

AFR/TR/HPN HIV/AIDS PREVENTION IN AFRICA
(HAPA) GRANTS PROGRAM

MIDTERM PROGRESS REPORT

PVO HIV/AIDS PREVENTION IN AFRICA

SWAZILAND, AFRICA

SEPTEMBER, 1989 THROUGH OCTOBER, 1990

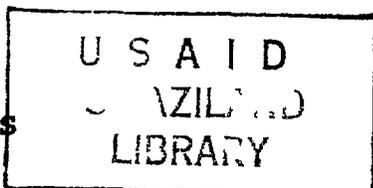
BY

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GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
DIP	Detailed Implementation Plan
FGD	Focus Group Discussion
FLAS	Family Life Association of Swaziland
FO	Field Officer (Traditional Healers Organization)
FP	Family Planning
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
KABP	Knowledge, Attitudes, Behavior, and Practices
MTP	Medium Term Plan of the NAP
MTPR	Medium Term Progress Report
NAP	National AIDS Program
PHC	Primary Health Care
Sebenta	Adult Literacy Program
Shebeen	Local Bars
SNAT	Swaziland National Association of Teachers
STD	Sexually Transmitted Disease
TA	Technical Assistance
THO	Traditional Healers Organization
TOT	Training of Trainers
USAID	United States Agency for International Development
WHO	World Health Organization

I BACKGROUND INFORMATION

A. Report of Baseline Data

- 1 A Knowledge, Attitude, Behavior, Practices (KABP) baseline survey for the Project HOPE/FLAS HIV/AIDS Prevention Project (hereafter referred to as the Project) was planned. However, the National AIDS Programme (NAP) and the Government of Swaziland, in November, 1989 requested that the project carry out a national KABP survey, rather than a more limited project KABP survey, as a key contribution to the Medium Term Plan (MTP) of the NAP. The project agreed to conduct the study as requested. Since the request came from government there was no difficulty in getting government clearance to conduct the survey. The time frame for the survey was March through June, 1990. During this period of preparation, development of the questionnaire, training of interviewers, pre-testing of the survey instrument, data collection, and the preliminary analysis of the data were completed. (See Appendix 1 for Preliminary Report of KABP Survey.)

Sample Size. The planned sample size was 2,000. The achieved sample size was 1,930. The sample distribution was based on the 1986 National Population Census according to sex, region, and rural/urban distribution. (See Report in Appendix 1)

Survey Instrument: The WHO/GPA questionnaire for use in African countries was modified for Swaziland with input from an inter-sectoral team made up of members from Family Life Association of Swaziland (FLAS), NAP Task Force, NAP Information Education Committee Action Group, Project HOPE, ManTalk, National Youth Council, and Manzini Town Council. (See Appendix 2 for KABP Survey Questionnaire)

Selection, Training, and Supervision of Interviewers: The interviewer candidates were screened from those responding to an advertisement run in the local newspaper. Minimum requirement was completion of Form V., (i.e. completion of high school). Previous experience as an enumerator was preferred. Of the 23 candidates selected for training, 18 were finally chosen for the positions. Two members of Project HOPE staff served as the supervisors.

Data Tabulation and Analysis. The WHO/GPA "Part IV. Tabulation Plans, Phase 1" were followed for data tabulation. The SPSS computer software programme and the SPSS Tables Procedure were used to analyze the data.

Technical Assistance Used in the KABP Survey The Social Sciences Research Unit of the University of Swaziland was contracted by the project to undertake the following duties for the KABP Survey

- o recruit a Survey Supervisor to be responsible for the management of all aspects of the survey,
- o recruit and train enumerators;
- o undertake data collection from 2,000 respondents;
- o enter and edit all survey data from questionnaires;
- o produce a report of the survey,
- o provide Project HOPE/FLAS with the entire data set on MS-DOS compatible floppy discs in SPSS, DBASE, or ASCII format; and
- o administer, through the office of the bursar (UNISWA), the project survey funds in accordance with the budget

1.1 Uses Made of Survey Findings in Project Planning: The survey findings have been and/or will be used as follows:

The National AIDS Programme -

The following quote from the NAP Medium Term Plan outlines the uses to be made of survey data:

"The survey will provide a retrospective evaluation of the AIDS education activities undertaken in the context of the National Short Term Plan (a 12-month period in 1987-88) as well as a baseline for planning and evaluation. This study will be repeated at the end of the evaluation. This study will be repeated at the end of the Medium Term Plan (due to various delays this currently means end of 1992) and will form one basis for evaluating the programme."

The Project HOPE/FLAS HIV/AIDS Prevention Project -

The survey has had very limited use in planning for the Project, since it was not a baseline survey for the Project but, rather, a national baseline survey. Such a major undertaking requires more time to implement than is possible for completion by the early stage of the Project when initial planning is done. However, the survey has influenced planning of Project activities in two spheres so far:

- a. Because activities with the Sebenta Adult Literacy Programme target group were not begun until after the KABP preliminary report was submitted, the survey effectively influenced planning of Sebenta activities. It provided sufficient KABP information on the population with little or no formal education to be

able to eliminate the planned Focus Group Discussions for that target group

- b. The results also will be taken into account in the development of Information, Education, Communication (IEC) materials for that target group later in the project.

1 2 Uses to be Made of Survey Findings in Project Evaluation:

The use of survey findings depends in part on whether or not the Project will receive additional HAPA funds to undertake the follow-up survey. The NAP has requested repetition of the survey.

In any case, the results will be used as a basis for comparison of the results from the end-of-project small sample KABP surveys of key target groups, (e.g., Sebenta and traditional healers). Specific expected results in the targeted groups, for comparison with information from the KABP Baseline Survey, include:

- o Increased knowledge, especially a decrease in incorrect understanding of modes of transmission and an increase in knowledge of maternal transmission;
- o Reduced risk behavior, especially reporting fewer casual sex partners, increased use of condoms, and greater willingness to discuss sex and HIV/AIDS with partner,
- o More beneficial attitude, especially more compassionate attitudes toward persons with AIDS and the understanding that use of a condom does not imply distrust or promiscuity but, rather, caring and concern for self and partner.

2. Target Group Specific Baseline Data.

In addition to the National KABP Survey undertaken by the Project other target-group-specific baseline data are being collected. The main purpose for collecting these data is to develop training curriculum for specific target groups. The method used is Focus Group Discussion (FGD), a qualitative research methodology. To date, seven (7) FGDs have been completed with non-school-going youths and ten (10) FGDs have been completed with traditional healers. A report of the results is scheduled to be completed in November, 1990. (See Appendix 3 and 4 for the Non-School-Going Youth FGD Instrument and the Traditional Healers FGD Instrument respectively)

Prior to the start-up of the Project and separate from it, discussions (which included KABP related to Sexually Transmitted Diseases (STDs) and HIV/AIDS) were held with traditional healers during Primary Health Care (PHC) training sessions sponsored by Project HOPE. This information was used to develop the first draft of the FGD Guide for Traditional Healers.

In July/August, 1990, FLAS conducted an extensive Family Planning Survey, which included substantial coverage of KAP related to condom use and to youths and their KAP regarding sex, STDs and HIV/AIDS. The external consultant for the survey is currently writing the report which is due to be submitted in December. This report provided useful information in planning IEC materials targeted for youths.

B Response to DIP Reviews

1. An Action Plan was developed (May, 1990) by an ad hoc on-site team that included Project HOPE HIV/AIDS Program Coordinator; Project HOPE Swaziland Country Director; the AIDS Coordinator assigned to this project; and the project consultant for development of information systems.

In addition the FLAS Program Director; FLAS Research Coordinator, and the U S A I.D. Assistant Health Officer, provided valuable assistance in reviewing drafts of the Action Plan prior to finalization. The Action Plan was further refined following a technical support visit by the HAPA Grants Support Programme.

The Action Plan implements the suggestions made in the Detailed Implementation Plan (DIP) review and is used by the Project personnel and their counterparts as a guide to the management of the Project activities. A complete copy of the Action Plan is attached to this report as Appendix 5.

2. Other responses, not covered in the attached Action Plan, to recommendations or concerns from the reviews of the project DIP are covered in other sections of this report.

C. National and Local Relationships

1. Local Relationships:

The functional relationship of the Project with the local counterpart organization has progressively evolved and strengthened since the start-up of the Project. The relationship is now one in which FLAS is the primary counterpart organization and the Project is an HIV/AIDS extension of their activities.

The key activity of FLAS has been the promotion and provision of family planning services through its three

family planning clinics located in the main urban areas of the country: Manzini, Mbabane, and Malkerns. Other FLAS activities support family planning, such as community-based distribution of condoms through rural health motivators and private industry, and the teaching about human sexuality. Prevention, diagnosis, and treatment of STDs is another major area in which FLAS is involved. HIV/AIDS prevention is a logical extension of FLAS activities because it is an STD and its transmission is linked to other STDs; because condoms are an important factor in its prevention; and because of its relevance to family planning. The extent and nature of the partnership between FLAS and the Project are demonstrated in the examples mentioned below.

- o Project HOPE-employed Project staff are considered an integral part of FLAS. There is mutual sharing of support staff to conduct project activities and meet deadlines. Both FLAS and Project staff keep one another involved and informed in regular joint staff meetings and ad hoc meetings and discussions.
- o The Acting Executive Director of FLAS and the Project Coordinator of the project jointly plan, problem solve, and participate in the implementation of project activities. Examples of coordination include: the review of the Preliminary KABP Report, organization of the Sebenta Training Course, and preparation of the Mid-Term Progress Report (MTPR). FLAS has included all the project activities scheduled for next year in its 1991 Implementation Proposal. The project coordinator was invited to review the document before it was submitted to IPPF, the umbrella organization of FLAS.
- o FLAS offices and the project offices are adjacent to one another, with shared storage facilities and conference facilities supplied by FLAS. Equipment has been pooled by FLAS and the Project for mutual use.
- o The functional relationship with the National AIDS Programme is one of official coordinated support. The NAP has approved the Project and supports it wholeheartedly. All of the Project activities are part of the NAP Three Year Medium Term Plan (1989-1991). The NAP specifically requested the Project to undertake the National AIDS KABP Baseline Survey, the training of sixty (60) counselors for HIV/AIDS related counseling, and the training of traditional healers in sterilization techniques and HIV/AIDS prevention. In addition, NGOs, including Project HOPE/FLAS, have been asked to mobilize public organizations and reach key groups for AIDS/STD education. The Project's activities are in compliance with all of these requests.

The Project is a member of the NAP IEC Action Group, with Project HOPE and FLAS each represented in the Group. The NAP Programme Manager and the Chairperson of the IEC Action Group (who is also the Senior Educator of the Health Education Unit of the MOH) have attended and contributed to each of the training sessions implemented by the Project as well as other Project activities, as has the Chairperson of the IEC Action Group. The Project keeps the NAP regularly informed of Project activities and progress.

Recently the NAP Task Force supported the recommendation from the NAP Programme Manager that a full-time position be established within the NAP office for a counselor. The Task Force asked the NAP Programme Manager to plan and coordinate the position in collaboration with the Project.

2. Relationships

- a. There has been an improvement in the HIV/AIDS reporting system and willingness to disclose reports to the public, beginning with donor blood screening at the Central Public Health Laboratory. Recently disclosed figures show that HIV infection is doubling every six months and the present HIV infection rate, according to donor blood sample screening, is 2.1%. A sample size of approximately 2,000 is tested every 3 months.
- b. Departure of the very active NAP Programme Manager in early August, 1990 for a three-year study leave in the USA was slowed the momentum of HIV/AIDS activities. The position is being assumed by a Health Educator attached to the NAP. The new Acting Programme Manager was not provided support staff.

Additionally, the move of the NAP office from Manzini to the recently completed NAP Headquarters in Mbabane has hampered decision-making. Indecision over whether or not the Acting Programme Manager would be appointed the Programme Manager led to a 'lame duck' situation for the NAP from August through September. Arrival of the WHO epidemiologist in early September, 1990 has helped revive the activity level of the understaffed NAP. A secretary and driver have recently joined the NAP staff and plans are under way to get a health educator, a counselor, and a statistician.

- c. The Health Education Unit, through the IEC Action Group, has designed several posters but progress on their completion is slow. There are very few IEC materials being produced by the government, although many are planned.

- d Care International has begun the School's HIV/AIDS Pilot Education (SHAPE) Project. The project aims to work with the Swaziland National Association of Teachers (SNAT), the Curriculum Development Center of the Ministry of Education, and twenty-six (26) schools in introducing HIV/AIDS education through the schools. SHAPE promises to be an important and effective project.

