. Focus groups indicate that songs and dance, drama, and discussions were often used with much effect. Use and disposal of a condom was demonstrated to family members individually or in groups using a banana and a condom. To ensure that the skill had been mastered, the members of families were allowed opportunity to demonstrate the skill using the same. One highly motivated VCW had a wooden model made for demonstrating condom use.

The content given to community members was similar to that given to the VCW/FHWs themselves but was simplified and local jargon understood by the community was used. This was necessary especially as traditionally sensitive topics such as sex and condoms were being discussed.

To assure that accurate information was given, the health workers (EHTs and SCNs) supervised the VCWs/FHWs; the latter gave constant reports to the area office and the RHC staff. SC staff also closely supervised the VCWs. Apart from giving support to the VCWs/FHWs, the community leaders also assisted in their supervision.

That the quality of the education was high was demonstrated by the great amount of knowledge on transmission and prevention of HIV/AIDS demonstrated by participants in focus group discussions, the KAP survey, and in-depth interviews. Males in all three project areas requested condoms following the focus group discussions, further supporting the evaluation team's impression that condom use is generally accepted by the communities, a marked shift from attitudes before the HAPA program.

C. OUTPUTS

Project objectives include three which specifically address outputs, or "things done", in terms of numbers of training sessions held and numbers of people trained. Each of the three output objectives addresses the training to be achieved by a different target group: rural health center staff and MCCD officers, VCWs/FHWs, and community leaders. The three objectives and project achievements related to each are outlined below.

Objective:

By August 1991, 85% of rural health center staff working with AIDS and all MCCD officers in the 3 IAs will attend 5 days of AIDS prevention training.

Achievement: 97% of the rural health center staff (29 out of 30) and all 3 MCCD officers in Muusha and Mutema have undergone 5 days of AIDS prevention training.

Note: In Mupedzanhamo, the project targeted commercial farms and did not include rural health center staff or MCCD officers in training programs.

Objective:

By August 1991, 90% of the VCWs/FHWs in the 3 IAs will attend a 3-day AIDS prevention Training of Trainers (TOT), with at least one 1-day refresher course attended.

Achievement: 95% of VCWs/FHWs (87 out of 92) attended a 3-day AIDS TOT workshop, and 93% (86 out of 92) attended at least one 1-day refresher course.

Objective:

By December 1990, 120-150 community leaders and all ward Coordinators from the 3 IAs will attend a 2-day AIDS awareness workshop.

Achievement: 526 community leaders and all ward coordinators (3) from the 3 IAs attended a 2-day AIDS awareness workshop.

Thus, all three output objectives were achieved.

Other outputs achieved by the project include the development of a 2-page AIDS handout written in Shona, the local language, which can be left with families. The handout, which summarizes basic information about AIDS transmission and prevention as well as how to use a condom, was adapted by project staff from materials developed by the MOH. This handout is included as Appendix G.

Another project output is the AIDS monthly report form filled out by VCWs/FHWs during home visits. The form is simple and is written in the local language. (See Appendix H.) Unfortunately this form will not continue to be used by the MOH after the EOP.

One final product which has come out of the HAPA project is the AIDS training curriculum which has been developed by staff from SC's Home Office Health and Training units. The curriculum has been under development for the past 2 years and includes lessons learned from SC's 3 on-going AIDS projects. Once finalized, this curriculum will be shared with other SC field offices and other organizations engaged in AIDS education worldwide.

D. OUTCOMES

Project objectives include three which specifically address outcomes, or changes in knowledge and skills of the target population(s). Two of these three objectives address acquisition of knowledge and skills by the VCWs/FHWs; the third addresses knowledge acquired by families. These objectives and project achievements related to each appear below.

Objective:

By August 1991, 90% of the trained VCWs/FHWs will be able to demonstrate the proper use of a condom on a model.

Achievement: 91% of the VCWs/FHWs interviewed were able to demonstrate the proper use of a condom on a model. (This percentage is up from 81% at the mid-term one year ago.)

Objective:

By August 1991, 90% of the trained VCWs/FHWs will be able to name the 3 main modes of HIV transmission and 3 ways transmission can be prevented.

Achievement: 86% of the VCWs/FHWs interviewed were able to name the 3 main modes of HIV transmission; 96% were able to name 3 methods of prevention. (These percentages are up from 69% and 35%, respectively, at mid-term one year ago.)

Objective:

By August 1991, 65% of the families trained in the 3 IAs will be able to identify the 3 major modes of AIDS transmission and 3 behaviors that prevent transmission.

Achievement: 87% of men and 85% of women surveyed correctly identified the 3 main modes of AIDS transmission; an average of 34% of men and 37% of women could state 3 or more ways to prevent transmission.

These results are impressive, especially when compared to the results from the mid-term evaluation conducted in August 1990. It is interesting that the VCWs/FHWs could not always name the 3 modes of transmission even though their answers on prevention usually corresponded to each of the 3 transmission modes. It was the FE team's feeling that the VCWs/FHWs "knew" the 3 modes of transmission even if they could not state all three when asked directly to do so.

The project evaluators relied on data collected during the household survey to determine progress made toward achieving the objective addressing families' knowledge of AIDS transmission and prevention. The gap between people's knowledge of modes of transmission and their knowledge about prevention will be difficult to explain definitively until the data can be more fully analyzed using a computer. Part of the reason for the gap, however, may be due to the way the two questions were asked in the survey. For transmission, respondents were asked to identify the true modes of transmission from a list which was read to them; for prevention, respondents were asked to recall preventive methods from memory.

(Note: The 30-cluster household survey was conducted in only two of the three project areas due to time and resource constraints. Mutema and Mupedzanhamo were the 2 areas chosen for the survey since they represent 2 different population groups and certain differences in data results

were anticipated. Mutema and the third site which was not surveyed, Muusha, are similar in terms of location, geography, and population profile and the survey team felt comfortable that findings from Mutema could be generalized to the Muusha area as well.)

Focus group discussions held with community leaders, VCWs/FHWs, and men and women (non-leaders) from the community showed that, in general, people felt that the HAPA project had had an impact on their communities. Men reported that they were cutting down on their numbers of sexual partners, avoiding prostitutes, and using condoms more often, especially with their extra-marital partners. Women concurred that condom use had increased among the men and members of both sexes said that people in the communities were now openly discussing such formerly sensitive topics as AIDS, sex, and condom use. Adults are also talking to their children about the dangers of AIDS, and MOH nurses talk to school children about AIDS in the schools, including giving condom demonstrations.

Project staff and MOH clinic staff trained by the project agree that AIDS awareness has been heightened in the communities. As far as the project's effect on them personally, all of the staff interviewed (both SC and MOH) report that they have been able to use what they learned about AIDS in their work and in their personal lives. In addition to practicing some of the risk reduction measures promoted by the project, all report teaching their families and friends about AIDS.

One unanticipated effect of the project was its impact on the primary school headmasters, resulting in an increased awareness of AIDS on their part and a desire to teach about AIDS at the primary school level. In Mutema, VCWs were invited to come to the schools to speak to the students about AIDS. AIDS education for the students stressed different strategies depending on the age level of the student. Younger children in grades 1-4 were taught not to go for a "backdoor injection" if they were ill, not to allow a used razor blade to be used upon them if they were having their hair cut short, and not to play with condoms that they might find. Lectures were usually given to children in grades 6 and 7 although some lectures were also given to children in grade 5. At one school, where girls often leave school after grade 5, special counselling groups were established for the children. Boys and girls were separated into groups by grade level 1-2, 3-4, and 5-7, and by sex. The groups met on a monthly basis with their same sex teacher/counsellor who encouraged them to air their problems and to speak out on AIDS and sexuality issues. Furthermore, in conjunction with the Ministry of Education, AIDS awareness programs for primary school children are conducted through competitions utilizing drama, poetry, essay writing,

music, and drawing. These contests are conducted initially at the individual schools and then at the district, provincial, and finally, national, levels.

The HAPA project has also had a positive effect on AIDS programming for Save the Children as a whole. At the Zimbabwe Field Office level, the Field Office Director, Dr. Gerry Salole, has come to the conclusion that AIDS should be the health priority for SC in Zimbabwe. The field office has developed an innovative AIDS board game (in both rural and urban versions) for use with teenagers as an ice-breaker and to facilitate a discussion about AIDS. A proposal for further development of this game, as well as other games focusing on agriculture, rural development, etc., is being developed for submission to a major foundation. The field office has also been working on a proposal to collaborate with the MOH on the production of a locally-made AIDS education/prevention video. Finally, in response to a request from UNHCR, a proposal has been developed to provide AIDS education in two refugee camps, Nyangombe and Tongogara, where SC already has a presence doing skills training with refugees. The proposal will be submitted as soon as MOH comments have been addressed and the budget finalized. Possible funders include the AID Mission in Harare, NORAD, and CIDA.

Save the Children also benefitted from the HAPA project at the Home Office level and in other field offices. With HAPA funding, SC was able to initiate two AIDS education programs in Cameroon and Zimbabwe, the first for the Agency. As part of SC's commitment to provide adequate technical assistance for these programs, HAPA funding also supported the creation of the position of AIDS Coordinator, based in the Home Office. Not only did creation of this position facilitate effective support of the 2 field programs and ensure good communication with the funder and HGSP, but the AIDS Coordinator was also able to advocate for AIDS programming at the Home Office and among other field offices.

