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WORLD VISION RELIEF & DEVELOPMENT, INC.

FINAL EVALUATION REPORT
HIV/AIDS PREVENTION
IN AFRICA PROGRAM
MARONDERA DISTRICT, ZIMBABWE

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PART I
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MARONDERA HIV/AIDS PREVENTION PROGRAM
ZIMBABWE

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LIST OF ACRONYMS

DDC	District Development Center
DHE	District Health Executive
DHT	District Health Team
DNO	District Nursing Officer
HAPA	HIV/AIDS Prevention in Africa
KAP	Knowledge, Attitude, and Practice
MOH	Ministry of Health
MTE	Midterm Evaluation
MTR	Midterm Report
NACP	National AIDS Control Program
PHT	Provincial Health Team
PVO	Private Voluntary Organization
SCN	State Certified Nurse
SRN	State Registered Nurse
STD	Sexually Transmitted Diseases
VIDCO	Village Development Committee
WVRD	World Vision Relief & Development
WVZ	World Vision Zimbabwe
ZINATHA	Zimbabwe National Traditional Healers Association

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EXECUTIVE SUMMARY

The Marondera District HAPA project has been an important activity for World Vision Zimbabwe (WVZ), as it is one of the earliest AIDS prevention projects in the country. The project was started at a time when the Ministry of Health (MOH) had a rather closed policy towards the epidemic. During the first year of the project, the MOH policy on AIDS became more open, and the spread of information on AIDS became easier.

Most of the problems encountered in this project are similar to those experienced by other pioneering projects. The lack of a clear strategy in the project design on the kind of high-level MOH-WVZ consultations that a new project like this would need affected the implementation of activities. Most district-level activities planned in the document have been implemented, in spite of the fact that district-level staff in both WVZ and the MOH have not received sufficient supportive guidance and supervision from their respective head offices. No joint monitoring activities from the head office were planned for, and there were no mechanisms to continually review problems and suggest solutions in such a new and challenging project.

The evaluation team concludes that the project has achieved most of its goals. The gap identified was that the relevance, appropriateness, and effectiveness of the original targets and indicators were neither tested nor reviewed in the course of this project. The planning workshop recommended in the Midterm Report (MTR) of 1990 was meant to review and reset these targets and indicators, but the opportunity was lost. The workshop produced more general recommendations instead of identifying more relevant indicators, and then developing appropriate targets for year two.

From the focus group discussions held with over sixty groups in the district during September 1991, it is clear that there are more people aware of AIDS today in the Marondera District than was the case two years ago. While this change cannot be attributed directly to the project, it can be assumed that the project has played a significant part. The WVZ field staff are, for instance, known in the districts by various people, itself an indication that they have been implementing activities in the district.

The most troublesome finding to come from these focus group discussions is the consensus among respondents that although more people know the seriousness of AIDS today than was the case two years ago, there is the continual problem of multiple sexual partners and a sexually active segment of the population. The need to earn money is one main reason given for prostitution by young women, but the reason given for married women is the search for sexual satisfaction from younger men.

Were this trend to be confirmed by a more detailed study, it would raise fundamental questions over the strategy currently being used to promote AIDS awareness in the country. The findings from focus group discussions suggest that there might be a need to look for more effective strategies to emphasize the message that AIDS is a most serious problem.

The perception from several respondents that health workers are not setting a good example as far as promiscuous behavior is concerned suggests that there is a need to develop a health education campaign specifically targeted at health workers. Considering that these workers were cited as the most important source of information on AIDS (KAP, 1990), the perception that "they are not practicing what they preach" has a great negative effect on the anti-AIDS campaign being spearheaded by these same health workers.

Were the project to be extended, one condition should be the preparation of a protocol spelling out roles and obligations of the partners—their officers, use of equipment, supervisory visits from various levels, integration of project into MOH planning structures and systems, etc. The distribution of planning responsibilities between WVZ and the MOH head office/provincial staff would need to be specified. The lack of such support in the current project might explain the failure of this project to utilize the KAP results to produce a revised schedule of targets and activities for year two as recommended in the 1990 MTE.

Another important finding from the limited number of focus group discussions concerns the attitude of health workers (especially in the hospital) towards HIV/AIDS patients. Various health workers are convinced that the care of HIV/AIDS patients is inadequate because many health workers avoid having to deal with such patients (be it in the administration of drugs, feeding, cleaning, etc.) Senior health workers are said to delegate these functions to junior workers (the chain being doctors, seniors sisters, SRNs, SCNs, Student Nurses, Nurse Aids, and General Hands) when it comes to an HIV/AIDS patient. Since these workers are expected to be well-informed on the transmission modes of HIV/AIDS, this reported perception among health workers would have serious implications for the design of anti-AIDS campaign.

I. INTRODUCTION

The Marondera District HAPA project, based in the Mashonaland East Province, was started in October 1989, although the project had been approved to begin in July 1989. As the project is run jointly by WVZ and the MOH, decisions on starting dates, selection of project district, and some of the working methods are subject to discussion between WVZ and the National AIDS Control Program (NACP). The decision by NACP to relocate the HAPA project from Mashonaland West to Mashonaland East was responsible for the delay in the project start-up date (MTR, 1990).

In the field, WVZ is expected to work with the District Health Executive (DHE) through the Provincial Health Executive in the MOH. In planning the project, the WVZ field office was particularly interested to integrate its efforts with those of the MOH to ensure that duplication of efforts was kept to a minimum. Furthermore, close collaboration with the MOH on such an important program was seen as creating the basis for project sustainability.

Overall, the project aimed to assess levels of AIDS awareness and knowledge, to assess people's attitudes and practices that might encourage the spread of AIDS, and then to design health educational strategies to promote measures aimed at controlling the spread of AIDS.

Marondera District, where this project is situated, is only 70 km from Harare. This closeness to the capital city and the spread of the district population between commercial, communal, and urban areas made the district an ideal choice for studying the way different population groups relate to the HIV/AIDS problem.

The project design and staff emphasized the concept of partnership between WVZ and the MOH. This project evaluation is to a large extent a commentary on how this partnership developed, and what kind of obstacles it encountered.

II. EVALUATION METHODOLOGY

A. Purpose

This is the second and final evaluation of this project. Its main goals are to:

1. Assess what has been achieved by this project, measured against the goals stated in the project document.
2. Identify what lessons have been learned for future project design.
3. Investigate problem areas in the way the project was run, and make some comments.
4. Contribute to the wider discussion on how best to combat the AIDS epidemic in Africa.

B. Evaluation Team

The Evaluation Team was composed of the following:

- Dr. N. Lenneiye, Consultant and Team Leader
- Dr. V. Canlas, Project Officer, IHPD/WVRD (USA)
- Ms. L. Malunga, AIDS Coordinator, Save the Children Fund (USA)
- Dr. M. Nsungu, Medical Officer of Health, Mashonaland East Province
- Ms. M. Tengende, District Nursing Officer, Marondera District

The composition of this team reflected the need to ensure that the evaluation was jointly executed between the partners, and that it was participatory so that its lessons could easily be utilized by the two implementing organizations.

The following health workers from Marondera District Health Service were selected to participate in the evaluation, to act as facilitators in focus group discussions:

Chakwizira	Savanhu
Mache	Shereni
Madzivanyika	Sirewu
Mpofu	Shoriwa
Ndengu	

Most of these health workers had participated in the KAP surveys conducted in the district during 1990.

C. Evaluation Methods

Most information for this project was obtained from groups comprised of health workers, extension staff, and the general population in Marondera District. Individual key respondents such as senior district government officers, managers of private firms, and farm managers were also important sources of information.

From discussions with health workers residing in the district, the work of traditional health practitioners was identified as important in the development of strategies to combat the spread of AIDS. These practitioners (ZINATHA members) were to be interviewed whenever encountered.

Discussions were held with focus groups selected to represent the three main population groups (urban, communal, and commercial farms). The sample was further stratified to ensure that residents from the higher income suburbs, as well as factory workers, were included (stratification schedule given in Appendix 1). A total of 62 focus groups were constituted in the districts to cover all these population groups.

A one-day seminar was held between the evaluators and health workers selected to lead focus groups. This seminar reviewed the technique of obtaining information from respondents through the use of focus group discussions. The main characteristics of the population were reviewed before deciding on the mix of focus groups within the three geographical subdivisions of the district.

Evaluators also interviewed key respondents and discussed their findings with each other. From these discussions, the main conclusions were drawn, and they were backed by the summaries prepared by evaluators (Appendix 2) after the focus group discussions.

D. Evaluation Schedule and List of Respondents

Appendix 1 contains details of focus group composition and a list of key respondents interviewed.

III. FINDINGS OF THE EVALUATION

A. Design

The project was designed to be implemented by WVZ, NACP, and the Marondera District Health Team (DHT), using funds made available by USAID under the HAPA program and WVRD. At the design stage, it was realized that the project would be carried out in one pilot district, with a view to developing approaches that could be tried in other districts. Secondly, the project had to be in a district where no other agencies, except the MOH, were involved in similar activities. It is for this reason that the project district was changed from Karoi in Mashonaland West to Marondera in Mashonaland East. (Another donor had entered Karoi during the period the WVZ HAPA project was being designed.)

In line with socioeconomic differentiation in the population, the project recognized three distinct groups whose AIDS awareness was likely to be quite different—the commercial, communal, and urban areas. On this basis, three KAP surveys were planned. Due to logistical problems, the three surveys could not be carried out simultaneously. This design led to delays because results from the first survey took a long time to become available (MTR, 1990). Due to time constraints, the second and third KAP surveys were combined into one in order to speed up implementation.

By the time the MTE was held in August 1990, the project had been running for less then ten months, but its achievements were quite remarkable (MTR, 1990). The project had been able to quickly recruit three officers to work on the project and commissioned a KAP survey in the Commercial Farming Areas soon after project launch.

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In the time it had run, the project generated some enthusiasm among some of the health workers in the district, and they were particularly keen to integrate the project into the District Health Service.

As the project was to be implemented by the MOH and WVZ, the relationship between project staff and members of the Marondera DHE was very important. During the Midterm Evaluation (MTE) in 1990, the MOH District Health Executive members in Marondera identified problems that had stood in the way of achieving harmonious partnership in the project. The main issues were given as:

1. Inadequate integration of WVZ staff into the DHT because the staff were based in Harare. It was explained that WVZ staff and DHT members had therefore realized few opportunities to undertake joint outreach activities during supervisory visits to health facilities by DHT members.
2. Inadequate exchange of information between the Provincial Health Team (PHT), District Health Team (DHT), and WVZ staff on the progress of this project (regarding funds available, spent, etc.).
3. The location of project resources such as vehicles, photocopiers, etc., in Harare while activities were taking place in a district 70 km away.