In August the Project Coordinator of CARE/SHAPE and the CARE Regional AIDS Advisor, visited the Project HOPE/FLAS Project to discuss the new project. The CARE/SHAPE Coordinator also participated in the recent Training Course for Sebenta and was an excellent resource person. The Project HOPE/FLAS Project and the CARE Project have much to gain from a collaborative relationship.

D. Human Resources Development

1. Changes in project staffing: The Project Coordinator who began the Project in September, 1989, left Swaziland in early August to begin a doctoral programme in the U.S.A. Her successor arrived in late July. The two week orientation period helped reduce the disruption to project activities often accompanying a change of key staff. (See Appendix 6 for Curriculum Vitae of the current Project Coordinator).

Another change in Project staff occurred in late September when the Project secretary, Ms. Busie Dlamini, began maternity leave. She will return in late December. Ms. Dlamini, who joined the Project staff in early August from a previous Project HOPE project, served as office administrator, in addition to providing secretarial skills, and was rapidly increasing her computer skills. She will be a great asset to the Project when she returns. Meanwhile, both FLAS and the main Project HOPE office in Swaziland are providing support staff assistance.

Changes in counterpart staffing: The FLAS Executive Director, Ms. Khetsiwe Dlamini, began a twelve month leave of absence for study in England in late September, 1990. The FLAS Programme Officer, Ms. Nomcebo Manzini, who is the counterpart to the Project Coordinator, became the Acting Executive Director. The transition has gone very smoothly. Ms. Manzini has a very strong support staff to whom she is able to delegate much of her extra work. This change has had no negative effect on Project activities. In fact, her support and involvement in the Project has progressively increased. In addition, the Head of the FLAS IEC Unit is attending a six-week management training course in Nairobi from September through October, 1990.

2. Training and other professional development activities undergone by Project staff include:

a. Management Information:

An Introduction to Computers and Beginning Wordperfect course was successfully completed in September, 1990 by the Counselling Officer, the Education Officer, and the Administrative Assistant/Secretary of the Project. An additional Course on MS-DOS was completed by the Administrative Assistant/Secretary

b. Counselor Training

During the three Counselling Training Courses conducted by the Project, the Project Counselling Officer, and the Project Education Officer participated, first as course participants, next as course assistants, and finally as course facilitators. The repetition and reinforcement of the information and skills, learned three times in succession from different perspectives, greatly contributed to enhancing the level of competency in counseling activities.

c. Continuing Education:

The Project Coordinator, Ms Agatha Lowe, attended the Second Symposium on AIDS which was held in Cameroon from 22-26 October, 1989. During the Conference, contact was made with AIDS Coordinators and educators in Botswana, Uganda, Zambia, Kenya, and Jamaica.

The Project was invited to send a member of staff to join the MOH/Swaziland team at the WHO-sponsored AIDS Education Conference in Accra, Ghana in August, 1990. The Project Education Officer was appointed to the team. At the Conference she was chosen to be the rapporteur. It was an excellent opportunity to exchange information and to meet representatives from other African countries involved in AIDS IEC activities, especially from Southern African countries

3. Technical Assistance Provided to the Project During the Past Year:

a. The HIV/AIDS Program Coordinator from Project HOPE Headquarters and an external Management of Information Systems (MIS) consultant visited the Project early in 1990. They provided assistance in refocusing the Project plan and identified strategies to evaluate the effect of the IEC interventions. Together with Project HOPE/Swaziland, they revised the DIP and developed the Action Plan. (See Appendix 7 for the Information System Report.)

b. The Programme Assistant for the HAPA Grants Support Project, visited the Project in May, 1990. Assistance was provided

in further delineating the Project objectives and in better identifying and quantifying targeted project outputs and outcomes.

- c. A consultant from CEDPA, provided technical assistance in Counselor Training throughout the month of June, 1990. During the consultancy three one-week counselling workshops, each with an intake of twenty (20) were presented CEDPA continues to provide technical assistance through the production of a Counselor Manual specifically for Swaziland.
- d. A lecturer in Demography at the University of Swaziland, served as the external member of the MTPR Team (See Appendix 8 for Curriculum Vitae.)
- e. AIDSCOM's Director and Africa Regional Director, met with the Project HOPE/FLAS staff in August, 1990 for the purpose of exploring program needs for IEC. U.S.A.I.D /Swaziland has contracted AIDSCOM for IEC technical assistance (TA) for a two-year period beginning late 1990. U.S.A.I D. will provide this TA to Project HOPE, FLAS, and the Federation of Swaziland Employers. It has been agreed that the AIDSCOM consultant will focus on IEC activities for traditional healers.

II. PROJECT ACCOMPLISHMENTS AND CONSTRAINTS

A. The main accomplishments of the project during its first year, including the training completed and supervisory systems developed, are listed below according to main project activity or target group

1. National KABP Baseline Survey -

- o Survey questionnaire developed,
- o Survey interviewers (20) recruited and trained,
- o Survey instrument pre-tested (N=43),
- o Survey data collection completed from 1930 respondents,
- o First draft of data analysis completed,
- o Data Analysis Draft reviewed and tables requiring corrections identified,
- o Arrangements for technical assistance to carry out corrections made,
- o Corrections begun.

2. Counseling Activities -

- o Selection of candidates for Counselor Training, including self-administered questionnaire on background knowledge and previous training of counselor candidates.
- o Discussions with candidates' supervisors for permission

to participate in training and to be allowed to use their skills after training held.

- o External technical assistance for counselor training contracted through CEDPA.
- o Counselor Training Curriculum developed for training course.
- o Three one-week Training Workshops held and sixty-one (61) counselors trained, including three FLAS Family Planning Clinic nurses
- o Reporting system for counseling activities established.
- o Follow-up letters sent to all trained counselors encouraging them to report regularly and for scheduling support visits from Project staff
- o Ten (10) trained counselors visited by Project staff.
- o STDs and AIDS Helpline Pilot Project undertaken by Project during ten days of 1990 Swaziland International Trade Fair. (See Appendix 12 for AIDS/STD Helpline report)
- o Development and production of AIDS Counseling Manual for Swaziland contracted to CEDPA

3. HIV/AIDS Education Through Sebenta Adult Literacy Programme

- o Collaboration Plan between Sebenta and the Project for AIDS prevention activities within Sebenta discussed and decided,
- o Education curriculum developed for increasing knowledge and concern for AID/STDs in Sebenta Field Operations and Headquarters staff Application of these knowledges and attitudes to the support and promotion of the IADS/STDs Prevention Course being developed for Sebenta students. The Sebenta Training Curriculum is presented in Appendix 10.
- o A one-week education/training course in and AIDS/STDs completed, in which fifteen (15) Sebenta Field Operations and Headquarters staff and twenty-two (22) additional participants from youth organizations and church organizations were educated in STDs and AIDS. Hand-outs on course topics, AIDS information leaflets, and condoms and condom instruction leaflets were distributed to all participants. (See Appendix 11 for Report of Sebenta Education/Training Course, 8-11 October, 1990.)
- o The Project will provide TA for the Sebenta staff for the purpose of conducting a Writer's Workshop in November, 1990. Projected outcomes of the workshop are to develop and produce a Student's Primer and Teacher's Manual on AIDS/STDs, and to introduce the AIDS Prevention course to be offered to Sebenta students in 1991.

4. Traditional Healers -

- o Memo of Understanding between the Traditional Healers Organization of Swaziland (THO) and Project HOPE for technical assistance in education and training activities for primary health care (PHC) and HIV/AIDS prevention was agreed upon and signed in July, 1990;
- o Preliminary Traditional Healers' Training Curriculum drafted from information received during PHC training sessions in 1989;
- o Project staff held an explanatory session attended by all seventeen (17) THO Field Officers on FGD methodology in August, 1990;
- o Instrument for FGD re-drafted and finalized jointly by THO and Project staff in September, 1990 (See Appendix 15),
- o FGD schedule drawn up for ten (10) FGDs, one in each of the ten THO regions, and completed by 5 October, 1990,
- o Analysis of FGD results begun;
- 7 o Funds for an in-house Health Education Advisor, to be based at THO Headquarters, as part of a quality control mechanism, were secured from Project HOPE's matching grant with A.I.D. in September, 1990;
- o Proposal drafted and submitted to Columbia University for a small grant to cover the salaries of two data clerks to be attached to THO to collate the information from the monthly supervisory checklist, which includes an HIV/AIDS component;
- o Preliminary supervisory checklist drafted.

5. Non-School-Going-Youths -

"Non-school-going-youths" are defined in Swaziland as "Any and all young persons up to the age of approximately twenty-five years who are not in school. This does include youths who have finished their schooling, i.e. even having completed Form V of high school, and is not limited to youths of school age who are not in school "

- o Instrument for Youth Focus Group Discussion (FGD) drafted.
- o Seven (7) FGDs with non-school-going-youths completed.
- o Fifteen (15) youth leaders, representing eight (8) youths organizations, were educated in a one-week course on STDs and HIV/AIDS prevention (8-11 October, 1990), with the purpose of equipping them with the knowledge and concern to return to their groups and educate others. They received hand-outs on the majority of topics presented on the majority of topics presented. AIDS information leaflets, and condoms and condom instruction leaflets.

- o In less than a week after completion of the course described above, two of the youths began to formally educate others in their group about STDs and AIDS

6. Firemen -

- o A one-day education course on HIV/AIDS and Hepatitis B prevention was developed specifically for firemen.
- o One hundred forty (140) firemen were educated in HIV/AIDS and Hepatitis B Prevention. This included 15 Airport Firemen, who come under the Ministry of Works, and 125 Firemen from the five fire stations in Swaziland, who come under the Ministry of the Interior. The original target of 210 to 225 firemen was incorrectly stated. The total number of firemen in Swaziland is around 155 or 160. Two one-day sessions were held at each fire station to cover the different shifts. Content of the training sessions included STDs and AIDS transmission and prevention and Hepatitis B transmission and prevention, with special emphasis on prevention in the fireman's work situation. AIDS information pamphlets, Hepatitis B hand-outs, and condoms and condom instruction leaflets were distributed to all firemen.
- o Brief follow-up by Project disclosed that firemen are not being provided with disinfectants, gloves, and other risk-reducing supplies and equipment. Project HOPE intends to provide an adequate supply of gloves for these workers.

7. Shebeen Owners -

Shebeen owners were one of the original target groups. Although they are a high-risk group, they were selected for elimination when the number of target groups was reduced in an effort to make the Project more feasible. Since one group of shebeen owners, at Siphofaneni, had already been contacted to explore the feasibility of CBD condom distribution, they were retained for follow-up activities (See Appendix 12 for Report of Shebeen Owners.)

- o Discussions with Tinkundla, (i.e., traditional government infrastructure), were held to get their cooperation in bringing together the Shebeen owners in the Siphofaneni area for discussions on STDs and HIV/AIDS prevention.
- o Thirty-three (33) shebeen owners (26 women and 7 men) were organized for a one-day education session on HIV/AIDS awareness in April, 1990. The Clinic Nurse from Siphofaneni participated as a resource person for the session. Seven of the 33 shebeen owners agreed to

promote and distribute condoms. One of the seven was already a community-based distributor (CBD) with the FLAS CBD programme.

- o A follow-up visit to Siphofoneni was made in May, 1990 to find out if the shebeen owners were or had been:
 - Educating others about HIV/AIDS,
 - Promoting condoms,
 - Distributing condoms.

Seven shebeen owners were contacted during the visit. According to the Clinic Nurse, some of the shebeen owners had been going to the clinic to replenish their supplies of condoms.

- o A visit to the Clinic Nurse in August, 1990 disclosed the discouraging information that shebeen owners had stopped coming to the clinic for more condoms. A possible explanation for this is that the women may have expected an incentive for doing condom distribution, especially since one of the shebeen owners is an 'official' CBD who receives a small stipend for distributing condoms. The issue of incentive shall be discussed with the shebeen owners

8. Additional Educational Materials Developed -

In addition to the education and training curricula, Focus Group Discussion instruments, AIDS Counseling Manual, and hand-outs prepared for the courses mentioned above, there were other materials developed. These include:

- o The first video on AIDS made in Swaziland. The video, "Kenub Uteza Bajywe" is in SiSwati and is 32 minutes long. The English screenplay is attached as Appendix 17. The script was written and performed by the Siphila Nje Drama Society and videotaped and edited by Project staff. A second screenplay is being completed which is scheduled for videotaping in November, 1990. This video was first shown, approximately 30 times, at the FLAS/Project HOPE stand at the 1990 Swaziland International Trade Fair. It is estimated that close to 1,000 people saw it during the 10 days of the Fair. It is very popular and the Project has received numerous requests from schools, Ministry of Health, NAP, WHO, churches and youth organizations for copies of the video.
- o A sound recording on tape cassette of a Swazi person with AIDS. This person was the client of the Project Counseling Officer and had just decided to publicly admit that he had AIDS in an effort to educate and warn others about the disease. Unfortunately, he died soon after the tape was made. The tape is in SiSwati and admonishes youths to protect themselves against AIDS by

what's done with the tape?

reducing their high-risk behavior. It is being transcribed into English. The IEC Action Group has requested copies of the tape for all their member organizations. The tape represents the first recording in Swaziland of a person with AIDS.