In June 1990, SC received a grant from AmFAR (American Foundation for AIDS Research) for a community-based AIDS education project in The Gambia. That program is similar to those piloted under the HAPA grant in that village-based workers (health workers, teachers, and agricultural extensionists) are targeted for AIDS TOTs. This cadre of worker is, in turn, responsible for educating community members about AIDS. This education is done through home visits and by holding village-wide meetings about AIDS during which a variety of methods are used, including drama, songs, discussion, and the presentation of a video made by the project.

Other SC field offices, especially those in Africa, are currently developing AIDS proposals. An interest in AIDS

programming has been growing slowly but steadily over the past two years.

The Home Office-based AIDS Coordinator reported that she expected the initiation of new AIDS projects in SC field offices will be aided greatly by the soon-to-be-completed AIDS training curriculum that has been in development over the past 2 years. The curriculum incorporates many of the lessons learned by SC's 3 on-going AIDS projects and, once complete, will be widely disseminated among SC field offices and other organizations working in AIDS education worldwide.

E. SUSTAINABILITY

The original plan to sustain the education started by this project as presented in the DIP emphasized implementation as a collaborative effort between SC and MOH. A second strategy was the training of community leaders to monitor and support AIDS prevention activities and behaviors within their respective communities. According to the DIP, these leaders would receive regular feedback on AIDS statistics and activities to encourage them to continue in this role. Furthermore, through the sustainability plan for the Child Survival project, the salaries of the VCWs and FHWS were to be picked up by the MOH, MCCD or farmers as appropriate.

The findings of the evaluation indicate that the first strategy of sustainability - integration of the SC program with MOH - has taken place. In the designated clinic sites and outreach sites that will remain open, MOH staff will continue to supervise VCWs/FHWS during the monthly visits made by the VCWs/FHWS to the clinics. District medical staff, especially in Chimanimani, are also committed to maintaining skill-levels of VCWs/FHWS through refresher training, although the frequency of such training will depend on funding.

While it is clear the AIDS education will continue, MOH staff at the District and Provincial levels both indicated that the intensity of the CS/AIDS activities in the IAs would not be able to be sustained for several reasons. The first was that the staff feel that a central area of excellence (the impact area concept), though perhaps warranted at the onset of the project, could not continue to be justified. In fact, both Muusha and Mutema had expanded their areas beyond the original impact areas at the request of the MOH. Singling out small IAs has resulted in some problems with the neighboring communities who wondered why they too were not receiving such intensive input. Even if possible, the MOH cannot justify continuing intense training in a small area while others are equally, if not more, needy.

A second issue affecting sustainability involves the realities of economic constraints upon the MOH and the belt-tightening accompanying Structural Adjustment. One unfortunate result of the economic restructuring is that even fewer resources will be made available for health than are currently available.

Another important factor affecting sustainability is the acquisition and retention of knowledge and skill by the various groups, including MOH staff, MCCD officers, and VCWs/FHWS, who are tasked to educate their communities about AIDS. Unfortunately none of the three nurses seconded from MOH to the SC program will remain in AIDS education per se. Their acquired knowledge may be used to promote AIDS awareness through their usual activities but not to the extent achieved under the HAPA program.

The acquired knowledge and tremendous enthusiasm of the VCWs/FHWS will help sustain AIDS awareness in the community. However, the loss of funding for 23 VCW positions in Mutema will certainly have a diminishing effect on sustainability. Funding of all 40 VCWs in Muusha has been completely taken over by the MCCD. In Mupedzanhamo, the salaries of 12 of the 13 FHWS are now being paid for by the farmers, with the remaining FHW having been paid by the project. Unfortunately, funding for this FHW will not be picked up either by the farm owner or another agency after the project ends in August.

Although the VCWs/FHW who will not continue to be funded after the project ends expressed a desire and planned to continue in their roles in spite of the loss of salary, the realities of the economics of lost income for a poor family portend otherwise.

The third area of sustainability involved the training of community leaders who would monitor AIDS prevention activities and behaviors and support the activities of the VCWs/FHWS. The training of community leaders greatly exceeded the number planned in the objectives. Community leaders have participated in training and are working to keep AIDS education in the forefront of issues of the community. Although updated on the AIDS educational activities, there was no clear evidence that they were receiving any information on AIDS statistics. Part of the reason for this may be due to the unavailability of such data generally. At focus group meetings, the community leaders asked for just that type of information which they thought would be helpful to the community.

Obviously, the most crucial element of sustainability are the knowledge, attitudes, and behavior of the community members themselves. The household KAP survey conducted just prior to the final evaluation showed that the project has

been successful in increasing people's knowledge of AIDS transmission and methods of prevention and, to a lesser extent, may have begun to affect certain attitudes. People report that they are discussing AIDS among themselves more often and some report However much work needs to be done, especially in dispelling certain widely-felt misconceptions about casual transmission which, in turn, seem to be supporting fear of and harsh attitudes toward people with AIDS. More work focusing specifically on men and adolescents is also warranted.

F. TECHNICAL ASSISTANCE & TRAINING FOR PROJECT STAFF

Training for project staff. The former National Liaison Officer (the AIDS/CS Coordinator's predecessor) and the AHCs from Muusha and Mutema IAs all attended a 3-week AIDS Training of Trainers workshop held by SC in Cameroon in October 1989. Of these three staff, only one, the AHC for Mutema, is still with the project. The AIDS/CS Coordinator has trained the new AHCs and AHCs have also benefitted from attending the training sessions given by their fellow AHCs.

In October 1990, the AIDS/CS Coordinator, Mrs. Malunga (who was previously trained in AIDS and Primary Health under the MOH), participated in a week-long AIDS workshop in Zimbabwe hosted by the HAPA Support Program. The workshop provided a valuable opportunity for sharing lessons learned among all of the HAPA grantees as well as building skill levels in certain methods such as conducting focus group discussions. Later that same month, Mrs. Malunga participated in the Fifth Annual Conference of AIDS in Africa held in Kinshasa, Zaire. Mrs. Malunga greatly valued the opportunities provided by both workshops to learn what her colleagues in Africa are doing vis-a-vis AIDS.

In January 1991, the AIDS/CS Coordinator travelled to SC's Home Office in Westport, CT where she spent a month learning more about SC's history, philosophy and methods of development, and what resources are available to field programs from Westport. In addition, she participated in planning meetings with Health Unit staff, received training in proposal writing, and networked with other individuals and organizations concerned with AIDS such as Connecticut State Representative, Shaun McNally, HGSP in Baltimore, and A.I.D..

Finally, in June 1991, the AIDS/CS Coordinator, the 3 AHCs, and the 3 DNOs from Seke, Chipinge, and Chimanimani travelled to Chikankata Hospital in Zambia for a 10-day AIDS counseling workshop. All of these SC and MOH staff reported being extremely impressed with the home-based AIDS counseling and care program being run from the hospital and the general openness about AIDS in Zambia.

Technical assistance. The project has received an adequate level of technical assistance throughout its 2 years. In November 1989, an adult education consultant and SC's Home Office-based AIDS Coordinator visited the program for one week to observe the first TOT given by the staff who had participated in the training in Cameroon in October of that year. Later in November, Linda Perez, a consultant from HGSP, also visited the project. Dr. Frances Nkrumah, a Ghanaian physician attached to the University of Zimbabwe, provided technical support to the project in its first year, including helping staff to devise the questionnaire for the KAP survey conducted in January 1990. Ms. Sally Scott, from HGSP, visited the project in May 1990, just after the new CS/AIDS Coordinator was hired. Ms. Scott helped to orient Mrs. Malunga with the reporting requirements of the grant and USAID. In August/September, SC's Home Office-based AIDS Coordinator, Nicola Gates, spent 3 weeks in Zimbabwe reviewing the program and participating in the MTE and report writing. Dr. Wendelin Slusser, SC Primary Health Care Coordinator from the Home Office, also assisted in the MTE and report writing as did the other MTE team members.

This high level of technical support continued during the second year of the project. When international travel using grant monies was banned due to the Gulf War, Dr. Slusser, who was able to travel to Zimbabwe for Child Survival, extended her visit and helped project staff to develop plans for a project to provide AIDS training to Mozambican refugees in two camps in Manicaland Province. In June 1991, Dr. Mary Anne Mercer from HGSP, Ms. Martha Holley, an HGSP consultant, and Nicola Gates from SC's Home Office all assisted the field office to conduct a 30-cluster household survey as part of the final evaluation of the project. Ms. Holley and Ms. Gates remained in-country an additional week to enter the data into the computer and write the survey report. Finally, Ms. Gates stayed and participated in the three-week final evaluation of the project (held jointly with the final evaluation for CS) and assisted in report writing. An outside consultant, Dr. Lynn Eckhert, was hired by HGSP to participate in the evaluation and report writing as well. Of all the technical assistance received, that which the AIDS/CS Coordinator found most useful programmatically was technical assistance that was rendered during the normal day-to-day functioning of the program versus technical assistance associated with an extraordinary event such as an evaluation.

In addition to the technical assistance provided by individuals, the project has also benefitted from written materials provided by HGSP (Quarterly Updates), AIDSCOM (monthly articles), and articles and papers forwarded to the field office from the Health Unit in SC's Home Office.

It is worthy of mention that most of the technical assistance the HAPA project received from individuals was from people sent to the field office from the U.S.. Given the great number of organizations doing AIDS work in Zimbabwe and the availability of trained professionals in-country, it is unfortunate the project did not take more advantage of AIDS resources and technical support available locally. On the positive side, SC staff did participate in NACP-coordinated meetings for NGOs working in AIDS and felt that they gained from the exchange.