From the MTE in 1990, it was recommended that a joint WVZ and Marondera DHT planning meeting to be held to (a) review progress, (b) identify constraints, and (c) prepare a schedule of activities, with budget, for year two of the project. The purpose of the workshop was to review the MTR as a basis of re-planning the project.

Various delays were experienced in organizing this planning workshop, and it did not take place until March 1991 (five months after the MTE), by which time the project had less than six months to run. According to respondents, activities of the project were slow during the period October 1990 to March 1991, and the project can be said to effectively have run for just over fifteen months.

Although the MTR had specifically recommended the production of "a plan of action outlining what various agencies and officers will do during year two" (MTR, 1990-1991). No such plan of action was given in the workshop report (see Appendix 5). The workshop report indicates that general recommendations were made without the accompanying specific activities, targets, inputs, and outputs. This outcome is understandable given that the workshop was held too late for its outcome to be integrated into the MOH plans for 1990/91.

The design of this project had several strengths:

1. It sought national guidelines on the AIDS control program so that its activities would complement those of the MOH.

2. Leadership of the project in the district was to be shared between project staff and the DHE members.

3. Baseline KAP surveys were conducted to guide them in the definition of specific activities and targets.

4. Project activities were defined in terms of strengthening the health system to become more effective AIDS awareness activities. In comparison to the less than ten workers in WVZ, the project had the potential of mobilizing over 100 health workers in the district.

5. The intersectoral thrust of the project plans had the potential to mobilize key agencies, institutions, and individuals in the district for AIDS awareness. The successes scored with the Ministry of Education are an example of this.

The main constraints in the way the project was designed are:

1. No regular consultative mechanisms were worked out to keep the NACP and WVZ members informed of progress.

2. The WVZ-MOH counterparts at the district level were of such unequal status and training that the planning and implementation of activities was hindered. The production of health education materials was, for instance, subject to the same strategy as the MOH employs in other areas—professional input is usually limited. The WVZ staff were, therefore, handicapped from developing alternative educational materials in response to the KAP survey findings.

3. The WVZ and the DHE did not have sufficient planning skills to translate the KAP findings into program activities in the districts, and there was no mechanism built into the project to ensure that such constraints were picked up at the higher levels of the MOH/WV.

4. There were no specific monitoring activities for WVZ and MOH head office staff to visit the project district and review the implementation of activities. Both WVZ and MOH staff operating at the district level were not given sufficient supportive supervision in the field from the head offices.

5. The project had not spelled out a mechanism to allow for the use of district-level institutions, like the District Development Center (DDC), to integrate AIDS awareness into the work of various sectors.

6. There was no explicit strategy to mobilize women's groups, cooperatives, VIDCOs, and other community-level institutions for the AIDS awareness program promoted by this project. Instead, attention was primarily focused on the role of health workers within the health structure.

The use of funds made available under the project will be discussed in a separate financial report being prepared by WVZ.

B. Process

Project field staff have undertaken monitoring activities and written reports based on what they saw in the districts. The supervision of these field staff from the head office has mainly taken place in Harare, with the district indicating that they would have welcomed more visits from senior WVZ staff to discuss the progress of this project.

In the execution of KAP surveys, project staff followed up the consultants and ensured that reports were produced. There has been no independent evaluation of training activities except by the field staff, who normally report on the number of participants, subjects covered, the outcome of evaluation by participants, and various administrative matters. A few comments from senior district staff seem to suggest that training is an area where more senior MOH staff could have been used to facilitate at the lower levels.

There is no indication that posters and pamphlets have been tested in the field. The one pamphlet that was under preparation during the MTE in 1990 is not yet out. From discussions, the pamphlet has been tested on a limited scale in the commercial farming areas. Field staff are concerned that the only posters they could distribute were those approved and produced by the NACP, and most of these are old and out of date. In some instances, those MOH posters have been criticized for the message they carry; for instance, associating smoking with prostitution and AIDS in some posters.

C. Outputs

From discussions held with project staff (WVZ and the MOH), most of this project's activities were in the area of training. Health workers were given orientation seminars on HIV/AIDS, and others were trained to become counselors.

In raising awareness, the project supported the education of school children, teachers, traditional midwives, and community leaders on AIDS awareness. In schools, drama, poetry, and music with anti-AIDS messages were promoted by the project.

The project targets for year two did not change from those set at the beginning, in spite of the recommendation from the MTE (1990) that they be reviewed and adjusted. The achievements are summarized in Table 2. A detailed breakdown of targets reached and activities undertaken is available in Appendix 4.

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Table 2. Targets Set and Attained in Marondera District HAPA Project

Distribution of Materials	Year 1	Year 2
Materials:	*Qty*	*Qty*
T/Shirts	248	248
Booklets:		
AIDS: Your Questions Answered Distributed	59	143
Let's Learn About AIDS: A Booklet for Community Workers	66	67
AIDS: Let's Fight It Together	120	150
ACTION: Finding Out the Facts on AIDS	59	7
Leaflets:		
How to Use a Condom	59	100
AIDS Nomutenderi	135	1,316
Facts About AIDS	73	120
Chokwadi Chiripo Nezve AIDS	160	250
Information on AIDS	86	317
Zvatingade Kuziva Nezve AIDS	47	
Posters:		
Jack and Jill	63	63
Condoms Distributed	12,300+	174,962
Stickers Distributed	1,000	1,000

Posters, stickers, T-shirts, booklets, pamphlets, and leaflets have all been distributed by project staff during the second year of this project. Fewer training workshops were held in 1991 than in 1990, but teachers, farm health workers, health workers, women's groups, and community leaders were trained at various workshops (Appendix 4).

The project had also used its resources to support the work of some health workers in the supervision of health facilities—especially rural health centers. The project field staff had been particularly active in providing field-level orientation for the most recently appointed District Nursing Officer (DNO) for Marondera District, and good working relationships had been established.

D. Outcomes

In the short-term, the project aimed at (a) bringing knowledge to the target population, and (b) influencing the population's behavior with respect to those practices that expose individuals to the risks of AIDS.

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From the focus group discussions, nearly one-third of the respondents in the commercial farms had heard about the WVZ HAPA project in Marondera. In the same sample, nearly half knew that AIDS is a disease, an improvement from the 25 percent recorded in the 1990 baseline KAP survey.

In the communal and high density areas, there seems to be little change since the KAP survey was conducted in late 1990.

Although the sampling methods are different between this study and the KAP survey in 1990, it would appear that the project has been particularly active in the commercial farming areas, and people are getting the message that AIDS is a disease.

The most disturbing feature to emerge from this study is the perception among all focus group members that men and women having multiple sex partners is seen to be a major problem (Appendix 2) in spite of the knowledge that AIDS is a disease with no cure. A variety of reasons have been cited for this increase, mainly economic considerations.

Another feature is the perception that health workers, especially in the hospital, avoid having to deal with HIV/AIDS patients whenever possible. Doctors delegate to sisters, who in turn delegate to SRNs, who in turn delegate to the SCNs. The SCNs then delegate to Student Nurses, Nurse Aids, and General Hands. This fear of AIDS patients is said to such areas as cleaning, feeding, administration of drugs, and taking blood samples. Although this is a perception expressed by health workers during focus group discussions, it is a matter for concern because health workers are at the forefront of promoting an informed campaign to combat the spread of AIDS. Negative values among health workers need to be tackled as a matter of priority before taking the program to the general population.

The implementation of HAPA has influenced the perception of staff in the WVZ field office on the seriousness of AIDS in Zimbabwe. It has established strong links between HAPA field staff and rural health center staff in the MOH as most of the work has taken place at that level. Strategies for reaching communities with AIDS information and counseling services have also been initiated by the HAPA field staff in the district.

At the national level, the project has not been able to develop skills in supportive supervision for field project staff. Opportunities offered by this project to strengthen planning and management capacity of WVZ staff have not been fully taken advantage of. There has, nevertheless, been a growing awareness at WVZ head office that a project such as the Marondera HAPA requires much more intensive follow-up and discussions with MOH staff at the head office and provincial levels. The experience of managing this project has influenced the design of projects currently being identified for joint implementation with MOH districts in other provinces.

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WVZ staff involved in the implementation of the Marondera HAPA project have participated in the evaluation of the HAPA project being implemented by Save the Children Fund-USA in the Manicaland Province. This is part of the HAPA "Exchange Program" with similar projects in the country.

E. Sustainability

In the original project document, it was planned that the project's sustainability would be assured by integrating its activities into the work of the District Health Team. There is an indication that this goal has been partially met as most health workers are distributing condoms from health facilities as part of the Sexually Transmitted Disease (STD) control program and are, therefore, unlikely to stop once HAPA funding is over.

Any specific activities undertaken by WVZ staff in the districts will most likely stop because the MOH cannot employ staff to replace the WVZ personnel. The Economic Structural Adjustment Program in Zimbabwe has put severe constraints on the ability of the different ministries to hire extra staff.

The unavailability of funds to support training workshops will be another activity likely to slow down once HAPA grants come to an end. Since little has been produced by way of materials outside the MOH program run by the NACP, the termination of HAPA grants will most likely not be felt in this area.

F. Staffing and Technical Assistance

For the job descriptions contained in the project document, the staff engaged in the project were adequate. The project could have benefited by engaging some short-term planning expertise to support the joint work of the DHE and WVZ staff. Such assistance could have addressed the issues of linking the project with district-level activities as planned by the DHE and identify ways of achieving more integration. It is in the articulation of what "partnership" in the context of this project meant that the project had great difficulties.

Some technical assistance was available from Johns Hopkins University. The first consultant who had visited the WVZ HAPA team was knowledgeable and contributed to the work of HAPA staff in Zimbabwe. The second consultant who visited was on more of a learning mission than providing technical assistance.

The few visits from the WVRD head office have been more useful from an administrative point than from a technical point as far as the HAPA project is concerned.

The project tried to engage local expertise in the form of consultants wherever possible. The KAP surveys, the MTE, the facilitation at the planning workshop, etc., were all executed with assistance from local consultants. During the KAP

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surveys, the MTE, and planning workshop, there was some orientation provided by the local consultants engaged to execute these activities, and some WVZ staff benefited by attending the sessions. This was not a systematic training activity for the field staff, but rather ad hoc, depending on what activity was being implemented.

The HAPA project staff favor the use of local consultants for the following reasons:

1. They are less expensive than international consultants.
2. The produce good quality work because they know the local conditions.
3. They are available when you need them.

The main problems with local consultants is one of meeting deadlines. The project staff are concerned that the local consultants:

1. Take on too many projects and, therefore, have difficulties meeting the deadlines set for the project.
2. Realistic time frames are often not set when these consultants are hired, and this results in delays.