Materials not developed by the Project, but used frequently include:

- o The leaflet "How to Use a Condom", developed and produced by FLAS for the Family Planning Clinics.
- o Several leaflets on AIDS developed and produced by ManTalk. These include both English and SiSwati versions of "Is This Your Attitude to the Condom?", "A Word to the Ladies," "AIDS, the Test: Yes or No?", and "AIDS and Your Job".

Samples of these educational materials are in Appendix 13

9. Other Key Project Activities -

- o Participation in Trade Fair activities with FLAS. The annual Swaziland Trade Fair is an important occasion for government, NGOs, and private businesses. It is a 10-day event. This year it was held from 31 August through 9 September. FLAS invited the Project to share its stand and the Project accepted. Several planning sessions occurred in which it was decided that the activities for the Project for the Trade Fair include:
 - Piloting an STDs and AIDS Helpline (Appendix 12),
 - Screening a SiSwati video on AIDS to be produced for the Trade Fair,
 - Distributing a pocket 8-month calendar with an AIDS message (6,000 were distributed),
 - Providing STDs and AIDS counseling and information
 - Holding an AIDS Quiz with prizes for the winners,
 - Assisting in a puppet show on STDs and AIDS

In addition, to these specific Project activities, FLAS sponsored the schools traditional dance and song (Sibhaca and Ummiso) competitions. The songs, although traditional in style, were modern in message. Family Planning, HIV/AIDS Prevention, breastfeeding, and avoiding teenage pregnancies were the main messages. Approximately 3,000 people watched the Sibhaca and Ummiso competitions. Family Planning films and videos were shown, IEC leaflets distributed, condoms and "How to Use a Condom" leaflets were available. (10,100 condoms were distributed during the Trade Fair.) The

FLAS/Project HOPE stand won 2nd Place at the Trade Fair.

- o Educational talks and presentations on HIV/AIDS, at the request of FLAS, community groups, the NAP, and the Health Education Unit/ MOH These include:

GROUP	TOPIC	NO. PARTICIPANTS
1. FLAS "Youth Group"	Gen. info on HIV/AIDS	88
2. Mbabane nurses	Counseling HIV/AIDS	7
3. Nurse Educators	Counseling HIV/AIDS	33
4. Community Project	General Information on AIDS	29
5. Prison Officers	Counseling HIV/AIDS	40
6. St. Michaels Girls	General Information on AIDS	86
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Some of these groups expressed a desire to pass on the information they gained to others and have requested assistance from the Project in doing so. Their requests are referred to the Health Education Unit for consideration.

- o The Project invites the mass media to attend all of its activities, as appropriate, both to report on them and to increase the knowledge and understanding of the mass media personnel regarding AIDS. The policy has helped in increased coverage and increased accuracy of reporting on STDs and HIV/AIDS. The Project also serves as a technical resource for mass media and shares current articles on AIDS with them
- o A two-day Training Course for Counseling and Education for the Prevention of AIDS was facilitated by Project HOPE HIV/AIDS Program Coordinator during her visit in early 1990. The targeted participants were FLAS staff, Project staff, Project HOPE non-HIV/AIDS staff, ManTalk staff, Catholic youth representatives, and CARE International staff representative. There were seventeen (17) participants.
- o A small survey was conducted (January-August, 1990) on outpatients at one of the main hospitals in Swaziland (Raleigh Fitkin Memorial Hospital) for whom HIV tests were requested. The purpose of the survey was to better identify the peri-test counseling needs, in terms of

caseload and estimated recommendation for a full-time HIV/AIDS Counselor at each of the major health service facilities in the country. The findings were:

- Between 2-4 HIV tests were requested weekly in January and constantly increased to between 22-35 per week in August.
- Of 350 HIV tests done, 35 (10%) tested positive.
- None of those patients who were tested received peri-test counseling and none returned after being told they were positive.

The conclusion is that there is ample need to justify a full-time HIV/AIDS Counselor in each of the major hospitals in Swaziland. Each of the major hospitals has trained counselors, but they are not being freed from their other nursing duties in order to utilize their counseling skills.

B. Project Interactions:

1. The Project has interacted with the target community as reported and has received feedback on the interventions described in this report.
2. The Project collaborated with all HIV/AIDS prevention efforts in the country (See list of participants and resource persons in all training and education activities of the Project.) In addition, by being a member of the NAP IEC Action Group, the Project keeps all other organizations and institutions with HIV/AIDS Prevention efforts informed of Project activities, and vice versa.
3. Influence of the Project on other Project HOPE health/development projects in Swaziland include:
 - Participation by the Project Coordinator of the Nazarene Nursing College in the two-day Training Course for Counseling and Education Prevention of AIDS, and the development of the HIV/AIDS Training Curriculum for Nursing Students.
 - The nursing students of the Nazarene Nursing College developed and performed a drama about AIDS.
 - Inclusion of two tutors from the Swaziland College of Technology (SCOT) as participants in the AIDS Counseling Training Course. The Bio-Medical Engineering Project is based at SCOT.

C. Progress in building the sustainability of the Project's activities and/or effects include:

1. The general public now associates HIV/AIDS prevention with FLAS, in addition to Family Planning. ^{— HOW DO WE KNOW THIS} the

connection is progressively reinforced, as reflected recently at the 10th Anniversary Celebration of FLAS. Each honored guest who made a speech praised FLAS for their efforts in Family Planning and HIV/AIDS Prevention, including the Minister of Finance. He encouraged FLAS to continue to expand their HIV/AIDS prevention efforts and he encouraged the Government to appropriate funds from its budget to support FLAS efforts.

2. The counseling training and associated activities have been completed. The NAP, in collaboration with the Project, plans to coordinate a counseling system in the country.
3. Sebenta is committed to developing and introducing a new course on STDs and HIV/AIDS Prevention. Sebenta already has assumed 'ownership' of its HIV/AIDS activities.
4. The KABP Survey was undertaken by the Social Sciences Research Unit of the University of Swaziland. Thus, it is a local institution which has increased its experience and competency in implementing a national AIDS survey. They would be able to undertake a follow-up KABP survey or other AIDS-related surveys requested by the NAP.

D. Constraints

1. There is the need for an additional KABP survey to be conducted to indicate if and to what extent interactions are being successful in obtaining their objectives. Funds are being requested from HAPA to finance this activity.
2. Prior consultation with Sebenta was not undertaken in drafting the Action Plan. As such, the activities planned for Sebenta needed to be modified to better conform with Sebenta's normal approach. This is as follows:
 - Educate Field Operations staff and Headquarters staff on the new topic.
 - In a Writer's Workshop, generally held once annual mid-year, develop the content of the Student Primer and Teacher's Manual for the new course and pre-test the materials.
 - Train Sebenta instructors in teaching the new course.
 - Introduce the new course in February when Sebenta classes resume.

The Project is following this approach for Sebenta and it is working well. However, the schedule of Sebenta activities has had to be changed to coincide with the Sebenta work calendar. It also results in more time and resources required from Project staff.

3. Completion of planned training of trainers (TOT) sessions for non-school-going-youths is behind schedule. The original plan was to gain access to this target group through the Swaziland Youth Brigade, the Boy Scouts Association and the Girl Guides Association. The problem is both in and out of school youths are represented in the membership of these organizations. The logistics of the population and accompanying evaluation difficulties present a viable rationale for redefining the work done with non-school-going-youth.

Therefore, it is recommended that only those youth organizations having representatives educated/trained in the Sebenta Training Course (October, 1990) be followed and have their AIDS prevention activities technically supported by the Project. The youth organizations will be responsible for organizing and funding their own activities. Project staff will give moral and technical support, and assist in monitoring and evaluation of their AIDS prevention activities.

III WORKPLAN

A Summary of Project's Work Plan for the coming year:

1. KABP
 - a. Complete corrections and modify interpretations of results according to corrections made by November, 1990.
 - b. Produce Final Report of KABP and distribute to all appropriate parties by early December, 1990.
 - c. Discuss findings in meeting with all relevant parties in order to identify those key findings to be broadly disseminated and used for education and planning purposes by mid-December, 1990.
2. Counseling
 - a. Complete support visits to all trained counselors by December, 1990.
 - b. Hold quarterly regional counselor meetings.
 - c. Hold bi-annual national counselor meetings and workshops to exchange information and experiences and identify needs and support required, including additional training.
 - d. Technically assist NAP to establish an AIDS Helpline to be operated out of the NAP Office in Mbabane, as soon

- as a full-time counselor is attached to their staff.
 - e. Technically assist FLAS to establish an STDs and AIDS Helpline at the FLAS Family Planning Clinic in Manzini, to be coordinated with the NAP AIDS Helpline.
 - f. Hold in-service counselor training courses, with technical assistance from CEDPA, in the first half of 1991.
 - g. Train nursing assistants and office assistants from the three FLAS Family planning Clinics.
 - h. Regularly monitor and evaluate counseling activities and provide feedback to the counselors.
3. Sebenta
- a. Assist in organizing Writers Workshop and serve as technical resource in producing Student's Primer and Teacher's Manual on STDs and HIV/AIDS Prevention in November, 1990. Pre-test the material 11-12/90.
 - b. Collaborate with Sebenta Field Operations staff in training Sebenta instructors in the new course in 1/90.
 - c. Introduce the new course (number of classes to be determined by Sebenta) in February, 1990.
 - d. Design and develop monitoring and evaluation system for the course in February/March 1991.
4. Traditional Healers
- a. Complete analysis of Focus Group Discussions data by end of October, 1990.
 - b. Jointly with the THO revise the Training Curriculum Draft according to FGD results November, 1990.
 - c. Train twenty (20) Traditional Healer Promoters and Field Officers in HIV/AIDS prevention in December, 1990.
 - d. Traditional Healer Promoters to introduce AIDS-safe practices into their own professional practice by January, 1990
 - e. Field Officers to be trained in utilizing the supervisory checklist, which also has the potential of serving as a monitoring tool.
 - f. Regularly analyse data from the supervisory checklist.
5. Shebeen Owners
- a. Delegate the follow-up of the Shebeen Owners in Siphofaneni to the FLAS IEC Unit member of staff who is responsible for the FLAS Community Based Distribution of Condoms Project.
 - b. Discuss approaches to incentives.
6. Fireman
- Delegate the follow-up of Firemen to the Swedish Social Welfare student whom the Council of Swaziland Churches has offered to the Project for four weeks of volunteer work in HIV/AIDS Prevention during December, 1990. She

YOUTH ??

will be supervised by the Project Education Officer.

The Project's main areas of focus for the second year will be those major activities begun in the first year, namely:

- Counseling - support, follow-up, and additional training;
- Sebenta HIV/AIDS prevention activities; and
- Training and follow-up of Traditional Healers

B Additional training for Project staff.

1. FLAS IEC staff

- a. increase and improve interpersonal communications skills, including general counseling skills, and
- 277 b. acquire skills in video production techniques, including video editing.

2 Project staff

- a. increase and improve counseling skills, especially how to develop a strong support system for counselors. -7
- b increase and improve practical information management knowledge and skills, and L7
- c. increase and improve skills in Focus Group Discussion methodology

In the coming year CEDPA will be providing the Project one more month of technical assistance in counseling. The Project will continue to identify those areas of counseling which are needed most, so that the CEDPA consultant can focus on them.

Computer Support Consultants in Manzini or the Research Assistant attached to FLAS by Lutheran World Service or other competent resource person(s) could be contracted short-term to train Project staff in information management skills. L7

The HAPA Grants Support Workshop in Harare will address FGDs and HOPE Center is sending additional materials on FGD methodology.

The Project Coordinator has begun to train FLAS IEC staff in basic video production skills. Time to schedule more sessions will be found.