IV. CONCLUSIONS AND RECOMMENDATIONS

Conclusion:

Until more acceptable methods are developed, condoms remain the best method to prevent sexual transmission of HIV. While condom use and acceptance has grown over the past 2 years, their promotion presents significant challenges for an AIDS education program. The challenge still remains to change sexual behavior.

Recommendations:

With MOH, develop a strategy for ensuring that sufficient supplies of condoms reach the rural clinics. (MTE recommendation) Condom availability must be guaranteed to support behavior changes expected to stem from educational programs.

More focus should be given to issues related to women's relative lack of power in their relationships with men and their difficulty in convincing men to use condoms. Education which can help women to communicate more assertively with their sexual partners should be stressed.

The conflict of stressing the use of condoms versus the desire of couples to reproduce must be considered.

Simple, pictorial instructions on condom use should be developed and made available for non-literate people.

Condom distribution should be monitored so that increased demand can be documented, supplies can be adequately maintained, and project effectiveness can be better tracked. (MTE recommendation)

Condom education should be conducted in single sex groups.

Condom distribution/promotion should be undertaken by members of both sexes (man-to-man and woman-to-woman) so that procurement of condoms may be less uncomfortable for those willing to use them. (MTE recommendation) Specifically, male EHTs, ward coordinators, and community leaders should intensify their efforts to promote condom use among other men.

Educational efforts need to address culturally relevant sexual issues including sexual responsibility, promiscuity, and faithfulness.

Conclusion:

An AIDS education project of 2 years' duration is insufficient to effect attitude and behavior change.

Recommendations:

AIDS education projects should be of no less than 3, and preferably at least 5, years' duration in order to have sufficient time to begin to affect attitudes and behavior.

Future projects should provide for baseline and end-of-project KAP surveys in both project and control areas. This will allow more reliable conclusions to be reached about effectiveness of project interventions.

Conclusion:

People will respond more effectively to AIDS education efforts which include concrete evidence of AIDS in their country and communities.

Recommendations:

Statistics on AIDS deaths by age group should be made public and available to the communities by the MOH. In rural areas, this information should be given orally and pictorially during public meetings and gatherings.

Posters and videos showing a person with AIDS and/or the effects of AIDS on the body should be developed and shown in communities.

Conclusion:

The effectiveness and sustainability of the HAPA project was enhanced by its high degree of integration into the existing CS health program and the MOH structure. The lessons learned from this collaboration and integration should be documented to ensure that future collaboration can be even stronger.

Recommendations:

Rather than standing on its own, AIDS education should be incorporated into Primary Health Care activities.

The nurses seconded to the program should document lessons learned to share with the MOH. (MTE recommendation)

Staff should be seconded on a full-time basis only.

MOH staff seconded to NGO projects should be utilized in similar roles after the EOP in order to fully profit from their newly-acquired experience and skills.

Joint planning meetings and decisions and agreements reached should be carefully documented and widely shared to ensure good communication between all parties involved in project implementation.

Monitoring of progress and steps taken to ensure sustainability should be on on-going process.

Conclusion:

AIDS is a new disease, and as such research is needed to bring to light new information which will add to the effectiveness of AIDS education efforts.

Recommendations:

Research on the impact of AIDS education on behavior change should be conducted.

Research on the future reproductivity of parents who have had a child die from perinatally transmitted AIDS should be conducted.

Conclusion:

VCWs/FHWS and community leaders are the two keys to providing effective community-based AIDS education. The VCWs/FHWS are the direct conduit for AIDS information to reach families while community leaders play a crucial role in creating awareness of and supporting the efforts of the VCWs/FHWS.

Recommendations:

MOH should continue to provide updates and refresher courses on AIDS for community-based workers, both those previously trained and new personnel.

MOH should continue to provide AIDS education to community leaders both inside and outside the project areas.

Education should continue to emphasize the care of the AIDS patient at home.

Meetings between project staff and community leaders should be held on at least a quarterly basis to keep leaders apprised of program progress and to identify solutions to problems which arise.

MOH should continue to supervise the activities of the VCWs/FHWS.

Future educational efforts should address high risk groups, i.e., truck drivers, prostitutes, soldiers, and people with STDs.

Conclusion:

Chances for sustainability of the HAPA program in the commercial farming areas may be improved if the program is broadened to include all vested groups in these areas.

Recommendations:

Recognizing that the Commercial Farmers Union has provided AIDS education for its members and the concern that most farmers have for AIDS, the extent of such education efforts should be ascertained and the education of farmers supported.

Since farm managers often have greater direct contact with the farm workers and the FHWS than the farm owners, AIDS education projects should also target this group.

Given that farmers' wives often have contact with farm laborers and their families vis-a-vis health matters, these women should be targeted for AIDS education, both for themselves and so they can be supportive of the FHWS.

Future efforts should focus on the Rural Council and how this body can be used to support the MOH and encourage promotion of the FHW concept among farmers. Specifically, the meetings begun in October 1990 between the MOH and Rural Council to discuss the FHW program should be continued.

Conclusion:

Families are concerned about and supportive of children's education on AIDS.

Recommendations:

AIDS education in primary and secondary schools should be continued.

Older youngsters and teenagers are a potentially high risk group who are not yet sexually active and may be receptive to discussions focusing upon sexual responsibility, faithfulness, empowerment of women in the sexual encounter, and diminution of promiscuity.

Conclusion:

Building on pre-existing SC programs when initiating new projects is a sound idea, however, management of the HAPA project, which required intensive effort at the family level, was hampered by the distances between the 3 project sites.

Recommendation:

If a project has multiple sites, care should be taken to choose areas near enough to each other geographically to ensure ease of management.

Save the Children/Zimbabwe Field Office

AIDS KAP Survey Report
June 1991

SUMMARY

A study of knowledge, attitudes, and practices related to AIDS among 658 Zimbabweans was conducted in June 1991. The study was designed to measure the impact of a two-year AIDS education project implemented by Save the Children/USA in three separate areas. Two of the three project areas were used to obtain the sample population. Over 90% of men and women could identify the three major modes of AIDS transmission, however a high degree of misconceptions persist. 50% of men and women thought AIDS could be transmitted by mosquitos and half of the men and a third of the women thought AIDS could be transmitted by sharing towels. Knowledge of prevention appeared somewhat lower, possibly due to a difference in question format, with approximately one-third of all respondents able to name three or more methods of prevention. 44% of men and 29% of women did not acknowledge any personal risk of getting AIDS. 53% of men and 29% of women reported having ever-used a condom; among these users, 50% of male respondents used a condom "always" or "sometimes". There was a high degree of fear concerning AIDS among the survey population, as reflected by surprisingly harsh attitudes towards people with the disease. The study shows that more work is needed to dispel widespread misconceptions and fears. Further study is necessary to determine whether behavior change has occurred.

I. INTRODUCTION

Zimbabwe is a southern African country with a population of 10 million people. The first case of AIDS in Zimbabwe was diagnosed in 1985; by the end of June 1990 6,000 people had officially been diagnosed with AIDS though the Zimbabwe Ministry of Health estimates that the true number may be three times as high. Save the Children Federation (SC), an American PVO, began implementing a community-based AIDS education program in three of its project areas in Zimbabwe in the fall of 1989. The two-year project, funded by the U.S. Agency for International Development under the HAPA (HIV and AIDS Prevention in Africa) grants program, was a pilot effort to train trainers - especially a village-level cadre of worker - and secondarily to educate 65% of the households in the project areas in AIDS prevention. The project was fully integrated into Child Survival program activities which had been on-going in all three areas since 1986.

The two-year project was evaluated in July 1991, and as part of the evaluation, a household KAP survey was conducted the preceding month. The survey had two purposes. The first was to assess the project population's knowledge, attitudes, and practices regarding AIDS. Unfortunately data from the survey are somewhat limited in their ability to assess project impact due to the lack of good comparison data - either from a baseline or a control. The second purpose of the survey was to test a survey methodology developed for Child Survival projects and adapted to AIDS education projects. The aim is to develop a standard methodology for conducting rapid, relatively inexpensive AIDS KAP surveys. The SaVe the Children survey in Zimbabwe was the first formal field-test of the methodology.

II. METHODS

Two of the three Save the Children project areas, with a total population of 22,532 were selected for the survey. The areas were Mupedzanhamo, with a population of 7,402 living on commercial farms located 30 km. outside of Harare, and Mutema, a communal farming area in Chipinge district with a population of 15,130. The third SC project area, in Chimanimani district, was not surveyed due to time and funding constraints. Mutema and Mupedzanhamo were selected since they represent two different population groups - Mutema more rural and Mupedzanhamo peri-urban - and certain differences in data results were anticipated. Mutema and the third site which was not surveyed, Muusha, are similar in terms of location, geography, and population profile and the survey team felt comfortable that findings from Mutema could be generalized to the Muusha area as well. The population data for both study areas had been updated within the month preceding the survey, and so was considered to be the most accurate available.

The total sample size for the survey was 658 persons, 418 from Mutema and 240 from Mupedzanhamo, with equal numbers of men and women represented. For both areas cluster sampling was utilized; because the population units available for sampling varied slightly, the sampling methods for the two survey sites will be described separately.