WVZ staff plan to continue using local consultants, but the field office will tighten the setting of deadlines for when work has to be handed in by these local consultants. The main areas identified for future use of technical assistance are:

1. Improving planning of projects so that there is more integration with MOH activities and planning system.
2. Development of training and educational materials so that these are relevant to the local conditions.
3. Development of counseling strategies and materials based on the social conditions prevailing in Zimbabwe.

Although the MOH staff in the Marondera district have indicated their desire to see more local consultants hired to support such activities as training in planning, counseling, audio-visual materials production, etc., there is no indication that any such assistance was ever requested from the HAPA project staff.

IV. LESSONS LEARNED AND RECOMMENDATIONS

The main lessons learned from this project are related to the meaning of partnership when projects are designed for implementation with a government agency. The failure to link a project with government management system (over transport, subsistence and travel, materials production, etc.) can slow down the implementation phase and frustrate the PVO staff. On the other hand, the ability to utilize government and

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community structures can be an effective way of making a few resources go far by way of activity implementation.

In a future project such as this, there should be a protocol of agreement between the PVO and the Government Ministry outlining what the commitments are, financial disbursement procedures, use of equipment and staff available under the project, monitoring and supervising responsibilities, etc.

The WVZ staff dealing with a HAPA project have advocated the joint project design of such a project so that the MOH staff are involved in developing the project, defining the activities, and allocating tasks to various staff involved in the project.

Inadequate planning capacity in both the MOH and WVZ has hindered the utilization of KAP survey results in the production of new strategies to promote AIDS awareness among the various groups studied by each of the KAP surveys.

This project has been particularly difficult to execute because it primarily tackles the changing of attitudes. As the NACP in the MOH is poorly integrated into other activities, the role of various MOH staff in the provinces, districts, and head office departments are not defined. The HAPA project in Marondera has suffered partly from inadequate planning and monitoring as a result of these difficulties.

As this project has been going on for less than 18 months (due to delays in commencement and in the replanning recommended after MTE of 1990), it is recommended that it be continued for another period of one to two years (as long as the protocol spelling out the various MOH-WVZ roles is developed and signed). The project time frame has been too short for conclusions to be drawn on the changes it might have brought in the way people practice sex. Although these changes are normally expected to take place over a longer period of time, there are important initiatives a project like this could have started. Nevertheless, the project has made a good start for WVZ and the MOH to build on.

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WORLD VISION RELIEF & DEVELOPMENT, INC.

PART II
SUMMARIES AND FINDINGS OF FOCUS GROUP DISCUSSIONS AND INTERVIEWS WITH KEY RESPONDENTS HELD DURING THE FINAL EVALUATIONS OF THE MARONDERA HIV/AIDS PREVENTION PROGRAM

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4. FY91 Work Plan

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GUIDELINES ON FOCUS GROUP DISCUSSIONS FOR THE MARONDERA HIV/AIDS PROJECT EVALUATION

A. INTRODUCTION

1. Introduction of facilitators and by Focus Group members themselves.

2. Introduce Subject: This is a review of activities undertaken in the district during the implementation of an anti-AIDS program by the Ministry of Health and the World Vision.

B. QUESTIONS/ISSUES FOR GROUP DISCUSSIONS

1. What has been done in the district under this program? How have the Focus Group members participated?

2. What do Focus Group members know about AIDS and HIV? What do these terms mean?

3. How serious is the AIDS problem—in Marondera, and in Zimbabwe?

4. What are the sexual practices in the area where the respondents live and in the district?

5. What is their attitude towards AIDS patients? multiple sexual partners?

6. What should be done about AIDS in the future?

C. DISTRIBUTION OF FOCUS GROUPS

Focus groups will be made up of 8-12 members; a few will be mixed, but most will be one of four groups (married men, unmarried men, married women, and unmarried women).

D. COVERAGE OF GROUPS DURING THE WEEK (key respondents to be covered on the same day as the focus groups are done).

1. MONDAY: 4 x Hospital Staff; 4 x Hospital Patients; 2 x Factories; PLUS 2 managers and 2 doctors as Key Respondents.

2. TUESDAY: 12 x High Density PLUS 6-10 District-level Government Staff as Key Respondents.

3. WEDNESDAY 4 x Growth Points; 8 x Villagers; PLUS some ZINATHA Members as Key Respondents.

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4. THURSDAY: 8 x Communal Areas Special Groups; 4 x Clinics; PLUS some ZINATHA Members as Key Respondents.

5. FRIDAY/SAT: 16 x Commercial Farms; PLUS 4-16 Farmers + wives as Key Respondents.

Site	Focus Groups	Composition	No.	Key Respondents
Hospital	Gen. Hands + NA	Mixed	1	Doctors
	Student Nurses	Mixed	1	
	Paramedicals	Mixed	1	
	Trained nurses	Mixed	1	
	Patients	One of each group	4	
Commercial farms	Farm workers	Four of each group	16	Farmers and their wives
High Density (3)	Residents	Three of each group	12	One per high density area
Factories	Workers (CSC/ Eagle Tan)	Mixed	2	Managers
Communal areas	Extension workers	Mixed (2 CAs)	2	
	Community leaders	Mixed (2 CAs)	2	
	TMs and VCWs	Mixed (2 CAs)	2	
	Women's groups	Mixed (2 CAs)	2	
	Growth points	One of each group	4	
	Villagers	Two of each group	8	
Clinics	Patients	One of each group	4	
Whole district	**TOTALS**		**62**	

Four Groups = Married men, unmarried men, married women, and unmarried women

1. Sites:

Criteria

a. Sex
b. Marital Status (married or unmarried)
c. Exclude children (under 14 years)

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Size of Focus Groups

a. Average size—10
b. Maximum—12
c. Minimum—8

2. Sites:

a. Commercial farms
b. High density suburbs
   1) Beer hall for men
   2) Market ("musika") for women
   3) Shopping center (unmarried women)
c. Factories/business—Managers (key respondents)
d. Communal areas
   1) Clinic site (extension workers)
   2) Community leaders (councilors, church leaders)
   3) General population
      a) Growth point
      b) Villages
      c) Patients
e. Hospital
   1) General hands and nurse AIDS
   2) Student nurses
   3) Paramedics
   4) Nurses (trained)
   5) Doctors (key respondents)
f. Farms
   1) Focus groups (farm workers)
   2) Farmer or wife (key respondents)
g. Zinatha members (key respondents)
h. Traditional Midwives plus Village Community Workers (FG)
i. Women's groups/clubs (FG)

3. Focus Groups:

Type	Number
a. Hospital	
1) GH & NA	1 mixed
2) Student Nurse	1 mixed
3) Paramedics	1 mixed
4) Trained nurses	1 mixed
b. Commercial farms	
1) Married/Unmarried	4
2) Married/Unmarried	4
3) Unmarried/Married	4
4) Unmarried/Married	4

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c.	High Density		
	1) Married	3	
	2) Married	3	
	3) Unmarried	3	
	4) Unmarried	3	
d.	Factory Workers	12 mixed	
e.	Communal Areas		
	1) Extension workers	2	
	2) Community leader	2	
	3) Traditional Midwives and VCWs	2	
	4) Women's groups	2	
f.	General population communal areas		
	Growth points		
	1) Married men	1	
	2) Married women	1	
	3) Unmarried men	1	
	4) Unmarried women	1	
	Villages		
	1) Married men	2	
	2) Married women	2	
	3) Unmarried men	2	
	4) Unmarried women	2	
	Patients	Hospital	Clinic
	1) Married men	1	1
	2) Married women	1	1
	3) Unmarried men	1	1
	4) Unmarried women	1	1

Four groups at hospital
Four groups at four clinics

4. Key Respondents:

Cadres		**No**
a.	Farmer plus/or wife	4-16
b.	Zinatha members (traditional healers)	4-16
c.	Managers	2
d.	Doctors	2
e.	Senior government workers	6-10
Total Key Respondents		**18-36**

5. Focus Groups Summary:

a.	Hospital Staff	MONDAY (4)
b.	Commercial farms	FRIDAY & SATURDAY (16)
c.	High density	MONDAY & TUESDAY (12)
d.	Factories	MONDAY (2)

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e. Communal Areas		WEDNESDAY & TUESDAY (20)
f. Patients		THURSDAY & MONDAY (8)
Total Focus Groups	=	62

6. Process:

   a. Individual introduction of each focus group member.
   b. Introduction of the subject.

7. Focus Groups ScheduleL

MONDAY

Eagle Tanning	Hospital
Cold Storage Commission	Factory
Dombo/Nyameni	High Density (Marondera)

TUESDAY
Macheke—Clinic and High Density
Dombotombo/Nyameni
Growth Point—Mahusekwa

WEDNESDAY & THURSDAY
Communal Areas
Svosve Ward & Masikana Clinic
Chiota West Ward and Chiota Hospital
Chimbwanda Rural Health Center

FRIDAY AND SATURDAY
Commercial Farms
Other farms to be identified by rural councils.

8. Individuals Responsible for Passing Information Before the Actual Survey:

MONDAY
a. Hospital—Sister Savanhu

MONDAY/TUESDAY
b. High density/DT/Nyameni—Sister Madzivanyika

FRIDAY/SATURDAY
c. Commercial farms—District Nursing Officer (she will also inform Rural Council)

MONDAY/TUESDAY
d. Macheke High Density—District Nursing Officer (inform Rural Council)

MONDAY

e.	Factories (Cold Storage Commission + Eagle Tanning)	
	DNO	Sister Savenhu
f.	Communal lands (2 wards)	Zoshe
	DNO	Chihota

E. SUMMARIES FROM FOCUS GROUP DISCUSSIONS

Below are summaries from the focus groups. Each of the evaluators was assigned the task of summarizing results from the four main sample groups:

1. Commercial farming areas (by Dr. Canlas).

2. Communal areas (by Ms. Tengwende).

3. Special groups (like hospital workers, extension staff, etc.) by Dr. Nsungu.

4. High density suburbs (by Ms. Malunga).

The team leader was responsible for coordinating, editing, and drafting the final evaluation report.

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1. **Summary from Commercial Farms**, Compiled by Dr. V. Canlas

Main Findings

A total of 16 focus groups of both men and women (married and unmarried) were held in two commercial farming areas namely, Marondera and Macheke. Several farmers and farm mangers were also interviewed by the survey team using the in-depth interview guide. All focus group discussions were conducted in Shona, the primary language of the majority of participants.

There was an average of 15-18 participants in each focus group held in the commercial arms. Each group session went well in both farming areas. The moderator started each session with introduction of all the members of the group and then reminded the participants why they have been invited to the group. Throughout the discussion, the moderator used the guide and made sure that all times issues relevant to AIDS were discussed.