C. BUDGET (see attached pages 21-22)

MPR Form A Current Budget

The People-to-People Health Foundation, Inc /
PVO/Project HIV/AIDS Prevention in Africa Country Swaziland

Part I FIELD BUDGET

	YEAR ONE (AID/PVO) (expended)	YEAR TWO (AID/PVO) (projected)	TOTAL (AID/PVO)
<u>A. PROCUREMENT</u>			
1. Equipment	0/ 38,897	1513/ 487	1513/39384
2. Supplies	0/ 3,955	2551/ 0	2551/ 3955
3. Services (excluding evaluation)	0/ 0	0/ 0	0/0
4. Consultants			
Local	13,675/0	15416/ 0	19,091/0
External	0/ 5,206	10,000/0	10,000/5206
Subtotal Procurement	13,675/48,058	19,480/ 487	33,155/48,545
<u>B. EVALUATION</u>			
1. Consultants	0/0	0/2,500	0/2,500
2. Other	0/0	0/6,222	0/6,222
Subtotal Evaluation	0/0	0/8,722	0/8,722
<u>C. PERSONNEL (list each key position and number of person-months separately)</u>			
1. Health personnel.			
2. Administrative.			
3. Other			
Subtotal Personnel	72,397/8,899	44,875/35,850	117,272/44,749
<u>D. TRAVEL/PER DIEM</u>			
1. In-country	2,385/0	48,217/0	50,602/0
2. International.	40,237/0	4,766/5,234	45,003/5,234
Subtotal Travel/per diem	42,622/0	52,983/5,234	95,605/5,234

The People-to-People Health Foundation, Inc /
 PVO/Project/Country HIV/AIDS Prevention in Africa/Swaziland

	YEAR ONE (AID/PVO) (expended)	YEAR TWO (AID/PVO) (projected)	TOTAL AID/PVO)
<u>E OTHER DIRECT COSTS</u> (rent, utilities, maintenance, printing, etc)	16,005/0	23,075/0	39,080/0
<u>F. SUBTOTAL FIELD COSTS</u> (Parts A through E)	144,699/ 56,957	140,413/ 50,293	285,112/ 107,250
<u>G. OVERHEAD ON FIELD COSTS</u> (x 55 %)	26,169/0	19,570/3,033	45,739/3,033
<u>H TOTAL FIELD COSTS</u>	170,868/ 56,957	159,983/ 53,326	330,851/ 110,283
<u>PART II HEADQUARTERS BUDGET</u>			
<u>A. DIRECT HEADQUARTERS COSTS</u>			
Key personnel (list).			
Other (list)			
Subtotal Direct HQ Costs:	11,248/3,750	9,748/3,249	20,996/6,999
<u>B HQ COSTS ATTRIBUTABLE TO FIELD PROJECT (list):</u>			
Subtotal HQ/Field Costs.	1,360/453	9,560/3,187	10,920/3,640
<u>C SUBTOTAL HQ COSTS (A+B)</u>	12,608/4,203	19,308/6,436	31,916/10,639
<u>D. OVERHEAD, HQ COSTS(x55 %)</u>	22,109/7,369	21,745/7,249	43,854/14,618
<u>E TOTAL HEADQUARTERS COSTS</u>	34,717/ 11,572	41,053/ 13,685	75,770/25,257
<u>PART III. GRAND TOTAL</u>			
<u>A GRAND TOTALS, FIELD + HQ</u> (Part I-H + Part II-E)	205,585/ 68,529	201,036/ 67,011	406,621/ 135,540

C.2 Budget Narrative

a. MAJOR CHANGES

The original budget included 12 person-months of an AIDS Coordinator. Because of the magnitude and complexity of this project, we have increased the AIDS Coordinator's time to 24 person-months. This increase affects indirect costs as well. Change of staff has resulted in higher relocation expenses than originally budgeted. Other direct costs are less than originally projected.

b. CAN THE PROJECT MEET ITS OBJECTIVES WITH THE REMAINING FUNDING

The Swaziland budget is redone projecting an increase of \$43,874 over the original budget (AID \$33,621/HOPE \$10,253). We expect to ask for a transfer of AID funds from the Malawi budget to cover Swaziland and thus keep the total AID funding for both of these projects at \$724,000 through the period 9/19/91.

In addition the DIP (pg. 16) presents the need for at least one other KAPB survey to indicate if and to what extent interactions are being successful in attaining their objectives. Additional funds of \$22,000 are estimated to conduct this survey using the Social Science Research Unit at the University of Swaziland.

IV OTHER COMMENTS

- A. The Traditional Healers Organization (THO) is predominantly a one-man organization. The Head of the THO frequently changes or amends his decisions regarding Project activities. This results in many delays, much time spent re-negotiating and arriving at mutually acceptable terms, and concern and doubt raised in Project staff about the potential effectiveness of the THO targeted activities.

The Project strongly recommends that the Traditional Healer Promoters, rather than the Field Officers, be trained in the coming year. The Field Officers are likely to be very transient in the future because they receive no salary, are freshly out of school, and more importantly, because they are not traditional healers themselves, while the Promoters are. The Field Officers, who are actually field recruiters, have themselves expressed their intent to look for more permanent, paying jobs.

It is thus anticipated that the Project will train twenty (20) Traditional Healer Promoters. A more detailed Work Plan, taking into consideration the actual distribution of Traditional Healer Promoters, where trainings are to be held, design of a monitoring system and realistic

supervisory system, including the drafted supervisory checklist, will be drawn up by the end of 1990.

B. The Project Action Plan, regarding HIV/AIDS counseling activities, calls for training of 60 counselors and the establishment of an HIV/AIDS Counseling Centre within a FLAS facility. The Project has felt obligated to pursue establishment of counseling activities beyond the single activity of training. Training is only the first step. After training, the new counselors require much supportive follow-up:

1. They need to be visited at their places of work.
2. Their accomplishments need to be made known to increase support for the services they provide and so they can be encouraged to continue. This includes strengthening of their reporting system.
3. Their constraints need to be identified and addressed so that their accomplishments can be increased and their morale, enthusiasm, and commitment maintained.
4. They need to come together as a group to exchange information and experiences and support one another.
5. Their additional training requirements need to be identified and met.

None of these training follow-up activities were planned, since the Project was requested by the NAP simply to train 60 counselors. However, they are essential activities and need to be done. In addition, the prevalence of HIV infection has significantly increased, more and more blood samples are being requested by medical services for HIV testing, and more and more people are becoming knowledgeable about AIDS and its association with STDs (which are very prevalent). These and other factors have resulted in a growing recognition of the importance and need for counseling. As mentioned earlier in this report, the NAP is preparing for a full-time counselor position in the NAP Office to nationally coordinate counseling activities.

The AIDS Task Force has recommended that the Project be asked to assist in the planning, coordination, and establishment of these activities. The Project and the NAP representatives need to meet to draw up the plan and time schedule. Thandi Shongwe, the Project Counseling Officer, has been suggested as the logical person to organize national counseling activities. The possibility exists that she could be seconded to the NAP for this purpose and then be employed as the NAP Counselor as soon as that position is authorized, which could well be before the Project ends.

This conclusion has been arrived at independently by both the Project and the AIDS Task Force. Formal discussions, decisions, and details need to be made. By working out of

the NAP office the Project Counseling Officer would greatly assist the NAP to establish on-going AIDS counseling activities, and simultaneously implement all of the Project's targeted counseling activities. This would obviously insure sustainability of counseling activities. Project support of FLAS counseling activities would not be affected. In fact, it would guarantee coordination and mutual support of FLAS counseling activities with those of the NAP. The only drawback would be that the Project would be understaffed in other activities to which Mrs. Shongwe would have contributed. However, solutions could be identified.

- C The collaboration, cooperation, and support among all agencies working in HIV/AIDS Prevention in Swaziland is unusually strong and evident. The collaboration and cooperation between the partners of the Project HOPE/FLAS HIV/AIDS Prevention Project is also unusually strong and evident. These two factors contribute tremendously to the effectiveness and efficiency of HIV/AIDS prevention activities.

APPENDIX 1
DRAFT OF NATIONAL KABP SURVEY REPORT

Appendix 1

DRAFT

KNOWLEDGE, ATTITUDES, BELIEFS AND PRACTICES ON AIDS

JULY 1990

Prepared for Project Hope
and
The Family Life Association of Swaziland

SOCIAL SCIENCE RESEARCH UNIT (SSRU)
University of Swaziland

Preface

This report is a result of a survey carried out by the Social Science Research Unit (SSRU) for Project Hope and The Family Life Association of Swaziland (FLAS)

The report contains an outline of the research methodology used in selecting areas to be included in the survey (Chapter 1), Chapter 2 contains a brief discussion of results of selected variables, In Chapter 3, is the conclusion, a collection of tables providing a summary of results can be found in the annex, A translated version of the questionnaire is attached at the end of the report

In this report, the main form of presentation of results is the collection of tables which appear in the annex. As such, the report does not contain a detailed discussion of the results and their implications. The report is intended for use by Project Hope and the FLAS as a guideline for their educational programme on AIDS prevention.

Acknowledgements

The staff of the Social Science Research Unit (SSRU) is acknowledged for professional assistance and otherwise during all stages of the survey

Acknowledgements are also in order for the following people for their assistance

- Dr Tom Kenyon (Project Hope)
- Ms Agatha Lowe (Project Hope)
- Mrs Thandi Shongwe (Project Hope)
- Ms Thandi Dlamini (Project Hope)
- Mr Tom Fenn (FLAS)

The survey team of enumerators, data coders and punchers are also acknowledged for their efforts in collecting data and punching it in for analysis

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from spouse/partner, if any) in the last four weeks, marital status and age

Table 6 22 Percent distribution of respondents who have had one or more sexual associates (apart from spouse/partner, if any) in the last four weeks according to regularity of condom use with sexual associates, by sex of respondent and coital frequency with associates in the last four weeks

Table 6 23 Percent distribution of currently married respondents who had sexual intercourse with partner and with sexual associates in the last four weeks, according to regularity of condom use with associates, by sex of respondent and by regularity of condom use with partner

Table 6 24 Percent distribution of female respondents who used condoms with sexual associates in the last four weeks according to regularity of such use, by source of condoms and decision to use

Table 6 25 Percent distribution of all respondents who used condoms with sexual associates in the last four weeks according to regularity of such use, by source of condoms and decision to use

Table 6 26 Percent distribution of all respondents who used condoms with sexual associates in the last four weeks according to regularity of such use, by source of condoms and decision to use

Table 6 27 Percent distribution of male respondents according to summary of personal risk behaviour in the last four weeks by current marital status and current age

Table 6 28 Percent distribution of female respondents according to summary of personal risk behaviour in the last four weeks, by current marital status and current age

Table 6 29 Percent distribution of all respondents according to summary of personal risk behaviour in the last four weeks by current marital status and current age

Table 6 30 Percent distribution of male respondents according to summary of personal risk behaviour in the last four weeks by summary of personal risk behaviour in the last six months

Table 6 31 Percent distribution of female respondents according to summary of personal risk behaviour in the last four weeks by summary of personal risk behaviour in the last six months

Table 6 32

Percent distribution of all respondents according to summary of personal risk behaviour in the last four weeks by summary of personal risk behaviour in the last six months

List of Figures

Figure 1 Map of Selected Areas

Chapter 1

Methodology

The survey on Aids in Swaziland was carried out between the months of March through June 1990. It was commissioned by Project Hope and The Family Life Association (FLAS) to aid them in their Aids educational programme. The main purpose of the survey was to obtain baseline data on the pattern of knowledge, attitudes, beliefs and practices of the Swazi people towards the AIDS epidemic. The target population was the sexually-active group and thus included females aged between 15 to 49 and males between 15 to 59. A sample size of 2000 was deemed to be adequate for purposes of including both sexes, over the four regions of the country by rural/urban classification.

(1) Sample Selection

According to the Population Census of 1986 the target population is 309,429 of which 52% are females and 48% are males. Based on these figures, therefore, the sample of 2000 interviewees would be divided accordingly thus resulting in 1040 (52%) females and 960 (48%) males to be interviewed. The following table shows the distribution of the 2000 by sex, region and rural/urban classification. Such a distribution is based on the census's distribution of the target population.

Table 1 Distribution of Sample by Sex, region and rural/urban classification

Sex	Hhohho		Manzini		Shiselweni		Lubombo		Total	
	Rur	Urb	Rur	Urb	Rur	Urb	Rur	Urb	Rur	Urb
F	191	90	193	109	217	11	165	64	766	274
M	163	87	156	122	169	13	148	102	636	324
Total	354	177	349	231	386	24	313	166	1402	598

The selection of areas to be included in the study, was done by means of the simple random sampling technique. In each region, two cluster areas were randomly selected for rural interviews and two urban areas were also randomly selected for urban interviews. Such selected areas can be seen in Figure 1.