The Mutema impact area is composed of 12 villages, each of which is served by 2 to 4 Village Community Workers (VCWs). Using the 40 VCW catchment areas as population units, 30 clusters were identified, and starting points for each cluster were selected at random based on the VCW's register of households. Interview teams of one man and one woman each began interviews at the assigned starting point, and continued to conduct interviews at the next nearest household, moving in directions also randomly assigned. They continued to visit the surrounding homes until each had

interviewed seven women or seven men between the ages of 18 and 45. When more than one eligible person resided in the household, the respondent was selected at random; if that individual was not home and could not be contacted for an interview, a second respondent was randomly identified. If the second individual was also not available for an interview, the surveyor moved on to the next nearest household.

The Mupedzanhamo impact area is subdivided into 21 commercial farms. Twelve of the farms were covered by a SC Farm Health Worker (FHW), with the exception of one large farm which had three FHWs. Only the farms covered by FHWs, or thirteen farms with a total population of 5,706, were included in the sample. Most of the larger farms are divided into compounds of similar size, but population data were not available for each compound. Thirty clusters were selected using the farms as sampling units. When possible, the cluster boundaries were defined by compounds within each farm; when the number of clusters needed exceeded the number of compounds on a farm, the houses were counted and the total number divided by the number of clusters needed. The starting point for each cluster was its geographic center. All of the houses visible in a direction randomly identified by a pencil toss were identified, and the starting house for the survey was selected from a table of random numbers for that set of houses. After the starting household was defined, interviewers followed the same procedures to identify respondents as described above for Mutema.

As stated above, a second purpose of the survey was to field-test its methodology. The questionnaire used for the survey was developed from a set of questions used in surveys conducted by other HAPA projects in Africa, questions used in an original baseline survey of the SC project sites, the objectives and strategies of the project, and future anticipated activities of SC in Zimbabwe related to HIV/AIDS. The questionnaire was revised and reworked extensively, first in Baltimore and again following pre-tests by project and MOH staff in Zimbabwe. The questionnaire was translated into the Shona language and retranslated into English to confirm the integrity of the original meaning of each question. Interviewers underwent two days of intensive training at the Mutema project site that included field practice; survey supervisors also attended this training as well as an additional day to cover issues particular to supervision. Frequency distributions of the data were hand-tabulated by survey trainers, supervisors, and a few especially skilled interviewers immediately following the completion of the interviews. These results were used to provide immediate feedback to the survey team, and are included in the initial survey report.

Data were also entered into the Epi-Info survey analysis package developed by the Centers for Disease Control in Atlanta for further analysis and entries randomly checked for errors. Data entry errors found ranged from zero to three errors per questionnaire form (33 questions) and the error rate was 3.6% among 67 questionnaires checked.

Of special mention, the survey used an innovative method to determine the numbers of sexual partners reported by interviewees. Culturally in Zimbabwe, especially in the rural areas, it would be considered extremely offensive to ask a woman directly about her sexual partners. The survey team was also concerned that, if men were asked this question orally, they might exaggerate their reported numbers of sexual partners. To solve these problems, men and women were asked to place one bean in a sock for each different sexual partner they had had in the last six months (or, since the survey was conducted during the month of June, since the New Year). Each sock was "seeded" with ten beans at the beginning of the day so that there would already be some beans in the sock at the time of the first interview. This was done in the hope that the interviewee, seeing that there were already beans in the sock, would feel more inclined to participate honestly. The interviewees were left alone to put the beans in the sock and were told that the beans would be counted for the entire cluster (minus the original ten). Cluster counts were averaged to determine the approximate number of sexual partners per person.

III. RESULTS

Sample Size

120 men and 120 women interviewed in Mupedzanhamo. 208 men and 210 women were interviewed in the Mutema impact area.

Age Distribution of Sample

The age break down of men in Mutema was: 43.8% were 18 to 23, 19.7% were aged 24 to 29, 8.7% were 30 to 34, 11.1% were 35 to 39, and 17.3% were 40 to 45 years old. The age distribution of the men in Mupedzanhamo was: 29.1% were 18 to 23, 18.4% were 24 to 29, 20% were 30 to 34, 17.5% were 35 to 39, and 15% were 40 to 45.

The ages of women in Mutema were: 23.3% were 18 to 24, 29.% were 25 to 29, 18.1% were 30 to 34, 17.1% were 35 to 39, and 11.9% were 40 to 45 years old. The age distribution of women in Mupedzanhamo was: 40.0% were 18 to 23, 27.5% were 24 to 29, 14.1% were 30 to 34, 10% were 35 to 39, and 8.4% were 40 to 45 years old.

Education Level

11% (36/328) of males and 22% (73/330) of females in Mutema and Mupedzanhamo had never attended school. 10% (33/328) of males and 16% (51/330) of females had attended primary school but could not read and 44% (143/328) of males and 51% (168/330) of females had attended primary school and could read. 35% (116/328) of males and only 12% (38/328) of females had completed secondary school (or a higher level).

Marital Status

In Mutema, 44% of males were single (92/208) compared to 25% in Mupedzanhamo (30/120). In Mutema, 55% of men were married (114/208) and in Mupedzanhamo, 73% (87/120) were married. Of the men who were married in Mutema 16% (18/114) had more than one wife and of the married men in Mupedzanhamo, 2% (2/87) had more than one wife. Only three (3%) male respondents in Mutema had more than two wives. Three men were separated or divorced in Mupedzanhamo and two men were widowed in Mutema.

Only 6% (19/330) of females were single in the two areas combined. 89% of the women were married (295/330) in both areas. 5% of women were separated, divorced, or widowed (16/330). More women reported having co-wives than men reported having more than one wife (male and female respondents did not come from the same household). 20% (38/188) of women in Mutema and 7% (7/107) of women in Mupedzanhamo reported having one or more co-wives.

KNOWLEDGE

AIDS Transmission

a) Shaking Hands

72% of women (237/330) knew that AIDS could not be transmitted by shaking hands and 9% (30/330) did not know. 57% (188/328) of the men said that shaking hands did not transmit AIDS and 10% (31/328) did not know. 33% (108/328) of men thought that AIDS could be transmitted by shaking hands compared to 19% of women (73/330).

b) Sharing Clothes or Towels

47% of males said "no" (155/328), AIDS could not be transmitted by sharing clothes/towels and 58% of the women also responded correctly (192/330). 48% of males thought that AIDS could be transmitted by sharing towels or clothes compared to 33% of females (110/330). 17 men and 28 women "did not know".

c) Mosquitos

40% (131/330) of the women said that mosquitos did not transmit AIDS compared to 33% of the men (108/328). Slightly more women, 43% (141/328), and 59% (195/328) of the men thought that AIDS could be transmitted by mosquitos. 8% of men and 17% of women did not know if mosquitos could transmit AIDS.

d) "Bad Air" or Evil Spirits

There was a difference among the men in the two impact areas. In Mupendzanhamo, 30% (36/120) of them thought evil spirits or bad air could transmit AIDS compared to 16% in Mutema (34/208). Correspondingly, 75% of the men in Mutema said that AIDS could not be transmitted by "bad air" or evil spirits compared to 58% in Mupendzanhamo. The proportion of women who thought AIDS could be transmitted by "bad air" in the two impact areas was nearly the equivalent. Sixteen percent of the women (54/330) thought that AIDS could be transmitted by "bad air" or evil spirits; 65% did not think so; and 18% were not sure.

e) "From an infected mother to her unborn child"

93% of both men and women (304/328 and 308/330, respectively) thought that a mother infected with the AIDS virus could pass it on to her unborn child. The remaining 7% were split between not knowing and not believing that infection could occur in-utero.

f) "Sexual intercourse with an infected person"

99% of men, 324/328, and 97% of women, 320/330, thought that AIDS could be transmitted by sexual intercourse. A very small minority of 1 to 3% did not think so or were unsure.

g) "Contaminated razor blades or needles"

94% of men and 90% of women (309/328 and 297/330) thought that AIDS could be transmitted by contaminated razor blades or needles. Another 5% of men and women did not know and 1% and 5% of men and women were not sure.

h) Three or more correct

Respondents were read the list, given above, of possible modes of transmission. Among those interviewed, 87% of the men and 85% of the women were able to correctly identify the three major modes of transmission. Only 13% of males, 42/328, and 15% of females, 50/330, did not correctly identify all three.

Latency and Infection

a) "Is it possible for a person to look healthy and feel healthy and still be infected with the AIDS virus?"

40% of men and 28% of women, 134/328 and 91/330, believed that a person could look and feel healthy and still

be infected with the AIDS virus. 54% of men and 65% of women did not believe in a latency period before onset of illness and 6% and 7% of men and women, respectively, did not know.

b) How long might a person be infected and still look and feel healthy? (days, months, years)

Among those who believed that a person might be infected yet look and feel healthy, 64% of males (84/131) and 74% of females (69/94) thought someone might be infected for years without looking or feeling sick. 15% of men and 18% of women thought you might be infected for months before appearing sick and 9% and 5% of men and women thought it would only take days before they would feel and look sick. The remaining 12% of the men and 3% of the women did not know how long the latency might be.

c) "Can a person look healthy and feel healthy but still pass on the virus to someone else?"