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When the groups were asked what they knew about the AIDS Program initiated by the Ministry of Health and World Vision Zimbabwe, only about 20 percent said they had heard and were aware that there was such a project in Marondera. Majority of those who had heard about the program were men. Of the focus group participants, only 30-40 percent said AIDS was a disease. Males were more likely to give a specific definition of AIDS and HIV than females. Fifty percent of both male and female participants, married and unmarried said that there is a strong association between prostitution and transmission of AIDS. Men and women were equally likely to mention prostitutes and promiscuity among married women as "high risk."

The majority of respondents (95 percent) expressed themselves as very much against having multiple sexual partners. However half of the total participants in all focus groups still believe that the majority of the populations in Marondera District today have not shown any change in their sexual practices. Peoples' morals have gone down and promiscuity is seen among all age groups and is on the rise primarily due to poverty or for socio-economic reasons wherein young women sell sex for money. Both male and female participants mentioned that it's a common practice among young women to have sexual relation with older men for financial reasons, and older women to sleep with young men for sexual experience and satisfaction. It was also stated by the participants that only a few people, about 30 percent, had made changes in their sexual behavior because of what they had heard about AIDS. Half of the male, married and unmarried, have never used condoms because they did not like them, and the same ratio of women stated that non-usage of condoms for protection against AIDS/HIV infection was due to the fact that their partners did not like condoms.

The participants' attitude towards the care for AIDS patients remain to be problematic, based on observations from the groups. Nearly 30 to 35 percent of the participants showed a negative attitude towards people with AIDS while 65-70 percent felt that assistance should be offered to AIDS patients, and that adequate support and treatment should be provided to them and their families. A few even expressed the desirability of isolating AIDS patients, burning and killing them. There is thus a need for a more extensive AIDS education and information program in respect to mode of transmission and its other implications.

All participants in the 16 focus groups covered in the farms indicated that there should be more utilization of a wide variety of media such as radio, audio-visual/video tape showing on AIDS to disseminate more information on AIDS. Others felt that health education on AIDS should be enforced by health workers who should conduct AIDS education campaigns in all target areas. The majority mentioned that extensive AIDS awareness activities should often be initiated in all areas; urban, rural, and commercial farms. Unmarried men stated that condoms must be distributed and should be made available at "strategic" points so that there's no need to go and see a female health worker to request condoms. All agreed that men and women should be encouraged to be faithful

to their partners. Some expressed the fact that they would want to see more health workers in their areas and educate the public on AIDS and HIV infection.

Comments and Observations

a. All focus groups had more than 12 participants in the commercial arming areas. It was difficult for the moderator to eliminate those who had come to listen.

b. Very few focus groups were not active. Participants remained silent and were typically shy to respond on the topics of AIDS, which forced the moderator to use some probing techniques to encourage the participants to start off the discussion and encourage more than one person to respond on a given topic. This technique was used by some moderators to dig deeper into the subject by getting the participants to clarify and elaborate what had been said during the discussion.

c. A few farmers were cooperative, the majority were more interested in getting their laborers back to work immediately. As one farmer stated "there will be low production in my farm today due to this long session on AIDS." Others were upset about holding this focus group discussions with the farm workers for more than an hour.

d. Two or three farmers were not interested in AIDS issues. One of them expressed the view that he was not even aware that AIDS is a serious problem in the country. He did not allow his farm laborers to meet with the survey team and discuss the project.

e. Majority of the focus groups showed a great interest in the discussions about AIDS. Participants communicated among themselves and interacted frequently during the discussion, which made the whole group feel more comfortable and at ease. In two focus groups of unmarried women, the session became very helpful in bringing up embarrassing and delicate issues on their attitudes towards condoms. The group dynamics brought these issues on condoms out even if the groups were composed of unmarried women. A number of questions were raised on this topic which fortunately made the discussion an enjoyable one. This gave the moderator, who is also a state registered nurse, the opportunity to demonstrate the proper use of condoms. Samples of condoms were shown toward the end of the focus group discussions.

f. Overall observation from most of the focus group discussions was that farm workers (men and women) still have a very limited information and education on AIDS and HIV infection. They have vague ideas about AIDS and its impact in Zimbabwe.

Constraints

a. Time allocated for group discussion was limited in some farms because of the demand for high production by the farmers from his laborers.

b. Names and locations of some farms were not accurately provided by the officials of the Rural Councils which caused some delay in arriving at the farming areas on time.

2. **Summary from Communal Areas,** Compiled by Ms. Tengwende

a. 1) Very few people have heard about the Anti-AIDS program in the Marondera District.
   2) Focus group members have not participated at all.

b. Although most focus groups' members know that AIDS means Acquired Immune Deficiency Syndrome, they do not know exactly what the term means.

   HIV in all cases has been associated with STD.

   Most of the people know the symptoms of AIDS, but not how it is spread as some seem to think shaking hands and using the same toilet seat will result in infection.

c. All focus group members have a fair idea on how serious AIDS is in Marondera nd Zimbabwe.

d. Everyone still has the same belief that it is alright for men to have multiple partners. Prostitution is on the increase, boys and girls are engaging in sexual relationship at times with older people, married women have become promiscuous mainly due to husbands being away at work in town.

e. All members are afraid of AIDS patients. They think these people should be isolated. A few want them burnt. Some women feel compassionate towards AIDS patients, maybe because they have children who are always looking after them.

f. 1) Most people are against multiple sexual partners. A few who have two wives or more feel a husband should be faithful to their wives and vice-versa.
   2) People want more videos as there are more effective and should reach every corner of Marondera District.
   3) More condoms should be distributed, and there should be more posters and programs on TVs.

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As most of them seem to think that only prostitutes have spread AIDS, they want all prostitutes rounded up by police, and if not, they should have regular AIDS tests which must be compulsory.

Conclusion

There is general understanding of the deadly disease AIDS. Knowledge is limited and facts about AIDS distorted in most cases. The seriousness of the AIDS/HIV is felt by almost everybody, but it's difficult to assess any change of behavior.

Dissemination of correct information on the AIDS/HIV is paramount throughout the District.

a. More radio AIDS program could help where people cannot be reached.

b. General impression of all groups about prostitution among married women is very worrying.

c. The HAPA Program has indeed helped—although people did not actually hear about it throughout the District.

d. Could help if the program could be extended for another two years—considering the adverse results from the Structural Economic Adjustment Program. It is clear that a lot of work was carried out on AIDS by the Ministry of Health and World Vision. Other ministries have also tried to disseminate information on AIDS/HIV, but more work is needed.

Unmarried Women

a. Only one person out of the three groups had heard about the Program. The rest of the focus group members had never heard of such a program.

b. 1) Seven only heard from radios and neighbors that it can be transmitted sexually, through blood transfusion. It has no CURE. Others thought by using the same water with an infected person, shaking hands, etc., you could get AIDS.
   2) Did not understand what HIV is, thought it some kind of STD which has always been there.
   3) Could not explain what AIDS is.

c. Did not understand the seriousness of the problem.
   1) Others think it is not that bad in Zimbabwe and Marondera.

d. Men generally tend to go around with different women, felt that unmarried people were more promiscuous than the married ones.

e. 1) Generally fear of AIDS patients; felt they should be isolated.
   2) All members were against multiple sexual partners.

f. More education on the subject of AIDS.
   1) Use of condoms by those willing to indulge in casual sex.
   2) Couples should stick to each other.

Married Women

a. Only a few members had heard about the program.

b. Generally what they had heard from others
   1) No cure
   2) Sharing razor blades
   3) Symptoms like diarrhea, headache, etc.

   People would not tell what HIV or AIDS meant. Some had never heard about HIV.
   1) Thought AIDS was an STD only, one woman had never heard about AIDS.

c. Most people understood that AIDS was a problem in Marondera and Zimbabwe.

d. Prostitution on the increase
   1) People still not sticking to one partner
   2) People do not believe in using condoms

   Housewives who in the past seemed to be faithful are now practicing prostitution.

e. 1) General fear of people with AIDS
   2) Suggested that they should be isolated
   3) Married women felt sympathetic though, maybe because themselves have kids.

   Everybody was against multiple partners.

f. Everybody suggested video should be used
   1) School children must be educated
   2) More condoms should be distributed

Unmarried Men

a. Only 13 people in the four groups interviewed have heard about the Anti-AIDS program—(World Vision).
   1) Most of the focus group members had seen drama in schools or heard about AIDS on radio, and in newspapers.

b. Generally what they heard from others.
   1) Transmitted through kissing, mosquitoes, or if one stays in the same house with someone with AIDS.
   2) Under the impression that there is now a cure (Kemron, AZT, etc.) understood the symptoms quite well.
      - Loss of weight
      — Vomiting
      — Loss of hair, etc.

   Most focus group members knew that AIDS means Acquired Immune Deficiency Syndrome but could not expand further. Almost all of them did not know what HIV meant although they believe that it is related to AIDS.

c. Everybody knew that the AIDS problem is very serious in Marondera and also in Zimbabwe.

d. Prostitution is on the increase.
   1) Older men going out with younger girls (traditionally acceptable).
   2) Lately older women were now going for young boys (prostitution).

e. 1) General fear of people with AIDS:
      — These people should be isolated.
      — Others even felt that these people should be burnt alive.
   2) Most people were against people having multiple sexual partners but understood this would be difficult as men cannot control themselves and it is a norm among Africans.

f. More posters (the only ones available are at Marondera Hospital).
   1) Videos
   2) Drama
   3) Others felt that the police should round up all prostitutes.
   4) Others wanted to see a living person with AIDS.

Married Men:

a. Only one person has heard about the program. The rest had seen drama in schools.

b. 1) Very little known about AIDS confused it with Runyoka.
   2) Did not know what the terms HIV and AIDS stood for.

c. Did not really understand the seriousness of the AIDS problem in Marondera or Zimbabwe.

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d. Prostitution is generally on the increase.
   1) In some cases, working men leave their wives in the villages when they go away. As a result, there unfaithfulness.
   2) Older men looking for younger girls.

e. Generally fear:
   1) That they should be isolated.
   2) They are to stay in hospital.
   3) They should have their own.
   4) Others seem to believe that if polygamy is encouraged, prostitution will eventually go (so no AIDS)

f. Use of condoms.
   1) More programs on radio, in newspapers, etc.
   2) Teachers must also be involved.

3. **Summary from Special Groups**, Compiled by Dr. M. Nsungu

a. Students Nurses (Marondera Hospital
b. Paramedics Marondera Hospital
c. Traditional Midwives and VCW
d. Extension Workers
e. Community Leaders
f. Women Fertilizer Group
g. Church Women Group
h. General Hands and Nurse Aides (Marondera)
i. Personnel Managers
j. Factory Workers
k. Farm Managers
l. ZINATHA Members

Question 1: What has been done?