Within each cluster, homesteads/households to be interviewed were randomly selected. The survey team consisted of 19 enumerators. Upon arrival in an area within a selected cluster, the survey team was split into two groups. Each team pursued a different direction from the central point. Homesteads/households were selected by skipping every other homestead/household after the first one selected. At each homestead/household, only one person was interviewed. The Household form, which is part of the questionnaire, sought answers on particulars such as age and sex of all occupants of the household. The aim being to establish members of the household who were eligible to be interviewed. From the list of eligible occupants, one person was then randomly selected to be interviewed. Table 2 shows the resultant

distribution from the actual survey

Table 2 Distribution of Sample by Sex, region and rural/urban classification

Sex	Hhohho		Manzini		Shiselweni		Lubombo		Total	
	Rur	Urb	Rur	Urb	Rur	Urb	Rur	Urb	Rur	Urb
F	191	84	192	107	217	9	159	64	759	264
M	159	86	140	97	169	10	148	98	616	291
Total	350	170	332	204	307	19	307	162	1375	555

Out of the initial 2000 interviews solicited, a total of 1930 interviews were completed. The non-response rate was 3.5%. Throughout the report, 1930 will be regarded as the sample size instead of 2000.

In view of the small number of questionnaires to be completed for the Shiselweni urban area (24), the Lavumisa urban area was excluded and all 24 interviews were conducted in the Nhlanguano urban area.

(11) Instrument for collecting data

A Standard World Health Organization (WHO) questionnaire was used as the main instrument for collecting data. The questionnaire was translated into Siswati to facilitate easier interpretation of questions asked. An identical questionnaire was used for both sexes and for both rural and urban areas. Each questionnaire was 34 pages long and a proper interview took an average of 45 to 60 minutes to complete. Each questionnaire was divided into 12 sections, each dealing with a specific topic as it may relate to the Aids disease. The different sections were as follows:

<u>Section</u>	<u>Description of topic</u>
1	Household form/community characteristics
2	Individual characteristics
3	Awareness of AIDS
4	Knowledge on AIDS
5	Sources of information about AIDS
6	Beliefs, attitudes and behaviour
7	Knowledge of and attitudes to condoms
8	Sexual practice
9	Injection practice
10	Locus of control
11	Drug Abuse
12	Drinking Habits

Information was collected on all sections. In this report only select, critical variables, contained in sections 2 to 8, will be discussed. A complete, translated version of the questionnaire can be seen in the Annex.

(111) Schedule of Activities

During the week of March 6th to 9th, 23 enumerators were trained for the survey. The translated version of the questionnaire was pretested on March 8th. A total of 43 out of 46 questionnaires was completed during the pretest. The non-response rate was, therefore, 6.5%. It transpired during the pretest that it was not absolutely necessary to restrict enumerators to interview respondents of their own sex. During the actual survey, this restriction was, however, maintained in order to keep a close count on the numbers of each sex interviewed per day. After the pretest, minor adjustments were made in the questionnaire.

Data collection began March 19th and was completed in April 21st. One week was spent in each region, with rural interviews being administered during the week and urban interviews during week-ends. Data coding and processing began on April 9 and was completed on May 11.

2

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CHAPTER II

SUMMARY OF RESULTS

A PROFILE OF RESPONDENTS

Table 3 is a breakdown of respondents by selected characteristics. Of the respondents, 47% were males and 53% females. For both sexes, the highest number of respondents are in the age group 25-39. The most prevalent religious group is the Protestant group (42%) followed by Zionists (33%). With regard to education levels, a higher percentage of female respondents have gone as far as secondary school (over 30%) than male respondents (over 29%). A much lower percentage of females has gone as far as High School (14%) compared to Males (23%). Over 70% of respondents were in rural areas.

SECTION 1. Knowledge and Beliefs About AIDS

In this section the knowledge level of the respondents was solicited in terms of how much is known about AIDS, in particular its transmission, and also what their beliefs are in relation to the transmission of the disease. The results on this aspect are presented in Tables 1.1 through 1.15.

From Table 1.1 results show that, for all categories, about 50% of the respondents professed to know 'just a little' about AIDS and about 4% said they knew a 'great deal' about the disease. The level of self-reported knowledge is only slightly influenced by the level of media exposure. About 41% of respondents with a high media exposure scale claimed to know 'just a little about AIDS. It can therefore be inferred that irrespective of the level of media exposure, most respondents seemed to feel that they knew very little about the disease. It transpires in subsequent tables that most respondents are, in fact, knowledgeable about types of people most likely/most unlikely to get AIDS (Tables 1.12, 1.13), whether AIDS is curable or not (Table 1.14), ways of avoiding transmission (Table 1.17), and specified causes of AIDS (Table 1.8). It is also true to say that though the level of knowledge about AIDS is substantial with respect to the variables already mentioned, it is inadequate with respect to other variables. In Table 1.4, 53% of male respondents and 49% of female respondents believe that AIDS may be transmitted through a mosquito bite. Likewise, 40.2% of all respondents who have heard of AIDS believe that it may be transmitted through kissing. Further, in Table 1.7, 89.8% of respondents who do not believe that AIDS may be asymptomatic, believe that it can be transmitted by an asymptomatic sufferer.

In general, the low percentage of respondents who believe that AIDS is curable is low (around 4%, Table 1.14). It is worth noting, however, that of the respondents who believe that AIDS is curable,

35% thought that 'some' of the AIDS sufferers will die and another 35% thought that 'all' AIDS sufferers will die. This clearly indicates that there exists 'knowledge gaps' in respondent's minds about AIDS transmission and its curability.

Table 1 2 is the table which gives a breakdown of those respondents who have never heard of AIDS or said they knew nothing about the disease. With respect to religion, the Zionist group showed the highest proportion of respondents who have not heard of AIDS (30.7%), exclusive of the 'No religion' group with 35%. AIDS unawareness seems to be linked to the level of education. Those with no schooling showed the highest percentage of unawareness (54%) whilst those who had completed high school had the least percentage of unawareness. Rural area respondents had a higher percentage of unawareness (30%) compared to urban area respondents (20%)

SECTION 2 Sources of Information about AIDS

Questions asked in this section pertained to sources of information about AIDS. Results are presented in Tables 2.1 through 2.6

In Table 2.1, results show that 81% of those who have heard of AIDS mentioned the radio as a source of information about general health matters. The second most mentioned source of information about general health matters is the clinic/health centre (47%). Likewise, amongst respondents who had not heard of AIDS, the radio and Clinic/Health Centre ranked high as information sources about general health matters.

In Table 2.2, the majority of respondents who have heard of AIDS (89%) also mentioned the radio as the main source from which they learned most about AIDS. The Clinic/Health Center was, again, the most mentioned (3%).

The most preferred source of information about subjects like AIDS is the radio (91%), followed by the Clinic/Health Centers (37%), then newspapers/magazines (30%) and television (19%). These results can be seen in Table 2.5.

In Table 2.6, it is significant to note the high percentages of respondents who never discuss AIDS either with family/relatives or with friends. Amongst those who have heard of AIDS, 52% said they never discuss AIDS with their family or relatives and 46% said they never discuss AIDS with their friends. This shows that whilst about half of those who have heard of AIDS regard AIDS as an important issue, warranting some discussion, the other half do not regard it as such.

Table 2.7 indicates that, overall, English is the language most preferred for purposes of receiving messages (76%) followed by Siswati (23%). The Siswati language was much preferred by respondents with a low media exposure scale, even more so than English.

SECTION 3. Perception of Risk and Behavioural Change

Tables 3.1 through 3.12 present results pertaining to respondents perceived risk of contracting the AIDS disease and whether or not AIDS can be avoided by changes in behaviour.

In Table 3.1, the results show that 55% of all respondents spontaneously mentioned AIDS as the most serious disease facing the country. Whilst this may be regarded as a high proportion, it is also indicative of the 'perceived lack of threat' of the disease, in this country by the other 45% of respondents who did not spontaneously mention AIDS as the most serious disease facing the country.

In Table 3.2, a higher percentage of females (who have heard of AIDS) thought that AIDS was a serious current threat to the health of the local community than their of the local community than their male counterparts. Amongst females, 45% thought AIDS was a serious threat as opposed to just 'some threat' (7%). Amongst males, an equal proportion (about one third) thought AIDS was either a serious threat or some threat.

Regardless of how much a threat AIDS is perceived to be currently, most respondents thought that it was a serious threat in the future (Table 3.3). It is difficult to reconcile the opinions on AIDS currently and in the future. The fact that AIDS is 'suddenly' perceived as a serious threat in the future when it was not so perceived currently, may only be a consequence of a simple logical view that any disease which is presently not curable can only get more serious in the future.

Table 3.8 shows that about 20% of respondents who have heard of AIDS think that they are somewhat or very likely to get AIDS. The percentages, for all categories, are much higher amongst those respondents with 'some risk behaviour' (about 32%), than those with 'no risk behaviour' (about 18%). This would indicate some awareness on the part of the respondents about the positive relationship between risk behaviour and the likelihood of getting AIDS.

In Table 3.9 about 80% of all respondents who have heard of AIDS believe that AIDS can be avoided through behavioural change. In Table 3.11, it can be seen that about 90% of respondents who have heard of AIDS said that they had made changes in their lifestyles as a prevention against getting the disease. Consequently, in Table 3.10 about 63% of respondents who answered the question mentioned monogamous sexual practice as a type of behavioural change to avoid getting AIDS, followed by the practice of condom usage (15%) and abstinence (12%). This shows that, to a large extent, respondents are relying on the trustworthiness of their partners to be monogamous than the use of condoms as a method of prevention against AIDS.

SECTION 4 Opinions on Treatment of AIDS Sufferers and AIDS Screening

Questions asked in this section related to respondents' opinion about the role of government in preventing the spread of AIDS, respondents' attitude towards taking a test for AIDS and the role of family, doctors, etc., once such results of the test were made available. Results on this aspect of the study are shown in Tables 4.5 through 4.7.

In Table 4.5, the most popular response to the question 'what steps can government take to prevent the spread of AIDS?' is that government should educate the people more about the disease (32%). The next most popular response was that government should find a cure for the disease (20%). Only a small percent of respondents were of the opinion that government is under any obligation to do anything about the disease (2%). This shows that most respondent sees the government as having a role to play in the prevention of AIDS by way of educational programmes.

In Table 4.7 40% of respondents who would like to know the results of an AIDS test also said they would like to inform their families themselves about the results. About 44% said they would like their doctor to inform their families. Of the respondents who said that they would not like to know the results of the AIDS test 76% did not want their families informed about the results.

SECTION 5: Knowledge of, and Attitude Towards, Condoms

Questions in this section were aimed at obtaining information about the respondents knowledge and use of condoms. The results are presented in Tables 5.2 through 5.8.

In Table 5.2 about 86% of all respondents have heard of condoms, whilst it is shown in Table 5.3 that only about 18% of all respondents have ever used condoms. In Table 5.4, condoms are also high on the list of methods of contraception which may be used as a way of avoiding getting AIDS. In this regard, 95% of respondents who answered this question mentioned condoms as a means of avoid AIDS, followed by abstinence (4%). This would suggest that respondent's awareness of condoms, though high, has not translated to high condom usage. The reason for this is not too clear. In Table 5.8, however, 52% of those respondents who had ever used condoms, agreed with the statement that 'condoms make sex less enjoyable'. Further, 41% of those who had never used condoms also agreed with the same statement. There were also high percentages of respondents who agreed with the statement that 'condoms can draft up into the womb or stomach of women'. These percentages were 54% of those who had ever used condoms and 44% of those who had never used condoms. It would seem that such misconceptions may contribute towards low usage of condoms.

SECTION 6: Sexual Behaviour

This section of the questionnaire sought respondents' sexual practices. The results are presented in Tables 6.1 through 6.32.

In Table 6.1, about 70% of all respondents had sexual intercourse in the last twelve months.

About 19% of total male respondents and 5% of total female respondents said they had one or more sexual associates in the last six months, apart from their regular partners (Tables 6.2 and Table 6.3 respectively). About 8% of total male respondents and 4% of total female respondents said they had one or more sexual associates other than their regular partners, in the last four weeks (Tables 6.15 and 6.16, respectively). This is indicative of the fact that there is a certain amount of casual sex taking place as people are involved in multi-partner instead of in monogamous relationships. The figures might even be higher if a longer period of time was considered.

The incidence of 'commercial sex' is very low as can be seen in Tables 6.6, 6.7, and 6.8. Such low figures should be viewed with caution as they may seem to suggest that 'commercial sex' does not occur to a large extent in the country. In general, the results captured with respect to this aspect of sexual behaviour are lower than expected. Many reasons could account for such low figures, among which would be the sensitive nature of the subject, itself, and also the time-frame referred to when the question was asked (i.e. 'in the last six months'). At the same time, one should not lose sight of the fact that 'commercial sex' does take place, despite the low figures presented here.

CONCLUSION

The study notes that though, in general, the level of knowledge about the transmission of the disease is moderate to high, it is still low in relation (a) specific modes of transmission, i.e. mosquito bites, kissing; (b) effective types of behavioural change as a means of avoiding contracting the disease, and (c) condom use.