84% of men (274/328) and 77% of women (253/330) thought that an apparently healthy person could pass on the virus to someone else. This large majority of people who think that an apparently healthy person could pass the virus on to someone else contrasts sharply with the much smaller proportions of 40% and 28% of men and women who did not think that someone could be infected with the virus but not appear sick. This discrepancy may reveal a belief that some people can be carriers of AIDS without getting the disease themselves. 16% of women and 13% of men did not think that a healthy person could pass on the virus; 7% and 3% of women and men, respectively, did not know.

d) Belief in a cure for AIDS

Only 5% of men (18/328) and 7% of women (22/330) believed that there is a cure for AIDS. 79% of men (259) and 64% of women (211) said that there was not a cure for AIDS and the remaining 16% of men and 29% of women did not know if there was a cure or not. Among the 18 men who said there was a cure: three specified "herbs", two specified "condoms", one said "the urine of a baboon", another said "tablets", "holy water", and "injections", the remaining nine did not give a specific cure. Among the 22 women who thought there was a cure for AIDS, eleven specified "condoms", four said "injections, one "African medicine", another "wash clothes with Jik or boil water", and another said "not using razor blades which had been used by another person". The remaining four women did not specify.

AIDS Prevention

Respondents were asked: "Can you name some ways people can prevent AIDS (not get AIDS) themselves?" They were not given any examples to choose from and were prompted twice whether answers were given or not.

a) "Faithfulness to one partner"

44% of the men (144/328) and 42% of the women (139/330) named "faithfulness to one partner" as a method of preventing AIDS.

b) "Avoid casual sex"

23% of the men (75/328) and 22% of the women (73/330) mentioned "avoid casual sex" as a method of preventing AIDS.

c) "Avoid sex with prostitutes"

Among male respondents, 38% (125/328) said that to keep from getting AIDS they should "avoid sex with prostitutes". Among the women, 29% (95/330) said to "avoid sex with prostitutes".

d) "Have fewer sexual partners"

27 women (8%) and 20 men (6%) said that they should "have fewer sexual partners" in order to keep from getting AIDS.

e) "Condoms"

61% (200/328) of all male respondents and 69% (228/330) of all female respondents mentioned using condoms as a way to prevent the transmission of AIDS.

f) "Abstinence"

10% of the women (33/330) and 8% of the men (27/328) said that "abstinence" would keep them from getting AIDS.

g) "Don't share needles or razor blades"

32% of the women (105/330) and 21% of the men (69/328) mentioned not sharing needles or razor blades as a way to prevent AIDS.

h) "Three or more correct" (ie: respondent stated three or more of the modes of prevention listed above)

In Mutema, there were 19% more men than in Mupedzanhamo who were able to state three or more correct ways to prevent AIDS. Specifically, 43% (89/208) of men in Mutema and 24% (29/120) of men in Mupedzanhamo gave three or more ways to prevent AIDS. There was not a great difference between women in Mutema and Mupedzanhamo and 37% (123/330) of them were able to state three or more correct.

Fatality

"Among all the people who get AIDS, how many do you think will die of this disease?" (all, most, some, or none)

53% of the men (173/328) said that "all" those infected would die of the disease. In Mutema, 50% of women (105/210) said "all" would die but in Mupedzanhamo, only 23% (28/120) said "all" would die. 36% of the men in both areas said "most" would die while 33% of the women in Mutema and 55% of the women in Mupedzanhamo said "most" would die. 10% of the men said that "some" would die and among the women in both areas, 18% (59/330) said "some" would die. Only 2% of men and 1% of women said that "none" would die of the disease.

ATTITUDES AND BELIEFS

a) "Do you think people in your village are in danger of getting AIDS?"

55% of women (183/330) and 49% of men (162/328) said "yes", people in their village were in danger of getting AIDS. 32% of women and 36% of men did not think people in their village were in danger of getting AIDS and 13% and 15% of men and women, respectively, did not know.

b) "Is it possible that you could get AIDS yourself?"

61% of the women (200/330) and 49% of the men (161/328) thought that they could possibly get AIDS. 11% and 7% of the women and men, respectively, did not know if they could get AIDS and 29% of the women and 44% of the men did not think that they could get AIDS.

c) "Do you think AIDS is Runyoka?" (Runyoka is a type of chastity belt or culturally defined disease where a married man can place a spell on his wife which will cause another man to die if he has sex with her)

27% of the men (89/328) and 21% of the women (70/330) thought that AIDS was Runyoka. 60% and 62% of men and women did not think that it was the same thing and 13% and 17% of the men and women did not know.

Attitudes about People with AIDS

"If you knew that someone in your community had AIDS, would you be willing to"

a) Shake his/her hand?

Only one-third (28%) of men and women (35%) were willing to shake the hand of someone who had AIDS from their community. The other two-thirds were not willing to shake their hand.

b) Share a meal with him or her?

Again only one-third of the men (29%) and women (35%) were willing to share a meal with someone who had AIDS. The other two-thirds were not willing to take that "risk".

c) Get water from the same well?

More men and women were willing to get water from the same well with someone who had AIDS than to shake his hand or share a meal with him or her. Approximately half of the men (44%) and half of the women (58%) were willing to get water from the same well.

"If someone in your family had AIDS, would you be willing to . . ."

a) Wash him or her?

About half of the men (48%) were willing to wash someone in their family if they had AIDS. Three-quarters of the women in Mutema (75%) and half of the women in Mupedzanhamo (54%) were willing to wash someone in there family who had AIDS.

b) Share a meal with him or her?

More women were willing to share a meal than men, 55% of women and 37% of men were willing to share a meal with a member of their family who had AIDS.

c) Live in the same house with him/her?

Again, more women (68%) than men (45%) were willing to live in the same house with a member of their family who had AIDS. Surprisingly the other 55% of men and 32% of women would not be willing to live in the same house with a family member who had AIDS.

"Do you agree or disagree with the following statements?"

a) People with AIDS should be isolated from the rest of the community.

87% (286/328) of all male respondents and 79% (263/330) of all female respondents agree with the statement that people who have AIDS should be isolated from the rest of the community.

b) People with AIDS should not be allowed to have children.

Again the majority of men, 87% (286/328) and the majority of women, 79% (260/330) agreed with the statement that people with AIDS should not be allowed to have children.

c) People with AIDS deserve our help.

86% of men (281/328) and 82% of the women (271/330) agreed that people with AIDS deserve their help, even though

they also thought that people with AIDS should be isolated and should not have children.

d) People with AIDS deserve what happened to them.

Although the majority thought people with AIDS deserved help, they also thought that they deserved what happened to them. 80% of men (263/328) and 76% of women agreed with the statement that people with AIDS deserved what had happened to them.

"If you had AIDS, would you tell

a) Your husband or wife?

80% (260/323) of all male respondents and 83% of all female respondents said that if they had AIDS, they would tell their spouse.

b) Anyone else?

Less than half of the men, 46% (152/328), and women, 40% (131/330) would tell someone else other than their spouse if they had AIDS.

"If someone in your family had AIDS, where would be the best place for him/her to be taken care of? (Home, hospital, or other)

10.4% (34/328) of all male respondents and 15.2% (50/330) of all female respondents think that the home is the best place for a family member with AIDS to be cared for; 74% (20/328) of men and 81% (268/330) of women think the hospital is the best place for care; and 6% (20/328) of males and 4% (12/330) of females named another source as the best place for care. Some of the other places mentioned were: sending them far away, isolating them, keeping them in camps, having the government provide a place for care, sending them to traditional healers, keeping them in jail, making them stay in the streets, and having them cared for by health workers or the social welfare system.

PRACTICE AND BEHAVIOR

Discussion of AIDS

With spouses: 94.3% (199/211) of all male respondents who are currently married and 93.7% (282/301) of all currently married female respondents report that they talk freely about AIDS with their spouses.

With children: 86.8% (171/197) of male respondents who have children and 90.7% (256/282) of female respondents who

have children report that they talk freely with their children about AIDS.

With anyone else: 83.2% (99/119) of male respondents from Mupedzanhamo and 97.6% of male respondents from Mutema report that they talk freely to others - besides/in addition to wives or children - about AIDS. Results from women were similar, with 72.5% (87/120) of females interviewed in Mupedzanhamo and 86.4% (172/199) of females interviewed in Mutema reporting that they talk freely about AIDS with other people - besides/in addition to husbands and children - about AIDS. Eleven women in Mutema and one man in Mupedzanhamo did not respond.

Condom Use

52.7% of males (173/328) and 28.5% of females (94/330) reported ever having used a condom.

Of men who reported ever having used condoms, 7.7% of men in Mupedzanhamo and 31% of men in Mutema report always using condoms, 50.8% and 51%, respectively, report using condoms sometimes, and 41.5% of men in Mupedzanhamo and 18% of men in Mutema report never using condoms. Of women in both areas who report ever having used condoms, 16.7% of women in Mupedzanhamo and 28.1% of women in Mutema report always using condoms, 83.3% and 59.4%, respectively, report using condoms sometimes, and 12.5% of the women who had ever used condoms in Mutema report never using them now. (None of the women in Mupedzanhamo who have ever used condoms reported never using them now.)

Changes in Lifestyle

46.0% (151/328) of men in both areas and 46.7% (154/330) of women report that their friends/others in the community have changed the way they live because they are afraid of AIDS. 29.3% (96/328) of men and 31.5% (105/330) of women feel people in their communities have not changed their behavior; 12.5% (41/328) of men and 21.5% (71/330) of women don't know.