Except the group of Paramedics, all the groups said that they are aware of the activities of Ministry of Health and World Vision against AIDS. These activities mainly are:

a. Health Education on the Prevention of AIDS
b. Drama
c. AIDS Competitions
d. Posters

Concerning the involvement of different groups:

a. Student Nurses attended meetings on Health Education and Placards.
b. VCW attend seminars

c. Community leaders were involved in workshops and teaching on AIDS prevention
d. Some Women Fertilizer attended workshops
e. Nurse aids are involved in Health Education.
f. Personnel Managers and farmers organize Health Education on AIDS in their farms and companies through drama and booklets.
g. ZINATHA members attended workshops on AIDS, ask their clients to bring their own razor blades and teach young adults on AIDS. Some of them were given condoms to distribute.

Question 2: Knowledge

a. The significance of both AIDS and HIV is well known among:
   1) Student Nurses
   2) Paramedics
   3) Community Leaders
   4) General Hands and Managers/Farmers
   5) Personnel and farm Managers/Farmers
   6) VCW and traditional Midwives

b. The difference between HIV and AIDS is really known among:
   1) Student Nurses
   2) Paramedics
   3) Personnel Managers
   4) A bit amongst farmers

Among the ZINATHA members, the following ideas prevail:

a. AIDS and HIV were brought in from the West by an unfaithful wife who had been given herbs by a person who started the illness.

b. AIDS is RUNYOKA and therefore can be treated by those who know how to treat RUNYOKA. If not treated early, it is transmitted to other people.

c. AIDS came because we broke away from our traditional way of living.
   1) On transmission, almost all the groups know that the disease is transmitted by sex intercourse, needle, blood, razors and from infected mother to a child. However, since VCW and TM and some extension workers think that it is also transmitted through mosquitoes. Some members of the women fertilizer group think that it is also transmitted through sharing dresses with an infected person. some factory workers think that it can also be transmitted through sharing towels with infected person.
   2) Except some ZINATHA members, almost all the group know that AIDS has no cure.

Question 3. How serious is the problem in the area?

The common ideas are that the problem is very serious and increasing. The reasons given for the seriousness being:

a. Many people die of AIDS
b. Because of AIDS, TB (tuberculosis) is increasing
c. 50 percent of people are HIV positive
d. MASHONALAND EATS has got the highest figure
e. The incubation period is long
f. Traditional healers are mixing it with RUNYOKA hence the difficulty to explain how it is spread
8. It spreads quite fast in MARONDERA because of tourist in towns, and there are too many prostitutes

To some ZINATHA members, the seriousness of the condition is explained by the fact that people give medicine to their young wives to remain faithful (see RUNYOKA).

However, some VCW and TM think that it is difficult to state on the seriousness of the disease since they don't see people with AIDS.

A farmer said that, on his farm workers think that AIDS is a problem of elsewhere since they have not seen anyone having it on the farm.

Question 4. Sexual practices

Except one Personnel Manager who said that there is a change in the educated people, and a farmer who thinks there is a change (condoms are being used, and decreasing number of girlfriends), all the groups agree that people are not changing their sexual practices. the situation is even becoming worst:

a. Prostitution is on increase due to the economic situation.
b. School girls are going with older people for money.
c. School boys are discovering sex very early.
d. Married men are continuing to have extra marital sexual relations and married women are going out with young boys.
e. AIDS victims are having a lot of sexual relations in order to spread more the disease.
f. People don't like condoms:
    1) Because it is like eating a sweet wrapper in its paper.
    2) Condoms are itchy.
    3) Condoms are too small.

Question 5. Attitude

a. <u>Attitude Towards AIDS Patients</u>

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The following groups were unanimous.

1) **Student Nurses:** Generally AIDS patients are neglected by Senior Staff and being left to students.
2) **Paramedics:** They use gloves while handling blood and open wounds.
3) **Women Group Churches:** AIDS patient should be isolated in a fence.
4) **General hands and Nurse Aides:** AIDS patient should be regarded like any other patients, but they need psychological support.
5) **Personnel Managers:** AIDS patients should be considered as any other patient, but in practice it is difficult.
6) **Factory Workers:**
   a) People are afraid of AIDS patients.
   b) Workers with AIDS should be given special duties.
7) **ZINATHA members:** AIDS patients should be looked after by their relatives.

For the other groups, opinions were divided:

1) **TM and VCW:**
   a) We must look after victims but we must take precautions in order not to be infected.
   b) If a woman is HIV positive, she should not be allowed to have children.

2) **Extension Workers:**
   a) AIDS patients should be isolated.
   b) AIDS patients should not be isolated, but the public should be educated on how to handle them.

3) **Community leaders:**
   a) AIDS patients should be considered as any other patient.
   b) AIDS patients should be isolated in hospitals.

4) **Women Fertilizer Group:**
   a) People are afraid to look after AIDS patients.
   b) AIDS patients should be isolated.

5) **Farm Managers/Farmers:**
   a) AIDS patients should be isolated they should be gathered in a center where they can be useful.
   b) They should not be isolated, but looked after by relatives according to traditions.

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b. Attitude Towards Multiple Partners

Except one person from the group of general hands and Nurse Aids who thought that having multiple partners is not a problem since it is from traditions and therefore very difficult to change, all the groups agreed that having multiple partners is a bad behavior.

However, some groups said that it is not very easy to change for following reasons:

1) Culturally the fact that a man has several partners is acceptable.
2) It is natural for a man to have several partners (You cannot eat meat very day).
3) Men are working a far way from their wives.
4) Girls are often obliged to have many partners for financial reasons.

Question 6. What should be done in future?

Common ideas were:

a. Since seeing is believing, emphasis should be put on films and videos with local actors and showing real cases of AIDS.
b. The economic problem to be looked into in order to decrease prostitution. Prostitutes should be given jobs.
c. Health education to be more vigorous. It should be done also in schools, churches, bars, towards teachers and traditional healers.
d. Research should be intensified not only on drugs and vaccine against AIDS, but also on drugs able to cure sexual desire.
e. Hospitals to be provided with enough material to attend AIDS patients.
f. Patients to be isolated.
g. Paramedics to be involved in workshop about AIDS or to be given feed back from Nurses and Doctors who attend those workshops.
h. Community to be involved more in AIDS activities.
i. People to be put in jail if they ignore the AIDS issue.
j. Centers for AIDS patients to be built by government.
k. Government should not deploy married civil servants to different areas.
l. ZINATHA members to use one razor blade per client.
m. Government should legislate one-man/one-woman relationship.
n. Nurses and community leaders should be educated to accept AIDS patients.
o. Prospective couples should be tested for HIV.
p. Prostitutes should be screened and isolated or locked up.
q. The use of condoms should be encouraged and condom should be distributed at public places.
r. Doctors should work together with traditional healers.

Besides these common ideas, there were some isolated opinions:

a. The available money should be used to acquire drugs rather than continuing propaganda which does not work.
b. There is nothing to do for two reasons:
   1) The event of AIDS was promised in the Bible.
   2) People will never understand.
c. Emphasis should not be put on the use of condoms since it is not a 100 percent protective measure.

4. **Summary from High Density Suburbs,** Compiled by Ms. Malunga

Married women

What has been done and how you have participated?

a. Had heard about the program but did not participate
b. One had participated by organizing drama competitions.

Knowledge on AIDS

a. Don't know meaning of HIV/AIDS.
b. Shona translation for AIDS was Shuramatongo.
c. Transmission is by mother to child, incubation period is long before onset of illness, AIDS does not kill but weakens the immune system, which then allows other infections to enter the body.
d. Signs: persistent cough, malaria for long time, headaches, diarrhea, nigh sweats, loss of weight.
e. No health worker had talked to them about AIDS--information got on radio.
f. It is sexually transmitted or by use of contaminated razors.
g. HIV infection in the abdomen.
h. One can live up to 40 years after a diagnosis of HIV has been made.
i AIDS kills and is incurable.
j AIDS defined as a combination of gonorrhea and syphilis.
k. Disease caused by people having sex when a woman is menstruating.
l. Whites who have sex with dogs then sleep with women.
m. Caused by people how have a lot of sex without washing.
n. AIDS and Runyoka are the same.
o. AIDS brought to Zimbabwe by wind.
p. AIDS can be spread by sharing cups, razor blades.

How serious is the AIDS problem in Marondera?

a. It is a serious problem as it is killing people.
b. AIDS cases are highest in Marondera

c. Identification of AIDS victims is by their hair which looks as if it is permed, diarrhea, lumps under armpits, illnesses that do not respond to treatment.
d. Most babies are born with HIV and soon die, so the country is going to have old people only and a gap in the young generation.
e. They said lice and mosquitos transmit the infection.
f. Husbands do not think it is there, they think it is not true that there is AIDS.
g. Wives and children will be left without anyone looking after them as the husbands would have died.
h. Condoms are unacceptable to married couples as you cannot eat a sweet in its paper.
i. Condoms are being thrown all over Marondera and kids are just picking them up.
j. Disapproval of the introduction of condoms to school children as it encourages them to have early sex.

Sexual Practices

a. Married women are indulging themselves in extra-marital affairs because they want to make ends meet.
b. Young girls are becoming prostitutes to make ends meet.
c. Sexual promiscuity is on the increase.

Attitude Towards an AIDS Victim

a. AIDS victims should be isolated.
b. AIDS victims must be comforted and looked after and treated like any other.
c. Single women should be employed in the farms far from married people.
d. Multiple sexual partners to be discouraged by government.
e. If one has been diagnosed it is important to tell spouses to keep away.
f. Health people should not share cups, plates with an AIDS victim.
g. You can share things like cups with an AIDS patient because it is not transmitted through that way.

Future Plans

a. Men can never be faithful.
b. Prostitutes be encouraged to use condoms.
c. Cure for AIDS be found.
d. Condoms are also bringing problems by poor disposal—children picking them up.
e. Increase Health Education in schools and community at large.
f. Test all people for HIV.

g. Isolate AIDS victims.
h. Isolate single women from married women.
i. Medication the answer to the problem.

Unmarried Women

What Has Been Done in the District Under this Program

a. They had heard about the program, some participated in the drama competitions.
b. Some were given Health Education talk at the clinic, but did not know about the WV/MOH program.

Knowledge on AIDS

a. Do not know what HIV stands for but knew what AIDS stands for.
b. Transmitted through razor blades if you share, contaminated blood transfusion, sexual intercourse, repeated STD mother to child.
c. If you are HIV positive, you do not respond to treatment.
d. Shona word for AIDS is Shura-matongo.
e. Not curable.
f. Not spread by shaking hands, sharing towels, sharing drinking cups.
g. AIDS is not a new disease, people have been dying from it long ago.
h. Signs and symptoms—cough, loss of weight, madness.
i. Obtained from animals (AIDS)
j. Transmitted by having sex with many partners.
k. AIDS is "Runyoka."
l. AIDS is not the same as "Runyoka."