The radio medium and clinic/health centre were high on the list of sources of information about general health matters and information about the AIDS disease in particular. This serves to highlight the importance of these two institutions as information sources. On a darker side, it is also apparent that other institutions have played a minor role in disseminating information about the disease. These are important institutions such as schools, the church, and the workplace amongst others. In addition, most respondents have indicated their wish for government to play a major role in educating the nation about the disease.

Condom usage is very low whilst condom awareness as a method of preventing pregnancy and protecting against AIDS is high. It may

be a further indication of the lack of seriousness with which the disease is perceived.

The low figures reported in Section 6 may suggest that a different approach be taken in soliciting answers pertaining to sexual behaviour and practices in the future.

The data in this report seeks to provide some guidelines about appropriate educational programmes which may help prevent the spread of AIDS in the country. The data also offers some guidelines for future surveys. In particular, future surveys should seriously consider the length of the questionnaire to be used so as to ensure the quality of results obtained

ANNEX

8004

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SWAZILAND
DENSITY OF POPULATION
1966

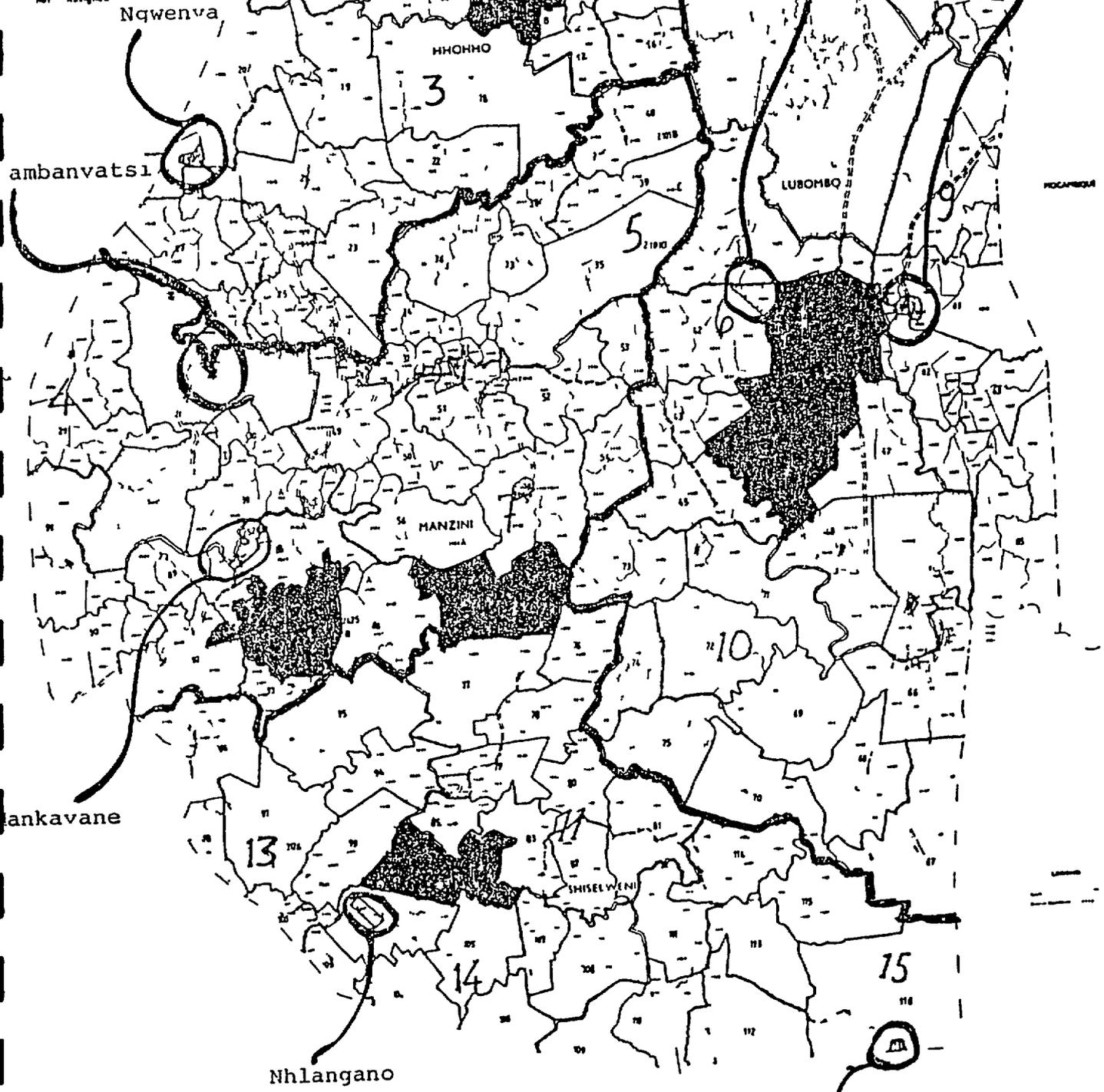
25

SWAZILAND
AGRICULTURAL CENSUS
1983 - 1984

(1-116) 4 kilometer Squares

(1-75) 5 percent Zone Boundaries

Not Assigned



Legend.

-  Selected urban clusters
-  Selected rural clusters

Lavumisa

TABLES

Table 3 Percent distribution of all respondents according to age, marital status and background characteristics by sex

Selected characteristics	Sex				Total	
	Male		Female			percent
		percent		percent		
Age						
14-19	210	23.2%	252	24.7%	462	24.0%
20-24	194	21.4%	253	24.8%	447	23.2%
25-39	325	35.8%	373	36.5%	698	36.2%
40+	178	19.6%	144	14.1%	322	16.7%
Total	907	100.0%	1022	100.0%	1929	100.0%
Current Marital Status						
Currently	347	38.3%	476	46.6%	823	42.7%
formerly	27	3.0%	65	6.4%	92	4.8%
Never	532	58.7%	481	47.1%	1013	52.5%
Total	906	100.0%	1022	100.0%	1928	100.0%
Religion						
Catholic	84	9.3%	108	10.6%	192	10.0%
Protestant	366	40.5%	461	45.1%	827	42.9%
Jion	263	29.1%	375	36.7%	638	33.1%
No religion	191	21.1%	79	7.7%	270	14.0%
Total	904	100.0%	1023	100.0%	1927	100.0%
Education level						
No school	208	23.0%	215	21.0%	423	22.0%
Primary	224	24.8%	323	31.6%	547	28.4%
Secondary	267	29.6%	334	32.7%	601	31.2%
Higher	204	22.6%	150	14.7%	354	18.4%
Total	903	100.0%	1022	100.0%	1925	100.0%
Locality						
Urban	291	32.1%	264	25.8%	555	28.8%
Rural	616	67.9%	759	74.2%	1375	71.2%
Total	907	100.0%	1023	100.0%	1930	100.0%

Totals differ

Table 4 Percent distribution of all respondents according to sex, age, marital status and background characteristics by whether they have heard of AIDS or not

Selected characteristics	Sex											
	Male						Female					
	Whether heard of AIDS or not				Total		Whether heard of AIDS or not				Total	
	Have heard of AIDS		Not heard of AIDS			percent	Have heard of AIDS		Not heard of AIDS			percent
		percent		percent				percent		percent		
Age												
14-19	182	39.4%	28	6.1%	210	45.5%	215	46.5%	37	8.0%	252	54.5%
20-24	177	39.6%	17	3.8%	194	43.4%	238	53.2%	15	3.4%	253	56.6%
25-39	272	39.0%	53	7.6%	325	46.6%	337	48.3%	36	5.2%	373	53.4%
40+	140	43.5%	38	11.8%	178	55.3%	115	35.7%	29	9.0%	144	44.7%
Total	771	40.0%	136	7.1%	907	47.0%	905	46.9%	117	6.1%	1022	53.0%
Current Marital Status												
Currently	302	36.7%	45	5.5%	347	42.2%	432	52.5%	44	5.3%	476	57.8%
Formerly	22	23.9%	5	5.4%	27	29.3%	45	48.9%	20	21.7%	65	70.7%
Never	447	44.1%	85	8.4%	532	52.5%	428	42.3%	53	5.2%	481	47.5%
Total	771	40.0%	135	7.0%	906	47.0%	905	46.9%	117	6.1%	1022	53.0%
Religion												
Catholic	76	39.6%	8	4.2%	84	43.8%	102	53.1%	6	3.1%	108	56.3%
Protestant	316	38.2%	50	6.0%	366	44.3%	414	50.1%	47	5.7%	461	55.7%
Zion	225	35.3%	38	6.0%	263	41.2%	325	50.9%	50	7.8%	375	58.8%
No religion	153	56.7%	38	14.1%	191	70.7%	65	24.1%	14	5.2%	79	29.3%
Total	770	40.0%	134	7.0%	904	46.9%	906	47.0%	117	6.1%	1023	53.1%
Education level												
No school	127	30.0%	81	19.1%	208	49.2%	150	35.5%	65	15.4%	215	50.8%
Primary	191	34.9%	33	6.0%	224	41.0%	291	53.2%	32	5.9%	323	59.0%
Secondary	251	41.8%	16	2.7%	267	44.4%	317	52.7%	17	2.8%	334	55.6%
Higher	199	56.2%	5	1.4%	204	57.6%	147	41.5%	3	8%	150	42.4%
Total	768	39.9%	135	7.0%	903	46.9%	905	47.0%	117	6.1%	1022	53.1%
Locality												
Urban	265	47.7%	26	4.7%	291	52.4%	240	43.2%	24	4.3%	264	47.6%
Rural	506	36.8%	110	8.0%	616	44.8%	666	48.4%	93	6.8%	759	55.2%
Total	771	39.9%	136	7.0%	907	47.0%	906	46.9%	117	6.1%	1023	53.0%

APPENDIX 2
KABP QUESTIONNAIRE

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OBSERVATIONS BY THE INTERVIEWER

No	Questions and filters	Coding Categories										
1	Was the spouse/regular partner also interviewed? If Yes, give their identification code	<table> <tr> <td>Yes</td> <td>1</td> </tr> <tr> <td>No</td> <td>2</td> </tr> </table> Initial of first name and number ---- ----	Yes	1	No	2						
Yes	1											
No	2											
2	How did the respondent react to this interview?	<table> <tr> <td>Seemed to enjoy it</td> <td>1</td> </tr> <tr> <td>Did not seem to either enjoy or dislike it</td> <td>2</td> </tr> <tr> <td>Seemed to dislike it</td> <td>3</td> </tr> </table>	Seemed to enjoy it	1	Did not seem to either enjoy or dislike it	2	Seemed to dislike it	3				
Seemed to enjoy it	1											
Did not seem to either enjoy or dislike it	2											
Seemed to dislike it	3											
3	How long did the interview last?	Minutes ---- ----										
4	Did this respondent have any problems in understanding questions so that you had to repeat or rephrase them?	<table> <tr> <td>No</td> <td>1</td> </tr> <tr> <td>Yes with a few questions</td> <td>2</td> </tr> <tr> <td>Yes with many questions</td> <td>3</td> </tr> <tr> <td>Yes with most questions</td> <td>4</td> </tr> </table>	No	1	Yes with a few questions	2	Yes with many questions	3	Yes with most questions	4		
No	1											
Yes with a few questions	2											
Yes with many questions	3											
Yes with most questions	4											
5	To what were those problems mainly due?	<table> <tr> <td>The difficulty of the Question</td> <td>1</td> </tr> <tr> <td>Respondents lack of Education</td> <td>2</td> </tr> <tr> <td>Respondents lack of skill in the language of the interviewer</td> <td>3</td> </tr> <tr> <td>Conditions under which the interview took place</td> <td>4</td> </tr> <tr> <td>Your difficulty in understanding the Respondents language</td> <td>5</td> </tr> </table>	The difficulty of the Question	1	Respondents lack of Education	2	Respondents lack of skill in the language of the interviewer	3	Conditions under which the interview took place	4	Your difficulty in understanding the Respondents language	5
The difficulty of the Question	1											
Respondents lack of Education	2											
Respondents lack of skill in the language of the interviewer	3											
Conditions under which the interview took place	4											
Your difficulty in understanding the Respondents language	5											
6	Was the respondent cooperative and willing to answer questions?	<table> <tr> <td>Quite cooperative</td> <td>1</td> </tr> <tr> <td>Mostly cooperative</td> <td>2</td> </tr> <tr> <td>Somewhat cooperative</td> <td>3</td> </tr> <tr> <td>Quite uncooperative</td> <td>4</td> </tr> </table>	Quite cooperative	1	Mostly cooperative	2	Somewhat cooperative	3	Quite uncooperative	4		
Quite cooperative	1											
Mostly cooperative	2											
Somewhat cooperative	3											
Quite uncooperative	4											
7	Which sections of the interview schedule posed most problems with this respondent?	Sections: _____ _____ _____ _____ _____										
8	Other observations.	_____ _____ _____										

APPENDIX 2

AIDS/KABP SURVEY

A: HOUSEHOLD FORM

NAME OF COUNTRY

NAME OF ORGANISATION

HOUSEHOLD/DWELLING IDENTIFICATION

001 Place Name

002 Cluster number

003 Household/Dwelling

004 INTERVIEW VISITS VISIT 1 VISIT 2 VISIT 3

Date

Interviewer

RESULT CODES *

Completed 1
No one at home 2
Household away for duration of survey 3
Dwelling vacant or address not a household 4
Dwelling not found 5
Refused 6
Postponed 7
Other (Specify) 8

Now I would like to get some information about the persons who normally live in your household or persons who are staying with you. (Age 14 + only to be listed.) List usual members as well as visitors who slept here yesterday

Ngitawutsandza kwati ngebantfu labahlala kulelikhaya nome lohlala nabo (kusukela kulaba nemnyaka lelishumi nane budzala) ungibalele baleli khaya kanye netivakashi lebetilele lapha ekhaya itolo.