Of those who report that people in their communities have changed their behavior:

37.1% (56/151) of males in both areas; 46.7% (23/49) of females interviewed in Mupedzanhamo, and 22.9% (24/105) of females interviewed in Mutema report that people are keeping to one sexual partner;

45.7% (69/151) of male respondents in both areas and 65.6% (101/154) of females interviewed report that people are using condoms;

58.9% (89/151) of all men interviewed; 14.3% (7/49) of women respondents in Mupedzanhamo, and 35.2% (37/105) of women respondents in Mutema report that men are not going with bar girls or prostitutes;

4.0% (6/151) of men interviewed in both areas and 7.1% (11/154) of women report people are reducing their numbers of sexual partners; and

9.3% (14/151) of all male respondents and 26.6% (41/154) of female respondents report people are not sharing razor blades or needles.

Numbers of Sexual Partners

Among males in Mupedzanhamo, 10% had, on average, less than one partner; 64% had 1 to 1.9 partners; 10% had 2 to 2.9 partners; 6.6% had 3 to 5 partners; and 10% had more than five partners in the last six months. In Mutema, 20% had less than one partner; 43% had 1 to 1.9 partners; 16.5% had 2 to 2.9; 10% had 3 to 5; and 6.6% had more than five.

Among women in Mupedzanhamo, 20% had less than one partner on average in the last six months; 33.3% reported having one partner; 43.3% had greater than one to two partners; and 3.3% had more than two. In Mutema, 33.3% of women had less than one partner; 46.6% had one partner; 13.3 had greater than one to two partners; and 3.3% had more than two partners.

SERVICES

Condom Availability

71.7% (86/120) of male respondents in Mupedzanhamo and 39.9% (83/208) of male respondents in Mutema felt that condoms were usually available for people who live in their communities. 25% of males interviewed in Mupedzanhamo and 50% of male interviewees in Mutema felt condoms were not usually available for people who live in their communities; 4 men in the Mupedzanhamo sample and 10.1% (21/208) of Mutema males questioned didn't know. Among women respondents, 64.2% (77/120) of women in the Mupedzanhamo sample and 47.6% (100/210) of women interviewed in Mutema felt condoms were usually available for people in their communities. 18.3% (22/120) of women respondents in Mupedzanhamo and 32.9% (69/210) of women respondents in Mutema did not think condoms are usually available in their communities; 18.5% of women in both areas didn't know.

Source of Condoms

75.8% (248/327) of males in both areas and 73.3% (242/330) of females named clinics as a place where condoms can be obtained; 15.3% (50/327) of males and 18.5% (61/330) of females named community-based distributors (CBDs). In Mupedzanhamo, 6 out of 240 respondents (men and women) cited pharmacies and 9 named the Save the Children office in Harare as a source of condoms; in Mutema, pharmacies (7/417) and local merchants (6/417) were also named. A total of 10 men in Mutema and 16 women in Mupedzanhamo and Mutema either don't know where condoms can be obtained or named another source.

Source of AIDS Information

Respondents were asked to name all of their sources of AIDS information.

Village Community Workers (VCWs) were mentioned as a source of information about AIDS by 38.1% (125/328) of all males interviewed and 64.8% (214/330) of females.

Radio/TV was mentioned by 38.7% of male interviewees, 31.7% (38/120) of female respondents in Mupedzanhamo, and 11% (23/210) of female respondents in Mutema.

Newspapers/magazines were cited by 36.9% (121/328) of male respondents and 19.4% (64/330) of females.

Clinic staff were mentioned as a source of AIDS information by 27.9% (92/328) of all men interviewed, 16.7% (20/120) of women respondents in Mupedzanhamo, and 40.0% (84/210) of women respondents in Mutema.

Community leaders were named by 5.8% (7/120) of males interviewed in Mupedzanhamo, 26.9% (56/208) of males interviewed in Mutema, and 3.9% (13/330) of all females interviewed.

Other sources were named by 15.5% (51/328) of all male interviewees and 9.7% (32/330) of all females. In Mutema, schools were mentioned most often by men as other sources of AIDS information, followed by friends. For women in Mutema, neighbors were mentioned most often, followed by schools, community meetings, and friends.

Children as Appropriate Targets for AIDS Education

84.1% (276/328) of all males, 86.7% (104/120) of female respondents in Mupedzanhamo, and 68.8% (143/208) of female respondents in Mutema think children 11 to 15 years of age should be taught about AIDS.

Slightly over one-third of all male respondents (37.2% or 122/328), 43.3% (52/120) of female respondents in Mupedzanhamo, and only one-fifth (19.5% or 41/210) of female respondents in Mutema thought that children 10 years of age or younger should be taught about AIDS.

95.7% (314/328) of all male respondents, 94.2% (113/120) of female respondents in Mupedzanhamo, and 84.7% (177/209) of female respondents in Mutema think children should be taught about AIDS by non-family members, such as teachers and health workers. In addition, 2 women in Mupedzanhamo and 7 women in Mutema gave a qualified affirmative response, saying that in some cases, non-family members are appropriate educators of young people about AIDS.

AIDS Service Most Needed in Their Community

Education was cited by 46.6% (154/328) of all males, followed by condoms (27.7%), and treatment/care (7.2%). Three men named counseling, 5.5% did not know or did not answer, and 12.2% named another type of service.

For women respondents, condoms were named as the most needed service by 43.8% (144/329), followed by education (23.7%), treatment/care (11.6%), and place to go/hospice (1.8%). Four women mentioned counseling, 10.6% did not know or did not respond, and 7.3% named another type of service.

Among men and women in Mutema who named another service, isolation of infected patients, isolation and decreasing the numbers of prostitutes, vaccination, blood tests, basic sanitation, and ensuring clinic stocks of clean needles were mentioned.

V. DISCUSSION

There was a high degree of self-reported literacy among the sample population, 79% of men and 62% of women. The sample of men from Mutema were younger and less likely to be married than the men interviewed in Mupedzanhamo. This was probably due to the difficulty of finding men at home in Mutema during working hours. A wider range of men were interviewed in Mupedzanhamo because interviewers worked during the farmers' off hours or breaks.

The level of knowledge regarding the three primary modes of AIDS transmission was very high, over 90%, for both men and women interviewed in the two impact areas. Despite this impressive knowledge there was also a high degree of misconceptions regarding AIDS transmission including beliefs that AIDS can be transmitted by mosquitos, shaking hands, sharing clothes, and "bad air" or evil spirits. Project education efforts appear to have successfully communicated

the correct modes of transmission yet misconceptions persist.

Approximately 85% of both men and women were able to correctly identify the three major modes of transmission. When asked to state modes of prevention, significantly lower proportions of men and women were able to state three or more correct ways to prevent AIDS. It is not clear whether this difference is due to the knowledge of respondents, or the way the questions were asked.

Exposure to Save the Children as a source of information about AIDS was associated with higher knowledge levels. A Save the Children source was defined as someone who has received AIDS training from project staff, namely Village Community Workers/Farm Health Workers, Community Leaders, and Rural Health Clinic staff. Approximately two-thirds of all respondents named one or more of these sources as a source of AIDS information. Using Epi-Info, a significant association was found between exposure to a Save the Children source of AIDS information and the ability to name 3 modes of AIDS transmission and prevention. A person who had cited Save the Children as a source of AIDS information was about 52% more likely to be able to name the three primary modes of AIDS information than someone who had not named Save the Children as a source of AIDS information. Similarly, the person who named Save the Children as a source of AIDS information was 38% more likely to be able to name three or more methods to prevent AIDS transmission.

A relatively small proportion of men and women, approximately one-third, thought that an apparently healthy person could be infected with the virus, however three-quarters of the respondents thought that an apparently healthy person could pass on the virus to someone else. This incongruence may reveal a widespread belief that people can be carriers of the AIDS virus but not succumb to the disease themselves.

Half of the respondents thought that people in their community were in danger of getting AIDS yet 29% of women and 44% of men did not acknowledge any personal risk of getting AIDS. The fact that almost half of the men did not feel at risk is worrisome and demonstrates a need to intensify education efforts among men.

Attitudes about people with AIDS differed depending on the infected person's relationship to the respondent. Generally the respondents were more willing to have non-intimate physical contact with members of their own families who have AIDS than with members of their communities. For example, only one-third of women were willing to share a meal with someone in their community who had AIDS while half of the women would share a meal with someone from their family who

had AIDS. In all cases, women were more willing to have contact with a sick family member than men, perhaps due to their traditional role as care-givers. Upon further analysis, there was a definite trend, though it was not significant, that people exposed to Save the Children as a source of information about AIDS were slightly more likely to have more enlightened attitudes about casual contact with people with AIDS.

Attitudes towards people with AIDS were remarkably harsh. Over three-quarters of all respondents thought that people with AIDS should be isolated from the rest of the community, should not be allowed to have children, and deserve what happened to them. However an equally high percentage thought that people with AIDS deserve our help. These attitudes may stem from a strong underlying fear of AIDS and people with AIDS.

Only 10 to 15% of all respondents said that the home is the best place to care for people with AIDS. The overwhelming majority preferred hospitals. Given the high prevalence of AIDS in Zimbabwe, this finding has important programmatic implications for home care in the future.

A surprisingly high proportion of respondents, half of males and one-quarter of females, reported ever-use of condoms. Half of men in both areas reported using condoms "sometimes". The consistency of reported "always" use among men in the two impact areas varied considerably, with 31% of men in Mutema compared to 7% in Mupedzanhamo. In contrast, 17% and 28% of women in Mupedzanhamo and Mutema reported "always" using condoms and 83% and 59%, respectively, reported using condoms "sometimes". These findings are somewhat unexpected and the data is not yet fully analyzed. Preliminary computer analysis shows no correlation between marital status or condom availability and condom use.