AIDS Problem in Marondera and Zimbabwe

a. AIDS is a problem in Zimbabwe and Marondera.
b. Prostitution is high in Marondera.
c. Men are to be blamed for the spread of HIV.
d. Some use condoms.
e. Numbers of HIV positive are increasing.
f. Under-five children are dying.

Sexual Practices in the District

a. Lots of prostitution.
b. Young girls are even being treated for STD and come to hotels and bars.
c. Married people are not sticking to their partners and are having extra-marital affairs.
d. Young people having sex with old people.
e. No change in sexual behavior.
f. Some men do not want to use condoms.

g. People whose partners have died of AIDS still have many sexual partners. Amazingly, even the people who used to work with her husband have sex with her.

Attitudes Towards AIDS Patient

a. AIDS victims must be isolated.
b. They are afraid of AIDS patients even to attend a funeral of an AIDS victim.
c. AIDS patients are neglected as it is felt they looked for it.
d. People with AIDS are bitter and always say that "I won't die along, I must spread it." And they do spread it to others.
e. Should be looked after just like any other sick person.
f. Avoid kissing the victim.
g. Eat with her from the same plate.
h. Keep the AIDS patients in a fence.

Future Plans

a. Isolate infected people.
b. Medicine for AIDS must be found.
c. Vaccine for AIDS must be found.
d. Female condoms to be prepared.
e. Avoid sex.
f. Use condoms.
g. Stick to one faithful partner.
h. People who want to get married should be tested.
i. Intensify Health Education.
j. Effective Health Education in the farming area.
k. Strict rules that ban women from beer halls.

Married Men

What Has Been Done in the District by the Program.

a. Have not heard about the program.
b. Heard about AIDS on the radio.
c. Has heard about the program but did not know how and where the money was being used.
d. Have not participated in the program.
e. Some people who had participated helped by organizing AIDS competitions for school children.

Knowledge on AIDS

a. Aids virus was brought by people who travel to Botswana.
b. HIV and AIDS stand for Human Immune Deficiency Virus and Acquired Immune Deficiency Syndrome.
c. AIDS is transmitted by mosquitoes, private doctors and nurses did a great job in spreading the disease by using unsterilized instruments between 1975-1989.
d. AIDS campaigns are targeting lower income groups leaving the higher groups, who have money and are spreading the disease.
e. Campaigns is focusing on children leaving the community at large.
f. Too much emphasis on use of condoms as opposed to morality even to school children.
g. All STD are AIDs.
h. The difference between HIV/AIDS not clear to the public.
i. Pamphlets with information on AIDS are available in communities where people can't read.
j. Disease got through having many sexual partners.
k. AIDS is the same as Runyoka.
l. AIDS is a fatal disease and has no cure with a long incubation period.
m. AIDS is an old disease coming up as a punishment from God.
n. A participant read verse Matthew 21 that said in the year 2000 this generation shall be destroyed, this AIDS is fulfilling that promise.
o. AIDS is scabies (Gnembe) caused by mixtures of bloods old and young, black and white, etc.
p. Signs and symptoms include swollen legs, loss of weight, hair thins out, loss of appetite, persistent cough.

AIDS—A Problem in Marondera and Zimbabwe

a. AIDS is a problem in Zimbabwe especially Mashonaland East.
b. The number of AIDS cases is increasing and some have actually seen AIDS victims who have since died.
c. In Marondera, there is a lot of prostitution which is caused by hunger and women indulge in prostitution to get money to buy food.
d. AIDS is a serious in Zimbabwe because of whites from outside and our Zimbabwean women go to whites to get money.
e. Read from newspapers that many people from Mashonaland East were dying.
f. Women are major sexual abusers.
g. Women who go to Botswana are bringing HIV to Zimbabwe.
h. Army people are also bringing the disease.
i. Zimbabwe is in trouble.
j. Government must get rid of poverty by offering more jobs to women so that they don't depend on prostitution for survival.
k. Incubation period a problem because you don't know has it and who has not.

l. Government conditions of service contribute to prostitution—transfer a single person without thinking that he is a member of a family and offer accommodation for single men therefore family has to separate encouraging prostitution.
m. People don't know how to use a condom.
n. Not enough publication in papers, radios on AIDS, Government still sweeping the problem under the carpet.
o. Mechanical personnel who preach the gospel of AIDS prevention are not exemplary so illiterate people when they see that they think there is no AIDS.

Sexual Practices in Marondera

a. People not changing—instead prostitution is getting worse—even married women are indulging in extra-marital affairs.
b. People do not like using condoms they say they are small and sex with a condom is like eating a sweet in its paper.
c. People even have sex in beer gardens, soon it will take place in open places (i.e., bus stops).
d. Equal rights—women are quick to want a divorce so that they get maintenance from their husbands and are seen later in night clubs making more money.
e. Girlfriends no longer stick to one man as, if you find with her with another man and you beat her you get arrested.
f. Women actually pull men to have sex with in the beer gardens.
g. People should not be allowed to drink occasionally and women must be banned from beer halls.
h. School girls go home late and parents do not know what to do because when they ask they are not answered.
i. School girls are practicing prostitution and young boys sleep with old women.

Attitudes Towards an AIDS Patient

a. AIDS patients are frightening.
b. AIDS victims must be isolated.
c. Soldiers, but drivers are the carriers of HIV.
e. Frightened to be near him because they could get infected.
f. Must look after an AIDS victim because if he dies alone that is Ngozi in the family.
g. Unmarried women should be screened for HIV.
h. No need to hospitalize them as there is no treatment.
i. Difficult to be sure your partner is faithful.

Unmarried Men

Some people had heard about the Marondera project but the majority said they did not participate.

Knowledge on AIDS

a. Did not know what HIV/AIDS stands for.
b. "Runyoka" is the same as AIDS.
c. AIDS can be spread through drinking from the same cup, shaking hands, airborne like TB, coughing, breathing, change of food when people have been overseas, blood transfusion, sexually, sharing razor blades, sharing towels, plate, deep kissing.
d. No cure for AIDS—but it is not a new disease, it has always been there.
e. Mosquitoes can transmit HIV.
f. Using condoms is like having a sweet wrapped in its packet.
g. Condoms are not safe.

Is AIDS a Problem in Marondera

a. Agreed that AIDS is a serious problem.
b. People are dying in Marondera because of AIDS, never seen an AIDS victim.
c. People are not taking AIDS seriously as such not changing behavior.
d. Long incubation period is also a problem as it takes a long time to know and by that time a person would have spread it to many people.

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
W.V.R.D./ZIMBABWE HIV/AIDS PREVENTION PROJECT
#AFR-0474-G-SS-9097-00

FIELD	Actual Expenditures To Date (09/26/89 to 9/30/91)			Projected Expenditures Against Remaining Obligated Funds* (10/1/91 to 10/31/91)			Total Agreement Budget (Columns 1 & 2) (09/26/89 to 10/31/91)		
COST ELEMENTS	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
I. PROCUREMENT									
A. Supplies	7,992	4,365	12,357	(4,992)	1,635	(3,357)	3,000	6,000	9,000
B. Equipment	0	81,920	81,920	0	(44,920)	(44,920)	0	37,000	37,000
C. Services/Consultants	44,919	0	44,919	(16,873)	5,700	(11,173)	28,046	5,700	33,746
SUB-TOTAL I	52,911	86,285	139,196	(21,865)	(37,585)	(59,450)	31,046	48,700	79,746
II. EVALUATION/SUB-TOTAL II	0	0	0	12,757	192	12,949	12,757	192	12,949
III. INDIRECT COSTS									
Overhead on Field (20%)	23,143	15,024	38,167	0	0	0	23,143	15,024	38,167
SUB-TOTAL III	23,143	15,024	38,167	0	0	0	23,143	15,024	38,167
IV. OTHER PROGRAM COSTS									
A. Personnel	62,541	0	62,541	31,913	300	32,213	94,454	300	94,754
B. Travel/Per diem	19,993	7,943	27,936	15,207	3,257	18,464	35,200	11,200	46,400
C. Other Direct Costs	39,338	3,747	43,085	(19,938)	6,053	(13,885)	19,400	9,800	29,200
SUB-TOTAL IV	121,872	11,690	133,562	27,182	9,610	36,792	149,054	21,300	170,354
TOTAL FIELD	197,926	112,999	310,925	18,074	(27,783)	(9,709)	216,000	85,216	301,216

APPENDIX 1
PROJECT ACHIEVEMENTS DURING THE SECOND YEAR

A. Total Number of AIDS Education and Learning Materials and Other Tools of Communication Provided in the Second Year

1.	Posters	Jack and Jill	63
		AIDS kills	25
		You may not like the condom	15
		AIDS inouraya	10
		TOTAL	**113**
2.	Stickers	Responsible boys and girls say no to sex	1,000
3.	T-Shirts		248
4.	Booklets	AIDS your questions answered	143
		Let's learn about AIDS ... A booklet for community workers	67
		AIDS ... lets fight it together	150
		Action ... Finding out the facts about AIDS	82
		AIDS action now	7
		TOTAL	**449**
5.	Pamphlets	How to use a condom	100
		Facts about AIDS	120
		Chokwadi Chiripo nezveAIDS	250
		Hurukuro nezveAIDS	100
		TOTAL	**570**
6.	Leaflets	Information nezveAIDS	317
		AIDS nomutenderi	1316
		Zvatingade kuziva nezveAIDS	50
		TOTAL	**1,683**

B. HIV/AIDS Information, Education and Communication Training by Project Staff

1.	Youth	1B
2.	School teachers	95
3.	Industrial workers	726
4.	Industrial workers	34
5.	Women (Interdenominational groups)	584
6.	Uniformed forces	262
7.	Village Community Workers	46
8.	World Vision Zimbabwe Office staff	36
9.	Health Workers	56

10.	Farm Workers	949
11.	Community leaders	225

C. AIDS Education activities by district Health Staff on HIV Infection and Aids

The following figures show the number of people reached by trained Health workers through the district.