Number	initial of First Name	Sex		Age	Usual Member?		Slept here last night		Elegibility
		M= Male	F= Female		Yes	No	Yes	No	
01	----	----	----	----	1	2	1	2	----
02	----	----	----	----	1	2	1	2	----
03	----	----	----	----	1	2	1	2	----
04	----	----	----	----	1	2	1	2	----
05	----	----	----	----	1	2	1	2	----
06	----	----	----	----	1	2	1	2	----
07	----	----	----	----	1	2	1	2	----
08	----	----	----	----	1	2	1	2	----
09	----	----	----	----	1	2	1	2	----
10	----	----	----	----	1	2	1	2	----

005 SUMMARY

Number of usual members aged 65	----
Number of usual members aged 15-64	----
Number of usual members aged 10-14	----
Number of eligible persons	----
Total number in household	----

Tick box for those aged 15-64 who are usual household members of visitors who slept here yesterday

B: COMMUNITY CHARACTERISTICS

No	Questions and Filters	Coding Categories		Skip To	
0006	Type of locality, urban or rural character	Large Town	2	-----0008	
		Small Town	3		
		Village	4		
	Luhlobo lwenzawo Lidolobha/emakhaya				
0007	Travelling time by typical means of transport to nearest large town	Hours	-----		
		Means of transport	-----		
	Sikhatsi lositsatsako ngenqola/ibasi kusuka lapho uhlatfa khona kuya edolobeni				
0008	Facilities available in community	in community		close by	
		Yes	No	Yes	No
	Tintfole emato kulesigodzi sakini				
	Umgwaco - All weather road	1	2	1	2
	umtfolomphilo - Health Centre	1	1	1	2
	Sibhedlela - Hospital	1	2	1	2
	Likhemisi - Pharmacy	1	2	1	2
	Sikolwa - School	1	2	1	2
	Indlu Yebhaysikobho - Cinema	1	2	1	2
	Sitolo/Emakethe-Trading Centre (Market)	1	2	1	2
	Liphosi/Lucingo - Public Telephone / Post Office	1	2	1	2
	Lisontfo - Church, Mosque, Temple etc.	1	2	1	2
	Lihotela - Hotel/Boarding house/bar	1	2	1	2
	Gesi - Electricity	1	2	1	2
	Umfula -Running water	1	2	1	2
	Umdangalazo - Shebeen	1	2	1	2
	Siteshi Semapoyisa - Police Station	1	2	1	2
	Sicishamilo - Fire Station	1	2	1	2
To adapt Locally					

SECTION 2 INDIVIDUAL CHARACTERISTICS

In order to compare your answers with others I would like to ask questions about yourself
 Kute ngikhona kucatsanisa timphendvulo takho netalabanye ngitawufisa kukubuta lokutsile lokuphatselele nawe.

No	Questions and Filters	Coding Categories	Skip to
Q106	How old are you (Probe for best estimate) Watalwa nini	Years old ----	
Q107	(Record Sex of respondent)	Male 1 Female 2	
Q108	Have you ever attended school? If YES , what was the highest level of school you completed? Wake waya yini esikolweni? waqcina kabani?	No School 1 Primary 2 Secondary 3 ---- Q110 Higher 4 ---- Q110 Other Specify	
Q109	Can you read a letter or a newspaper (in any language) If YES ,is this with difficulty or easily. Uyakwati yini kufundza nome liphephandzaba ^{incwadi} _{Le libhalwe} Ngesingisi nome Siswati	Not at all 1 ---Q111 With difficulty 2 Easily 3	
Q110	Do you ever read newspapers? If YES, every day, most days, at least once a week, or less often Uke ulifundze yini liphephandzaba (if yes) kangakhi ngeliviki	Every day 1 Most Days 2 At least once a week 3 Less often 4 Never 5	

Q111 Do you ever listen to the radio? Every day 1
 If YES, every day, most days, at Most day 2
 least once a week or less often? At least once a week 3
 less often 4
 Uyawulalela yini umsakato Never 5
 (if yes) kangakhi ngeliviki

Q112 Which station do you listen to SBIS 1
 Radio Swazi 2
 Ngimuphi umsakato lowulalela Radio Zulu 3
 kakhulu Metro 4
 Other_____ 5

Q113 Do you ever watch the T.V. Every day 1
 Most Days 2
 Uyawubuk ~~ele~~ yini umsakato At least once a week 3
 wetitfombe less often 4
 Kangakhi ngeliviki Never 5

Q114 Which T.V Channel do you watch STBC 1
 Ngimuphi umsakato wetitfombe TV 1 2
 lowubukelako TV 2 3

Q115 What is your religion? -----
 Usontfo Lini

Q116 (COUNTRY SPECIFIC QUESTION
 RELIGIOSITY, THE FOLLOWING
 IS ONLY AN EXAMPLE)
 How important is religion
 in helping you deal with
 problems in your daily
 life? is religion very
 important.
 Somewhat important or not
 important?
 - Imcoka kangakanani inkholo
 - Enyphilweni yakho

Very Important 1
 Somewhat important 2
 Not important at all 3

Q117 What language do you speak
 at home -----
 Nkhulu xa lulwimi luni lapha
 ekhaya

Q118 Were you born in this village
 Watalelwa kulenzawo yini
 Yes 1---Q121
 No 2

Q119 How long have you lived in this
 Country. Years -----
 Unesikhati lesingakanani uhlala if less than 1 year enter
 Laka Ngwane 00

Q120 (If less than one year) where did
 you live before Country -----
Bowukha kuphi ngaphambili

Q121 Have you ever been married or had a
 regular partner? Yes 1
 No 2---Q128
 Wake Wendza nome watsatsa umfuti

Q122 Have you ever had a regular sex partner Yes 1
No 2

Wake waba naso yini singani

Q123 Are you now married or have a regular sex partner, or are you widowed, divorced or seperated? Currently married or remarried 1
Not currently married but has regular partners 2
widowed and no regular partner 3-
Divorced and no regular partner 4-
Seperated and no regular partner 5-

Utsendzile / use naye umfati (1200)

-Q128

Q124 How many wives do you have

Bangakhi bafati bakho

Q125 Do you know if your regular partner has other regular partners? Yes 1 -----Q127
No 2

unyaku hula yini hula? Inkululeko... ngapheleli kwakho

Q126 If YES, how many including yourself Number ---

Tingakhi tona sekunawe ekhatsi

Q127 How many sex partners do you yourself have? Number ---

Wena takho tingakhi tingani

Q128 How many children do you have Number of living sons ---
(Probe) Unabangakhi bantfwana Number of living daughters ---
(Probe) if none enter 0 ---

Q129 What is your usual (main) occupation/job?
(Probe: What kind of work do you do most of your time? Record verbatim & then code)

Utiphilisa ngani (Umsebenti) probe

- Farmer, works in agric. Forestry, fishing 1
- Soldier, Policeman, Gendarme 2
- Driver 3
- Manual worker 4
- Sales service worker 5
- Clerical, office worker 6
- Professional, management administrative 7
- No employmet (housework, student, unemployed, retired) 8
- Other 9



SECTION 3: AWARENESS OF AIDS

No	Questions and filters	Coding Categories	Skip to
Q201	<p>What do you think are the most serious diseases or health problems facing the world today? (Record verbatim and then code)</p> <p>Nawu cabanga ngutiph1 tifo letiyingoti nome tiyinkinga leti khungatse umhlaba lomuhla</p> <p>----- ----- ----- -----</p>	<p>AIDS Mentioned 1 AIDS not mentioned 2 Do not know, cannot answer 3</p>	
Q202	<p>And what do you think are the most serious diseases or health problems facing your country today? (Record verbatim and code)</p> <p>Nawucabanga ngu tiph1 tifo letiyingoti nome letiyinkinga letikhungatse live lakini</p> <p>----- ----- ----- -----</p>	<p>AIDS mentioned 1 AIDS not mentioned 2 Do not know, cannot answer 3</p>	
Q203	<p>AIDS not mentioned in Q201 or Q202 ----- -----</p>	<p>AIDS mentioned in Q201 or Q202 ----- -----</p>	
Q204	<p>Have you ever heard of a disease called AIDS (Probe using either of these terms or local equivalent, if there is one.) Wake weva yini ngalesifo lokutsiwa yi AIDS</p>	<p>Yes 1 No 2 ---Q301</p>	
Q205	<p>How much do you think you know about this disease called AIDS? would you say that you know?</p> <p>Ungatsi wena wati kangakanani ngalesifo lokutsiwa yi Aids, Ungatsi wati kakhulu, kakhulu-nje kaçane, awati lutfo</p>	<p>A great deal 1 A moderate amount 2 Just a little 3 Nothing 4</p>	

SECTION 4 : KNOWLEDGE ON AIDS

No	Questions and filters	Coding Categories
Q206	Have you yourself ever known anyone who has had AIDS in this community or country? Ukhona yini loke wambona aphefwe yi AIDS laka Ngwane	Yes 1 No 2 Do not know, not sure 3
Q207	What do you think causes AIDS? (Probe and record verbatim all causes mentioned) Nawucabanga ibangwa yini AIDS?	----- ----- ----- -----
Q208	Do you think that a person can be infected and have the virus that causes AIDS but not the symptoms? Nawucabangaumuntfu lingamgena yini leligciwane lelibanga i AIDS kepha angabi nato timphawu talesifo	Yes 1 No 2 Do not know, not sure 3
Q209	Do you think a person can catch AIDS from someone who has this disease? Umuntfu angasitfoli yini lesifo se AIDS kumuntfu lonaso	Yes 1 No 2 Do not know, not sure 3
Q210	Do you think someone who looks healthy but who has the AIDS virus can pass it to other people? Umuntfu lobukeka aphilile kepha abe analeligciwane i AIDS kungenteka yini kutsi atselele labanye bantfu	Yes 1 No 2 Do not know, not sure 3
Q211	How do you think AIDS is transmitted. (Probe and record verbatim all means of transmission mentioned.) Nawucabanga sisatselwana kanjani lesifo se AIDS	----- ----- ----- -----
Q212	Do you think that one can get AIDS by touching the body of a person who has AIDS/AIDS virus? Uyavumelana yini nekutsi umuntfu angayitfoli le AIDS ngekutsi ntsana nemuntfu lone ligciwane le AIDS?	Yes 1 No 2 Do not Know 3

No	Questions and filters	Yes	No	Do not know
Q213	Do you think that one can get AIDS by kissing a person who has AIDS/AIDS virus? Uyavumelana nekutsi angayitfola i AIDS ngekucabuzana nalo nayo	1	2	3
Q214	Do you think that one can get AIDS by sharing food or cups with a person who has AIDS/AIDS virus? Umuntfu angayitfola yini i AIDS ngekudla sisha sinye nemuntfu lone AIDS	1	2	3
Q215	Do you think that one can get AIDS by injection using needles used by a person who has AIDS/AIDS virus? Umuntfu angayitfola yini, i AIDS ngokusebentisa umjovo losenti entiswe ngumuntfu lone AIDS	1	2	3
Q217	Do you think that one can get AIDS by having sex with many people? Ungayitfola yini i AIDS ngekulala nebantfu labanyenti	1	2	3
Q218	Do you think one can get AIDS by being bitten by a mosquito or other blood sucking insects? Ungayitfola yini i AIDS ngokulunywa timbulwane nome ngutiphi tilokatana letimunye ingati	1	2	3
Q219	Do you think that one can get AIDS by having sex with a man who has AIDS/AIDS virus? U Ngayitfola yini i AIDS ngekulala nalomdvuna lona liligciwane le AIDS	1	2	3
Q220	Do you think that one can get AIDS by blood transfusion/receiving blood from a person who has AIDS/AIDS virus? Ungayitfola yini i AIDS ngokufakwa ingati yemuntfu lona liligciwane le AIDS?	1	2	3