There was a large discrepancy between perceived availability of condoms among males in the two impact areas. Only 40% of the men in Mutema vs. 72% of the men in Mupedzanhamo thought that condoms were usually available in their communities. Clinics were the most frequently mentioned source of condoms, named by 75% of all respondents. Clinics appear to be the most important source of condoms in these areas and thus maintenance of clinic supply is essential.

Village Community Workers (VCWs) were mentioned most often by women as their source of information about AIDS. Men were more likely to obtain information from the radio/TV and newspapers, followed closely by clinic staff and community leaders. This is not surprising since most VCWs are women and are more likely to have contact with the women during home visits.

Most men mentioned education as the AIDS service most needed in their communities while women were more likely to mention condoms. When asked about educating children, there was resistance to teaching children under 10 years of age but the majority support educating children 11 to 15 years of age. There was little resistance to the idea of education given by non-family members such as teachers and health workers. Teenagers are clearly an acceptable target for AIDS education in these project areas.

Almost half of all respondents thought that people were changing their lifestyle because of fear of AIDS. The most common behavior changes cited were condom use and avoiding prostitutes.

CONCLUSIONS

The survey provided some useful information in terms of people's knowledge and attitudes about AIDS in SC's project areas. Preliminary analysis of the results suggest that SC's program has had an effect on people's knowledge about AIDS transmission and prevention, and, to a more limited extent, on people's attitudes toward others with the disease. However, much remains to be done, such as:

- * education efforts need to place more emphasis on still prevalent misconceptions regarding transmission by casual contact and mosquitos;

- * new methods need to be developed to more effectively target men in these areas;

- * education needs to focus more on increasing tolerant attitudes toward people with AIDS, and

- * AIDS education in schools should be increased; education campaigns should be directed at teens as well as adults.

In terms of methodology, the rapid KAP survey technique can be successfully adapted to AIDS surveys. The survey, from planning through execution and preliminary analysis, took a total of three to four weeks: 10 days preparation and training of trainers in the U.S., then in-country: 2 days for questionnaire review, 3 days for training of interviewers and supervisors, 3 days interviewing, 1 day hand-tabulating the data, and 1 or 2 days for report writing. Entering the data onto the computer took an additional 3 days. The total cost of the survey was approximately USD 2,000.

Focus Group VCWs and FHWs

1. VCW ONLY

Did the change in your jobs from VHW to VCW help or hinder your work in AIDS education? How?

2. What factors helped or hindered your work? (staffing, work load etc.?) Do you have sufficient support to do your work? What do you need?

3. How have you educated members of your community about AIDS? What methods have been most effective? (eg. one on one, drama, songs, community meetings? etc.)

4. Have your community leaders been supportive of your AIDS education programmes? Describe.

5. Has this programme made a difference in the behaviour of the people in your area? Why? Why not? How? How do people feel about using condoms?

6. When you talk with people what are their most common concerns? Do these differ for men and women?

7. Will you carry on this job when Save the Children is no longer here to help you? If you have problems what will you do?

Focus group-Community Leaders

1. Have you participated in this program on AIDS education?
How? What contact have you had with vews?

2. What has been good about the program? What has not been
so good? How could the program be made better?

3. Should this program continue? If yes, what will your
role be when Save the Children leaves in August? How should
it be supported?

4. Has behaviour in the community changed because of this program?

5. How and where should AIDS patients be cared for?

6. If you thought that you had AIDS where would you want to be cared for?

Focus Group Questions

Adults- Male and Female.

1. When you discuss AIDS with your spouse what do you talk about?

2. When you discuss AIDS with your children what do you talk about?

3. What type of education did you receive from your vov/fhw? What was most helpful? Could the education be better? How?

4. Women only Can you ask your partner to wear a condom?
How do you ask him? Are condoms acceptable?

5. Men only What would you say if your partner asked you to
use a condom? Are condoms acceptable?

6. Where should someone with AIDS be cared for?
What is the advantage of having AIDS patients cared for in
hospital versus at home? Where should an AIDS patient spend
the last few days?

7. What would you do if you thought that you had AIDS?
Where would you want to be cared for?

8. What would you do if your infant had AIDS?

Appendix C

SAVE THE CHILDREN FEDERATION/USA
Zimbabwe Field Office

HAPA Grant Final Evaluation Schedule

Monday, July 8

team meeting; review of expectations & planning

Tuesday, July 9

team meeting; planning; development of evaluation tools

Wednesday, July 10

finish planning & tools development; orientation to Mupedzanhamo program by AHC and review of records

Thursday, July 11

am: travel to Mupedzanhamo; interviews and focus groups with FHWs

pm: interviews with farm managers; focus group with community leaders

Friday, July 12

am: meeting with DNO for Seke

pm: meeting with Rural Council; interviews with farm managers; focus groups with male and female community members

Saturday, July 13 OFF

Sunday, July 14 Travel to Chimanimani

Monday, July 15

am: travel to Muusha; orientation to programs by IA staff; review of records; interviews and focus groups with VCWs

pm: focus groups with VCWs; interviews with IA manager and AHC

Tuesday, July 16

am: meeting with DMO and acting-DNO for Chimanimani; focus groups with male and female community members

pm: focus groups with community leaders and traditional healers; interviews with rural clinic staff; travel to Chipinge Guest House

Wednesday, July 17

am: travel to Mutema; orientation to programs by IA staff; review of records; interviews and focus groups with VCWs

pm: focus groups with VCWs; interviews with AHC and MCCD ward coordinator

Thursday, July 18

am: meeting with DMO and acting-DNO of Chipinge; focus groups with community leaders and male and female community members

pm: focus groups (above) continued; meeting with PNO for Manicaland in Mutare; interviews with rural clinic staff

Friday, July 19

travel to Harare; meet with PMD for Mashonaland East

Saturday, July 20 OFF

Sunday, July 21 OFF

Monday, July 22

group review of findings, conclusions, lessons learned, and recommendations

Tuesday, July 23

am: report writing

pm: report writing; interview with SC Financial Director

Wednesday, July 24

print of 1st report draft; revisions; print of 2nd draft

Thursday, July 25

am: evaluation debriefing with A.I.D.; travel to Svosve-Chiduku

pm: feedback to project staff; end-of-evaluation party; return to Harare

Friday, July 26

am: polishing report and tying up loose ends

Appendix D

List of Contacts

Save the Children/USA Westport, CT:
Nicola Gates AIDS Coordinator

Field Office, Harare:
Gerry Salole Field Office Director
Linile Malunga AIDS/Child Survival Coordinator
Elijah Maunga Financial Director

Impact Area Office, Muusha
J. Matandaudhle Impact Area Manager
G. Munaku Seconded Nurse/Area Health
Coordinator
D. Mandinya SCN, Biriwiri Rural Hospital
G. Vumisai SCN, Biriwiri Rural Hospital

Impact Area Office, Mutema:
J. Matandaudhle Impact Area Manager
N. Temberere Seconded Nurse and Area Health
Coordinator
S. Mlambo EHT
P. Barauta SCN, Mutema Clinic
S. Chijokwe SCN, Mutema Clinic
A. Marinyame SCN, Mutema Clinic

Impact Area Office, Mupedzanhamo
E. Chieza Seconded Nurse and Area Health
Coordinator

Provincial Medical Office, Manicaland
A. Mashamba Provincial Nursing Officer

District Medical Office, Chimanimani
Dr. Razum District Medical Officer
P.S. Dungare Acting District Nursing
Officer
I. Mpofo District Health Education
Officer

District Medical Office, Chipinge
Dr. D. Chandramohane District Medical Officer
S. Mutyambizi Acting District Nursing
Officer

Provincial Medical Office, Mashonaland East
Dr. Sena Provincial Medical Officer
Mrs. Masaugwi Provincial Nursing Officer

District Medical Office, Seke
Mrs. Bhila District Nursing Officer

Rural Council, Seke
Mrs. Van Tonger

Director

Farm Owners/Managers
Mr. Mandaza
Mr. D. MacIntosh
Mr. R. Chakantika

International Crest Breeders
Ellerton Farm
Ellerton Farm

10-Sep-91 aidszia

AIDS EDUCATION: ZIMBABWE

BUDGET VS. ACTUALS FOR YEAR 2 AND TOTAL EXPENSES TO DATE VS. TOTAL GRANT AWARD

	YEAR 2: EXPENSES VS. PLANNED BUDGET **					LIFE OF GRANT: CUMULATIVE EXPENSES VS. TOTAL GRANT AWARD *			
	EXPENSES YEAR 1	EXPENSES 6/30/91*	PLANNED BUDGET**	BALANCE	% EXPENDED	CUMULATIVE ACTUALS	TOTAL PLANNED BUDGET	BALANCE	% OF TOTAL GRANT EXPENDED
HO Support	21,686.22	18,292.07	29,041.78	10,749.71	63.0%	39,980.29	50,730.00	10,749.71	78.8%
Overhead	6,515.59	7,004.78	11,588.41	4,583.63	60.4%	13,520.37	18,104.00	4,583.63	74.7%
Evaluation	0.00	0.00	5,960.00	5,960.00	0.0%	0.00	5,960.00	5,960.00	0.0%
Project Activities	28,586.40	29,033.78	55,619.60	26,585.82	52.2%	57,620.18	84,206.00	26,585.82	68.4%
TOTAL	56,790.21	54,330.63	102,209.79	47,879.16	53.2%	111,120.84	159,000.00	47,879.16	69.9%

* Field Office expenses and Overhead through June 1991; preliminary Home Office expenses through July 1991.