1.	School teachers	164
2.	Mixed group (men and women)	10,665
3.	Traditional midwives	51
4.	Women in Child Bearing Age	996
5.	Youth in Schools reached through drama	1,135
6.	Village Community Workers	109
7.	Farm Health Workers	98
8.	Youths	173
9.	Community Leaders	392
10.	Community leaders	100
11.	Farm Workers (mixed groups)	4,839

Condoms Distributed

1.	Project staff	16,120
2.	Health Workers	158,842
	TOTAL	**174,962**

WORKSHOP ATTENDED BY I.E.C. ASSOCIATE

DATE	WORKSHOP
11-15 December 1989	Staff development workshop
7 December 1989	UMP Baseline Survey Report
8-10 January 1990	Provincial AIDS Counseling Workshop
22 February 1990	Agronomy Foundations Workshop
9-27 April 1990	Photojournalism course
26-29 June 1990	Spiritual Life Development Conference
3-6 December 1990	Defensive Driving Course
25 January 1990	ZAN Congress
13-14 March 1991	Planning Review Workshop
April	Budget Training for FY1992
13-15 May 1991	AIDS Counseling Resources Persons Workshop
23-27 June 1991	National Council for International Health Conference
29 July—2 August 1991	WID Workshop
Project coordinator attended Chikanakta AIDS Management workshop (Zambia) 27 May 1991—31 May 1991	Provincial AIDS Counseling
Project Manager	Provincial AIDS Counseling

APPENDIX 2A
FOCUS GROUP DISCUSSION—GUIDELINES FOR AIDS PROGRAM

A. What they have done in the program.

B. What they know about AIDS. What is is?

C. What they think. How serious is the problem?

D. What is their practice?

E. Attitudes towards AIDS patients. Attitudes towards multiple sexual partners.

F. What is the future of AIDS?

G. Observations/comments from interviews.

APPENDIX 2B
GUIDELINES ON FOCUS GROUP DISCUSSIONS FOR THE MARONDERA HIV/AIDS PROJECT EVALUATION—AUGUST 1991

Focus groups will be 8-12 members; a few will be mixed, but most will be one of four groups (married men, unmarried men, married women, and unmarried women).

INTRODUCTIONS

A. Introduction of facilitators, then introductions by focus group members themselves.

B. Introduce subject: This is a review of activities undertaken in the district during the implementation of an anti-AIDS program by the MOH and World Vision.

QUESTIONS/ISSUES FOR GROUP DISCUSSIONS

A. What has been done in the district under this program? How have the focus group members participated?

B. What do focus group members know about AIDS and HIV? What do these terms mean?

C. How serious is the AIDS problem in Marondera and in Zimbabwe?

D. What are sexual practices in the area where respondents live and in district?

E. What is their attitude towards AIDS patients and multiple sexual partners?

F. What should be done about AIDS in the future?

HIV/AIDS PREVENTION IN AFRICA PROGRAM

MARONDERA DISTRICT

ZIMBABWE

REPORT OF THE PROJECT REVIEW WORKSHOP 13 - 14TH MARCH 1991

BY

J.C. MAKINA

22ND MARCH 1991

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ACKNOWLEDGEMENTS

I would like to thank Mr. Sibanda (the Director), Mrs. Mushapaidze, Mrs. Tagwireyi, Mrs. Makarawu and Ms. Murazvu for affording me an opportunity to lead the workshop. Also the Community Sister Mrs. Sirewu and the District Medical Officer Dr. Takundwa for the support they gave during the proceedings. The workshop could have not succeeded had it not been for the valuable contributions by all the participants to whom I am deeply indebted. Last but not least to Stephen George for typing this report.

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EXECUTIVE SUMMARY

The workshop was divided into three main sections viz: presentation and discussion of the KAP survey results, tabling and discussion of the Mid Term Report and discussion of the Draft Project Proposal (for continued funding).

The KAP survey results culminated in 12 major points of focus and action. apart from summarizing the developments and successes of the project, the twelve points covered issues that could be implemented both at field as well as management levels.

The Mid Term Report highlighted three major issues which related to solving information gaps, role definition between MOH and World Vision and the progress made so far in the project.

The Draft Project Proposal was tabled and discussed and additional information was given for inclusion in the final document.

Eight recommendations were formulated and the source of funds for the continuation of the project after August 1991 was given as priority.

MARONDERA DISTRICT ZIMBABWE

REPORT OF THE PROJECT REVIEW WORKSHOP 13 - 14TH MARCH 1991

BACKGROUND

The HIV/AIDS Prevention in Africa Program, Marondera District, had its funding approved in July 1989 and started operations in October 1989. The funding received as for an initial two year period and it was hoped that extension could be granted after these initial two years. The extension was dependent upon availability of funds and success of the project.

In order to monitor the progress and measure the success of the project, a mid-term evaluation, which had been built into the Detailed Implementation Plan, was carried out. This was after Knowledge, Attitude and Practices (KAP) surveys had been done.

Two KAP surveys were carried out at the end of the first year of the project life and, after some delays, the results were made available in April 1990 and August 1990 respectively. After consultation with the cooperating agent, Ministry of Health, it was decided to hold a two day workshop to discuss the results of the two KAP surveys, to restrategize the program and to consider proposals for the extension of the program.

OBJECTIVES OF THE WORKSHOP

The objectives of the workshop were:

(a) To share information on the results and findings of KAP surveys carried out in

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Marondera District.

(b) To discuss the message development process following the KAP findings.

(c) To review the mid term progress report.

(d) To identify the problems encountered in the project and come up with suggested solutions.

(e) To review the work plan for the year 1991.

(f) To discuss possible strategies to consolidate project activities and strategies for project sustainability.

(g) To plan the extension period of the project, should funding be granted.

WORKSHOP PROGRAM

The workshop took place at Marondera Hotel. The major activities centered around KAP survey results, the Mid Term Progress Report, the Detailed Implementation Plan, problems encountered and extension of the project.

(The detailed workshop program is given in Appendix I.)

WORKSHOP PROCEEDINGS

A. KAP Survey Results

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The summary of the KAP Survey Results were presented by two World Vision personnel. The presentation highlighted several aspects; demographic characteristics of the population surveyed, literacy levels, knowledge levels, attitudes and practices.

Twelve major points highlighted in the presentations formed the basis for group discussions. The groups were tasked to make suggestions, solutions or recommendations.

The following is a summary of these group discussions.

1. <u>How Well the Purpose of the Project was Achieved in Terms of Knowledge, Attitudes and Practices</u>

   (a) Knowledge:

   It was noted that people had generally heard about HIV/AIDS but there was still some information gaps that needed further exploration and rectification. An example was misinformation on transmission of HIV/AIDS. There was also a need to improve the value on AIDS education.

   It was necessary for the project to stress qualitative data more than mere quantitative data when determining the knowledge levels e.g. knowing much about condoms but failing to use them due to various social factors (traditional and religious beliefs and over trust of partners).

   Improved knowledge levels could be achieved through small focus groups.

   (b) Attitudes:

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There was a need to explore the individual attitudes towards HIV positivity. There was also need to explore why there was a low usage of condoms compared to numbers who knew about condoms. More work was needed to be done towards the problems of social and religious beliefs which led to people dissociating themselves from HIV and AIDS. This resulted in development and perpetuation of negative attitudes among married couples and yet this formed a major sub-group of the population which was at risk.

It was evident from the results of the KAP surveys that sexual practices had not changed significantly during the life of the project. More work needed to be done to influence and change peoples' practices in order that they practice "safe sex."

2. There is Limited/Wrong Knowledge of HIV/AIDS

It was agreed that health information should be targeted to a variety of different people and organizations in the district. Examples given were senior police and army officers, managers, traditional leaders, political leaders, businessmen, farmers as well as civil servants.

To do this, workshops were to be decentralized so as to improve coverage in the project area.

3. Discrepancy between the Number of Women in Health Education Compared to the Number of Men who Needed Health Education

It was noted that there was a disproportionate ratio of female health workers to male recipients. This discrepancy led to messages not being passed on because of social barriers. It was therefore agreed that more men should be

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deployed at local level so that dissemination of HIV/AIDS information was balanced between sexes.

4. Improvement of Sources of Information and how Health Workers Could be More Influential

It was noted that health workers were not being as influential as had been expected. The mass media channels were more powerful and popular yet tended to give quantity information, but Health Workers gave quality information.

It was agreed that:

(a) refresher courses and "on the job" training for health workers should be stepped up, the provision of pamphlets and information sheets be increased;

(b) health workers live by example and need to increase the detail of teaching AIDS/HIV at training institutions.

5. Risk Groups had People Dissociating Themselves From the AIDS/HIV Problem

On this, it was noted that there was need to intensify the campaign in the project area so that everybody realized that it was everybody's problem.

It was necessary to encourage families to take part in teaching children about AIDS/HIV; and local communities be involved in designing appropriate messages e.g. through schools competitions.

There was also need for more cooperation with local production companies to produce entertainment messages for local audiences; to develop positive attitudes so that it would not be seen to be shameful to be HIV positive or have AIDS; and to place condoms at most public places.

Since the project had only run for an initial short period, condoms could be free. With attitude change over time, it was hoped people would eventually buy condoms.

6. Ways of Counseling and Support of AIDS/HIV People

(a) It was agreed that: family, relatives, employers and friends could have some training in order to counsel and support HIV positive or AIDS sufferers.

(b) Health workers were to be trained in counseling and especially in maintaining confidentiality.

(c) Information on AIDS/HIV support could be made available by use of posters, drama, role play, churches and schools. Families and traditional healers were be to encouraged to support HIV/AIDS sufferers.

(d) Community interest groups were to be encouraged to take on the role of HIV/AIDS support.

7. Improving Employer Participation in HIV/AIDS Education

It was noted that a lot of commercial farmers were difficult to work with as they did not seem to want to give their workers prime time to attend to

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AIDS/HIV programs.

It was agreed that there was a need to restrategize approaches to commercial farmers by:

(a) communicating through the Executive Officer of the Council;

(b) joining and attending farmers' meetings;

(c) organizing multi-sectorial workshops in which farmers/farmers' representatives would be present.

8. Improving Availability of Condoms

Noting that the practice of safe sex was reported in the mid term report as being "low," it was agreed that:

(a) condoms be placed in public areas

(b) use Community Based Distributors;

(c) have information on the use and disposal of condoms readily available;

(d) shops be allowed to sell condoms.

9. Problems of Emotional Actions Which Occur when AIDS is Detected in a Partner

It was noted that there appeared a high percentage of people who would get

into a high emotional state or contemplate suicide if AIDS was detected in them and/or especially their partners.

It was then agreed that:

(a) counseling services be increased and decentralized;

(b) that a register of trained counselors be kept at local health centers;

(c) that ways be explored of strengthening marriage ties.

10. Bridging the Gap Between Knowledge and Practice

It was agreed that this required a multi-disciplinary approach of which issues had already been raised in the debate on other points. However, there was need to have in-built evaluation of Health Education programs and information regimes.

11. General Lack of Emphasis on Preventative Measures:

It was agreed to:

(a) strengthen the number of health educators;

(b) increase HIV/AIDS prevention information through various mass media;

(c) decentralize and increase Health Education and to use existing groupings and structures as bases (VIDCOS, WADCOS, etc.)