** Planned budget reflects October '90 revision submitted to A.I.D.

Year 1 = September 1, 1989 - August 31, 1990

Year 2 = September 1, 1990 - August 31, 1991

Appendix F

AIDS Training of Community Leaders on
Commercial Farms in Mupedzanhamo

DATE	VENUE	PARTICIPANTS	
July 22, 1990	York Farm	Community Leaders	39
July 29, 1990	Shrewsbury Farm	Community Leaders	
July 31, 1990	International Crest Breeders	Community Leaders	16
August 5, 1990	Ingwe farm	Community leaders	21
August 16, 1990	International Crest Breeders Farm	Community Leaders	37
August 19, 1990	Imbgwa Farm	Community Leaders	34
September 30, 1990	Adino Farm	Community Leaders	24
November 18, 1990	Nhuku Farm	Community Leaders	43
November 25, 1990	Simukai Cooperative Farm	Community Leaders	30
REFRESHER COURSES			
April 5, 1991	Crestbreeders	Community Leaders VCWs	3 3
April 7, 1991	York	Community Leaders	25
April 14, 1991	Ingwe	Community leaders VCWs	7 2
April 21, 1991	Imbgwa	Community Leaders	16
April 24, 1991	Gabaza	Community Leaders	5

April 28, 1991	Nhuku	Community Leaders	11
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May 14, 1991	Gilestone	Community Leaders	8
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Community Leaders were identified by the farm workers themselves. They were primarily community leaders although some traditional midwives and traditional healers were included.

AIDS Training Workshops - Mutema

DATE	VENUE	PARTICIPANTS	
June 11-15, 1990	Mutema	VCWs	48
June 27-29, 1990	Birchenough Bridge	Community Leaders	55
August 3, 1990	Chipinge	Community Leaders	49
September 18, 1990	Mutema	Community Leaders	21
April 8-9, 1991 Refresher Course	Mutema	Nurses, EHTs, MCCD Officers	9
April 10-12, 1991	Mutema	VCWs	49

REFRESHER COURSES

April 15, 1991	Mutema	Community Leaders	23
April 16, 1991 1991	Mutema	Community Leaders	24

AIDS Training Workshops - Muusha

DATE	VENUE	PARTICIPANTS	
November 7-10 1989	Chimanimani	MOH	14
		SCF	11
		MCCD	2
January 12 1990	Chimanimani	MOH	29
		SCF	8
		MCCD	2
		VCWs	39
		Community Leaders	27
June 26 1990	Kwaedya	MOH	11
		SCF	2
July 17-19 1990	Mkakare	VCW	33
		Community Leaders	1
July 27-29 1990	Chimanimani	MOH	39
		Other	3
March 25-26 1991	Kwaedza	MOH	11
		Other	3
April 22-26 1991	Makwe	VCWs	31
		Community Leaders	70

Appendix G

ZVATINGADE KUZIVA NEZVECHIRWERE CHE AIDS

Mashoko aya ndeekuti muzive chokwadi chezvechirwere che AIDS. Izvi zvichaita kuti mugozokwanisa kuzvidzivirira kuchirwere ichi uye munozogonawo kuyambira vamwe.

CHIIKO CHINOMBONZI AIDS?

AIDS chirwere chapararira pasi pose. Mushonga wekuchirapa hausati wawanikwa. Imo muno muZimbabwe vamwe vanhu vakatofa nacho.

AIDS inokonzerwa neutachiwona hudikidiki husingakwanisike kuonekwa neziso. Utachiwona uhwu hunotadzisa muviri wemunhu kuzvidzivirira kuzvirwere.

NZIRA DZINOBATWA NADZO CHIRWERE CHE AIDS:

1. Kusangana kwe vakadzi nevarume.

Iyi ndiyo nzira inopananwa chirwere che AIDS. Vamwe vanogona kuva neutachiwona hwe AIDS mumviri mavoasi ivo vasingazvize uye vanenge vasati vave nezviratidzo zvechirwere ichi. Vanhu ava vakangosangana nemurume kana mukadzi vanobva vatomuzadzawo utachiwona hwe AIDS.

MUNHU WESE ANOGONA KUBATA AIDS - MUROMBO KANA MUPFUMI UYE MARUDZI OSE ZVAVO.

SAKA NGATINGWAREI TIREGE KURUMWA NECHEKUCHERA.

TINGAITA SEIKO KUTI TISABATE CHIRWERE CHE AIDS?

(1) Musawanze vamunorara nawo varume kana vakadzi nekuti zvinonetsa kwazo kuti muzive kuti anechirwere ndeupi.

(2) Kune vamwe vanhu vanozvibaya majekiseni zvisina mvumo yana chiremba. Tsika yekuzvibaya iyi ndiyo inoparadzira chirwere che AIDS.

CHENJERAI!!

Musashandise tsono kana masirinji ahandiswa nevamwe. Zvakare musa shandise reza yashandiswa nevamwe pakutema nyora kana kubisisa ndebvu

Umhutu kana tumwe tumbuyu tunosveta ropa kana tukaruma munhu, hapana zvati zvaratidza kuti tunga paradzire chirwere che AIDS.

(3) Imwe nzira inowanikwa nayo AIDS ndeiyi inoitika pana amai vane pamuviri vaine AIDS. Vanozadza mwana chirwere ichi achiri mudumbu kana panguva yekuzvarwa kwake.

KANA MUKAUDZWA KUTI MUNE AIDS EDZAI NEKWAMUNOGONA KUTI MUSAITE PAMUVIRI

(ii) Musarare nepfambi kana vaye varume vanorara nevamwe varume.

(iii) Kushandis makondomu (Condoms) kunobatsira vese varume nevakadzi. Nzira dzose idzi ndedzekudzivirira kupararira kwe chirwere che AIDS.

(4) Imwe nzira inogona kubatwa nayo chirwere che AIDS ndeye kupihwa ropa rne utachiwona hwacho. Izvi hazvichawanza kuitika nekuti ropa rose rinotanga raongororwa risati rapihwa kuvarwere. Rinenge raongororwa risati rapihwa kuvarwere. Rinenge raonekwa riine chirwere rinobva rapiswa. Kupa Ropa HAKUZADZE CHIRWERE CHE AIDS, saka tisyate.

AIDS inogona kuzadzanwa netsono nemasirinji kana zvikange zvambo-shandiswa pamunhu ane utachiwona kwacho. Mumakiriniki nemuzvipatara masirinji netsono zvinoviriswa zvakakwana kuitira kuuya utachiwona hwese.

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Hazvisati zvawanikwa kuti chirwere che AIDS chingazadzanwe nenzira dzinotevera:

- kunwidzana

- kugara mumba mumwechete nemunhu ane chirwere che AIDS
- kuhotsira kana kufema mweya mumwechete nemunhu ane AIDS
- kufuga mbatya nemunhu ane AIDS

MUNHU ANGAZIVE SEYI KUTI ANE AIDS?

Dzimwe nguva zvinonetsa kuti munhu angazive seyiki kuti ane AIDS, nokuti munhu anogona kufamba asina zvaanoona, kunzwa kuti ane chirwere asi anogona kuzadza chero munhu wese waanenge arara naye.

NDEZVIPI ZVIRATIDZO ZVECHIRWERE ICHI?

Zvinotevera izvi zvimwe zvezviratidzo zve chirwere che AIDS apo chinenge chichitanga.

- * Mapundu mumuviri munzvimbo dzakaita se muhapwa ne muhuro. Izvi zvinoratidza semwambabvu.
- * Kupera kwe mumuviri kwakanyanyisa nenguva dukuduku
- * Kudikitira usiku, kupindwa nechando nekurukutika kunoramba kuchingoendera mberi.
- * Manyoka anotora nguva yakarebesa

KUVA NECHIMWE CHEZVIRATIDZO ZVATATAURA PAMUSOR APO HAZVIWANZO KUREVA KUTI MUNHU ANE AIDS. ZVAKANAKA KUNOTARISWA NANA CHIPEMBA KANA PAINE ZVANETSA.

Kana mukaudzwa kuti mune Aids ibvai matangisa kushandisa makondomu (Condom) apo munenge muchisangana ne murume kana mukadzi wenyu.

CHENJERAI!!!

Mukawanza vekurara navo hamuzivi anogona kukuzadzai AIDS. Zivai kuti hamuzivi zviri muropa mevanhu vakasiyanasiyana. Saka NGWARAI!

AIDS INOURAYA: MUKAIBATA MATOFA:

MUNHU ARI KURWARA NE AIDS ANORATIDZA SEYI?

Zviratidzo zvese zvatambotaura pamusoro zvinobva zvanyanya. Munhu anoperesesa muviri, manyoka anonyanyisa. Kazhinji munhu anozofa nezvirwere zvakaita se mabayo, dzihwa kana manyoka nekuti muviri wake unenge usisagone kuzvidzivirira kubva kuzvirwere.

- * AIDS HAIRAPIKE
- * KUIDZIVIRIRA NDIKO CHETE KUNOGONA KUPONESA
- * SHANDISAI MAKONDOMU APO MUNENGE MUSINA CHOKWADI NEMUNHU WAMUNENGE MAVEKURARA NAYE
- * CHENJERAI PFAMBI NEVAMWE VANORARA NEVANHU VAKAWANDA.