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12. Changing Negative Attitudes of the Special Group and Religious People

It was noted that the category of "special group" in the KAP survey did not show a higher level of knowledge about HIV/AIDS. In fact, this same group together with people who claimed to be highly religious, tended to have very negative attitudes towards HIV/AIDS.

It was agreed that where religious people were concerned, it was easier to get to them through the church leaders.

For those who were economic and professional leaders, it was agreed that AIDS/HIV education activities be tailored to fit into their daily routines.

It was agreed to start with "soft targets" i.e. people who were likely to agree and accept the message before going onto the hard targets.

It was agreed that tact and friendliness, more than officialdom would win the hearts and support of some of the hard target groups (e.g. farmers) who became unfriendly and unsupportive because of factors extraneous to the AIDS/HIV project.

B. THE MID TERM REPORT

After lengthy discussion on the points raised from the KAP survey and the Mid Term Report, and "the Detailed Implementation Plan" was tabled. This arrangement offered comparability of data what was set out to be achieved against what was actually done.

It was noted that in spite of the various constrains as detailed in the mid term report (pages 9-10), the project was on course and hoped to achieve set quantitative targets

by August 1991 when the first two year period comes to an end.

Some issues came out of the debate on the Mid Term Report and it was decided to discuss these thoroughly in small groups and to come up with possible strategies to implement decisions so made. some of the issues over lapped with those raised when discussing the KAP survey results. It was however agreed that repetition served as a means of emphasis.

A summary of the points and strategies discussed is given below.

1. How to solve information gaps:

It was recommended that:

(a) more in-service and on-the-job training be given to all MOH staff os that they are seen to be knowledgeable about HIV/AIDS;

(b) interested persons be identified and trained in counseling (preventive, crisis and bereavement);

(c) registers of trained counselors be kept at the District and Rural Health Centers for referral of people who need counseling.

2. Farmers' Negative Attitudes

The issue of farmers' negative attitudes to HIV/AIDS education was further discussed. Commercial farms hold almost 50 percent of the total population of the district, therefore are an important component in the HIV/AIDS program.

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It was agreed that tact, friendliness and interest in the farmers' problems was paramount in winning the farmers' support.

It was important that health workers cover all aspects of health including HIV/AIDS so as to be seen as people interested in the total health of people.

It was also agreed to increase meetings and training of the Farm Health Workers. The use of films was to be considered seriously for farm workers (mixing education with entertainment). There was need to acquire a 16mm film projector for this purpose. This, it was agreed, would vastly improve accessibility of information to more people as film shows created a conducive platform for Health Education messages.

3. Role Definition Between MOH and World Vision and Low Level Integration of WV Staff in District Health Activities

It was noted that at times the role of WV staff was unclear especially in relationship to MOH staff when doing other health programs.

It was noted that:

(a) liaison between WV and MOH should be at all levels of the project (planning, implementation and evaluation);

(b) MOH attaches specific persons to work with WV persons so that when the project phased out there would be people who can carry on with the project;

(c) WV staff should take part in all health activities of the MOH team they worked with. This would remove the "AIDS" label and they

would be more acceptable as people genuinely interested in people's overall health.

It was noted that part of the problems arose because the question of "partnership" was not clear - both for WV as well as MOH staff. After a lengthy debate it was agreed that the question of equal responsibility, equal decision making be instituted in the project area.

It was further agreed that basing project staff in the project area rather than in Harare would improve this partnership.

From the discussions and debates on the KAP survey results and the Mid Term Report, it was clear that:

(a) the project was on target in spite of the late start. Most of the constraints experienced so far were mainly attributed to the "teething" problems usually associated and expected of such projects which aimed at attitudes and practices change. However, there were areas which needed major restrategizing in order to ensure meeting of the targets and improvement of the quality of the project;

(b) quality results were difficult to attain as it meant targeting attitudes and practices which took a long time and at times generations, to change;

(c) while the present Mid Term Evaluation gave numbers, it lacked the qualification of those same numbers. It was then debated whether in fact within the time span of two years the project will have had such an impact as to be self sustaining in terms of momentum. The clear answer to this was an unqualified "no."

It was noted that several areas of the project still needed consolidation. Such areas included information, knowledge, attitudes and support towards AIDS patients and the general administration of the project. From this discussion, it was agreed that the project be funded for at least another two years. The question of lack of funding having been raised, it was agreed that a proposal be drawn up to source funding from the present or any other donor.

Discontinuation and folding up of the project in August 1991 represented a retrospective and negative step and it was noted that negative attitudes among the population in the project area would ensue especially after raising their homes.

C. The Draft Proposal

A draft proposal was then presented. The justification, objectives and strategies were discussed.

Justification: This needed strengthening and to include more statistical projections and analysis. There was need to specify issues like "appropriate messages" and to argue strongly the short-comings of short-term projects.

Objectives: Some needed to be quantified so as to be measurable at the end.

Strategies: More strategies needed to be formulated. Strategies also needed to be specific and attainable.

Overall: It was unanimously agreed to support strongly the extension of the project for a further two years from September 1991.

ACHIEVEMENTS OF THE WORKSHOP

The workshop achieved the following:

(a) The KAP survey results were successfully reviewed and important issues from these surveys were raised and participants were able to come up with possible strategies as solutions to these issues.

(b) The Mid Term Evaluation was successfully reviewed and solutions to issues raised were discussed.

(c) Constraints in the project were candidly discussed. This was done without fear or recrimination. It was the first such meeting and it was hoped more would follow when planning various stages of the project.

(d) The time allocated for the workshop could have been two full days of participation. There was desire to discuss issues for a longer period and to examine all possible avenues. Time constraints meant curtailing discussions and at times at crucial points.

SUMMARY OF MAJOR FINDINGS.

1. Knowledge levels are generally high but more work needs to be done on misinformation which seems to be prevalent.

2. Negative attitudes towards AIDS/HIV are prevalent resulting in continuation of risky sexual behavior. This is especially so among those who are supposed to be knowledgeable.

3. Employers do not seem to take the need to educate their employees on AIDS/HIV seriously.

4. There is a wide gap between what people know about AIDS/HIV and what people practice to prevent contracting the same.

5. The concept of "partnership" and its implications is not quite clear for both parties - MOH and WV.

6. The operationalization of some issues e.g. development of suitable message and strategies has not yet reached saturation level.

7. The Mid Term Report gave a candid summary of the state of the project.

8. The project is likely only to achieve quantitative targets if it runs for the initial two year period only.

RECOMMENDATIONS

1. More workshops at decentralized venues need to be organized so that all leadership levels are involved in the AIDS/HIV program;

2. Strategies need to be worked out on how to approach various employers to elicit their willingness to involve workers in the program;

3. Drama and other innovative ways of passing information need to be explored and matched with various targets;

4. The gap between knowledge and practice needs narrowing and strategies to do this need to be worked out;

5. MOH and WV should work out the operationalization of partnership and clearly state the relationship between their staff at various levels;

6. The development and dissemination of more messages should be vigorously pursued, especially those messages that relate to attitude and practices change;

7. More training sessions should be carried out to train:

   (a) counselors

   (b) people who work at health centers and

   (c) health education personnel.

8. The project should seek for funding for a further period of two years beginning September 1991.

APPENDIX 4

FY91 WORK PLAN

Situation Analysis

HIV/AIDS has now become one of the top five diseases in the district. It affects all ages, including children five years. This is the age group which succumbs quickly to the disease. They present as recurrent pneumonia usually admitted about three times in a year and difficult to treat with antibiotics, as well as failure to thrive and persistent generalized lymphadenopathy.

In Male Adults

In a 42-bed male ward, 15 are occupied by HIV+ patients. The rate of positivity in outpatient department is roughly 60 percent. Almost all blood taken comes back as positive, especially that taken for confirmation. They present with TB and wasting which do not respond to treatment. Some present with non-reactive chancroid without a bubo and the HIV test is usually 100 percent positive, and do not respond to erythromycin.

In Female Adults

Patients present as chest infections, and pregnancy makes the chest infections worse as the immunity is reduced during that period, or they present as recurrent pelvic inflammatory disease, and these cases are referred to the central hospital for investigations.

The KABP results revealed some information gaps on the differences between HIV infection and AIDS, how AIDS is not transmitted and non-acceptance of people with HIV/AIDS.

Problem

1. There is general awareness of HIV/AIDS, but adequate information on mode of transmission and prevention still lacks.

2. Some behavioral cultural attitudes and beliefs towards sex increase the spread of HIV infection.

3. Promiscuity in couples results in babies born with HIV infection.

4. Illiteracy in rural and farming communities.

5. Inadequate interministerial and intersectoral coordination.

6. Socioeconomic status which results in some people being involved in high-risk sexual behavior.

WORK PLAN FY91

Activity	Responsible	O	N	D	J	F	M	A	M	J	J	A	S
1. Training of Farm Health Workers	Project staff and FHW trainer and Rural Council Sister	<---	------	------	------	-------	------	------	------	------	----	----	--->
2. Information, Education, and Communication Workshops for health workers	District Health Executive (2) Project Staff					<-->							
3. IEC Workshop for teachers	Project staff and District Health Executive							<->					
4. IEC Workshop for youths	DNO, DSC, Project staff				<->								
5. World AIDS week/day activities	District Health Team and Project staff PHEO and Women's groups		<---	--->									
6. IEC workshop for industrial workers	Project staff, community Sister, and DNO					<--->							
7. One-day workshop for community leaders	Rural health center staff, Project staff			<->			<->		<->		<->		<-->

Activity	Responsible	O	N	D	J	F	M	A	M	J	J	A	S
8. Workshops for community leaders in commercial farms	Rural Council health staff and Pro Comm. Sister and DNO		<->		<->		<->		<->		<->	<-	---->
9. Refresher course and training for traditional midwives	RHC staff and Project staff						<---	-----	-----	-----	-----	----	---->
10. AIDS counseling workshop	Project staff and District Health Executive						<->						
11. One-day workshops for uniformed farmers	Project staff, DNO, and Community Sister			<---	--->								
12. Workshops for traditional healers	DNO and Project staff				<---	----->							
13. Development and Production of AIDS education materials	District Health Executive and Project staff, HEO		<---	-----	->								
14. District nurses monthly meetings	DNO, DEHO, Project staff												
15. Quarterly reports	Project staff				<->			<->			<->		<-->

Activity	Responsible	O	N	D	J	F	M	A	M	J	J	A	S
16. Workshops for church leaders	DNO, DCS, and Project staff						<->		<->				
17. Intersectoral AIDS workshop	DMO, DNO, DCS and staff							<->					
18. Follow up visits to Rural Health Centers	DNO, DCS, and Project staff			<->		<-->		<->		<->		<->	
19. End of Project evaluation	Evaluators, Project staff, DEHO											<->	