No	Question and filter	Coding Categories		
Q221	Do you think that one can get AIDS by wearing clothes used by a person who has AIDS/AIDS virus? Ungayitfola yini i AIDS ngekusebentisa ntimpahla letisetjentiswe ngumuntfu lone AIDS?	Yes 1	No 2	Do not know 3
Q222	Do you think that one can get AIDS by having sex with a woman who has AIDS/AIDS virus? ungayitfola yini i AIDS ngekulala nalomsikat1 lone ligciwane le AIDS?			Yes 1 No 2 Do not know not sure 3
Q223	Do you think a woman who has AIDS can pass it on to her baby? Umfati lone AIDS angamtselela yini umntfwana wakhe			Yes 1 No 2 Do not know not sure 3
Q224	How does this happen? Would you say that it may happen: (READ OUT) Kugenteka kanjani: - ngesikatsi atetfwele - ngesikatsi abeleka - ngesikatsi amunyisa - ngesikatsi atetfwele nanaka-beleka - ngesikatsi atetfwele <i>nanaka amunyisa</i> - ngato tonkhe letindlela lotingetulu - nangaletinye tindlela (probe, specify)			During pregnancy 1 During Delivery 2 Through Breast feeding 4 During pregnancy and delivery 5 During pregnancy and through breast feeding 6 During delivery and through breast feeding 7 All of the above 8 Other (Specify) 9 Do not know, not sure
Q225	What kinds of people do you think are most likely to get AIDS? (Probe: make a verbatim record of all responses) Bantfu labanjani labangahle bangayitfole i AIDS			----- ----- ----- -----
Q226	What kinds of people do you think are least likely to get AIDS? (Probe : Make a verbatim record of all responses) Bantfu labanjani labangahle bangayitfole i AIDS			----- ----- ----- -----

No	Questions and filters	Coding Categories
Q227	Do you think that a person who has AIDs or the Aids virus can be cured? Nawucabanga umuntfu lone AIDs angalapheka yini?	Yes 1 No 2-Q230 Do not know not sure 3-
Q228	Tell me what you think can cure AIDs? (Probe but do not read out list) Ingalashwa ngani i AIDs? (Probe)	Drugs in general 1 Antibiotics 2 Drugs for cancer 4 A new drug (e.g.AZT) 5 Drugs that strengthen bodys defense/immune system 6 Prayers 7 Traditional Healers 8 Changing ones lifestyle 9 Other (Specify) ____10 Do not know not sure 3
Q229	Among people who get AIDs, How many do you think will die of this disease? Would you say: Kubantfu labatfole i AIDs, bankakhi locabanga kutsi itababulala?	None of them 1 Some of them 2 Most of them 4 All of them 5 Do not know not sure 3
Q230	What do you think a person who has AIDs or its virus should do in order to avoid passing it to other people? (Probe and record verbatim all responses given) Umuntfu losanaleli gciwane nome sifo se AIDs angenta njani kutsi angatseleli labanye?	

SECTION 5. SOURCES OF INFORMATION ABOUT AIDS

No	Questions and filters	Coding Categories	
Q301	Where do you usually get most information /news about such health matters as new drugs, vaccination, child care, what doctors have discovered etc.? Ulutfola kanjani lwati nome tindzaba maqondzana ne temphilo, imitsi lemisha, imijovu yoku- vikela, tifo kunakekela banftwana nange letisandza kutfolakala	Radio	1
		TV	2
		Newspaper/magazines	4
		Workers	5
		Church/Mosque/Priest	6
		Clinic/Hospital/Doctors	7
		Family members	8
		Friends/Colleagues	9
		Other people	10
		At school/teachers	11
		Public posters/handouts/ billboards	12
		Government Officials/ Authorities	13
		Workplace	14
		Other (Specify) _____	15
		Do not know, not sure	3
Q302	From which source do you think you have heard/learned more about AIDS? (Probe but do not read out list) Weva ngani nome wafundza kuphi ngalesifo se AIDS?	Radio	1
		TV	2
		Newspapers/magazines	4
		Public Health/extension workers	5
		Church/Mosque/Priest	6
		Clinic/Hospital/Doctors	7
		Family members	8
		Friends/Colleagues	9
		Other people	10
		At school/teachers	11
		Public posters/handouts/ billboards	12
		Government Officials/ Authorities	13
		Workplace	14
		Other (Specify) _____	15
		Do not know, not sure	3

No	Questions and filters	Coding categories
Q303	Where would you prefer to get your information on subjects like AIDS?	Radio 1 TV 2 Newspaper/magazines 4 Public health/extension workers 5 Church/Mosque/Priest 6 Clinic/Hospital/Doctors 7 Family Members 8 Friends/colleagues 9 Other people 10 At school/teachers 11 Public posters/handouts 12 Gov.Official/authorities 13 Workplace 14 Other (Specify) _____
	Ungatsandza kusetjentiswe yiphi indlela ekwatiseni nekufundziseni sive nge AIDS? (Probe)	Do not know, not sure 3

Thinking back over the last four weeks in response to the next 3 questions, how many times would you say:

Esikhatsini lesingange nyanga lesendlulile ucabanga kutsi kube kangakhi wenta naku lokulandzelako

Q304	You have discussed AIDS with your family or relatives?	Never 0 Once or twice 1 More often 2 Do not know, not sure 3
	Uke ukhulumeyini nemndenani wakho nome netihlobo takho nge AIDS?	

Q305	You have heard or seen something about AIDS on Radio/TV or in the newspapers?	Never 0 Once or twice 1 More often 2 Do not know not sure 3
	Sewuke weva yini emsakatweni noma emsakatweni wetitfombe kukhulunywa ngale AIDS?	

Q306	You have discussed AIDS with your friends, colleagues, or neighbours	Never 0 Once or twice 1 More often 2 Do not know, not sure 3
	Uke ukhulume yini nebangani bakho, losebenta nabo nome bomakhelwane ngale AIDS?	

SECTION 6: BELIEFS, ATTITUDES AND BEHAVIOUR

No	Questions and filters	Coding Categories
		Yes _____ NO _____
Q400	Were Q206 to 231 in section 4 asked?	
Q401	How much of a threat do you think AIDS is to the health of your local community now? Would you say that it is. Iyingoti kangakanani i AIDS emphilweni yebantfu bemango wakini	No threat at all 0 Some threat 1 Serious threat 2 Do not know not sure 3
Q402	How about the next few years? is AIDS going to be a serious threat to the health of this community? would you say that it is: Itaba yingoti kangakanani i AIDS eminyakeni letako kulommango wakini?	Not likely at all 0 Somewhat likely 1 Very likely 2 Do not know,not sure 3
Q403	What are the chances that you yourself might catch AIDS? Would you say that it is. Litfuba lokutsi wena utfole i AIDS lingakanani?	Not likely at all 0 Somewhat likely 1 Very likely 2 Do not know not sure 3
Q404	Can a person avoid getting AIDS by changing his/her behaviour? That is to say by doing certain things and not doing other things? Angati vikela yini umuntfu ekutfoleni i AIDS ngekushintja indlela latiphatsa ngayo?	Yes 1-Q406 No 2 Do not know,not sure 3
Q405	What kind of changes in behaviour do you think will help avoid getting AIDS? (Record verbatim) Nguquko yini yekutiphatsa lengamsita kutsi avikele kutfola i AIDS?	----- ----- ----- -----
Q406	Have any of your friends changed their behaviour as a result of hearing about AIDS? Bangani bakho sebaququlile yini tindlela tabo njengha sebafile nge AIDS?	Yes 1 No 2 Do not know not sure 3

No	Questions and Filters	Coding Categories
Q407	<p>Have you made any changes in your own behaviour or way of life as a result of what you have heard or learned about AIDS?</p> <p>Wena sewuguqulile yini tindlela lotiphatsa ngayo njengoba sewuvile nome sewufundzile nge AIDS?</p>	<p>Yes 1-Q408 No 2 Do not know not sure 3</p>
Q408	<p>Do you intend to make any changes in your behaviour as a result of what you have heard or learned of AIDS?</p> <p>utimisele yini kuguquka njengoba sewuvile nome sewufundzile ngale AIDS?</p>	<p>Yes 1 No 2- Do not know not sure 3- -Q410</p>
Q409	<p>What kind of changes have you made/ do you intend to make in your life?</p> <p>Luhlobo luni lwenguquko lolwentile nome locabanga kulwenta mayelana nendlela lotiphatsa ngayo</p>	<p>----- ----- ----- -----</p>
Q410	<p>Suppose that a close friend or relative becomes ill and doctors decide that he/she has AIDS. Where do you think he/she should be cared for?</p> <p>Ake ngitsi umngani wakho nome sihlobo sakho siyagula batsi bodokotela u ne AIDS, ubona kutsi angalashelwa kuyiphi <i>intaba</i></p>	<p>At Home 1 In a general Hospital 2 In a special Hospital or clinic 4 Somewhere else (Specify) 5 ----- Do not know not sure 3</p>
Q411	<p>Who do you think should pay for the care and treatment of an AIDS patient?</p> <p>Ngubani lofanele akhoke tindleko tekulaphisa lomuntfu laphetfwe yi AIDS?</p>	<p>Family(parents/children) 1 Charitable organizations 2 Government 4 Somebody else(Specify) 5 ----- Do not know, not sure 3</p>

No	Questions and filters	Coding Categories
Q412	<p>Who do you think should take care of a person with AIDS? (Read out alternative)</p> <p>Ucabanga kutsi kungaba ngubani longafanela anakekele lomuntfu logula sifo se AIDS?</p> <p><i>- Bem ndeni wakhe</i> <i>- Dokokotela na kanye</i> <i>- Dokokotela nabanye esibhedlela sayo nje kuphela i AIDS</i> <i>- Esinye isinye</i> <i>- Kuyilwane beliso nje lakhe</i> <i>- Ayawabanye labagula yona le AIDS</i></p>	<p>His/her own family 1 Ordinary doctors/nurses 2 Doctors nurses specially trained for this purpose 4 Friends 5 Religious or charitable Groups 6 Other ill or high risk People 7 Other (Specify) 8 Do not know, not sure 3</p>
Q413	<p>Some people may have the AIDS virus and pass it on to other people without knowing it. What do you think should be done to make sure that such infected individuals do not pass their disease on to other people? (Record verbatim all responses)</p> <p>Labanye bantfu labanaleligciwane le AIDS, kepha babe bangati bangabatselela labanye bantfu, rawucabanga, kungentiwa njani kute kuqiniseke kutsi labantfu labaleligciwane ababatseleli labanye bantfu .</p>	<p>----- ----- ----- ----- ----- ----- ----- -----</p>
Q414	<p>Do you think that the government should take steps to prevent the the spread of AIDS? If Yes what are those steps? (Record verbatim all responses)</p> <p>Ucabanga kutsi Hulumende fanele atsatse tinyatselo mayelane nekuvikela kwandzakwe AIDS? (if Yes) Tinyatselo tishi</p>	<p>----- ----- ----- -----</p>
Q415	<p>Doctors can tell if you have AIDS virus by carrying out a test on you. Would you be willing to take this test?</p> <p>Bodokotela bangakujela nawu naleligciwane le AIDS ngekutsi bente luhlolo lolutsite ungatsandza yinikwentiwe loluhlolo kuwe.</p>	<p>Yes 1 No 2- Do not know, not sure 3- -Q501</p>

No	Questions and filters	Coding Categories
Q501	<p>People who do not want to get pregnant or to make their partners pregnant can use a variety of methods. Can you name all such methods that you have heard of? (Probe and then code)</p> <p>Bantfu labangafuni kwemitsa nome bamitise tingani tabo, bangasebentisa tindlela letinyeti ake usho losoke weva ngato (Probe and then code)</p>	<p>Condom 1-Q503 Pill 2 IUD 4 Diaphragm 5 Jelly 6 Withdrawal 7 Safe Period 8 Sterilization 9 Abstinence 10 Injections 11 Other (Specify)_____ 12 Do not know, not sure 3</p>
Q502	<p>Men can wear a rubber or a Condom during sex to prevent STD. have you heard of this?</p> <p>Emadvodza angasebentisa lijazi-lemkhwenyana (Condom) kuvikela ekutfoleni tifo tabo gounsula</p>	<p>Yes 1 No 2- Do not know, not sure 3- -Q503</p>
Q503	<p>Have you ever used a condom?</p> <p>Wake walisebentisa yini lijazi lemkhwenyana (Condom)?</p>	<p>Yes 1 No 2 Do not know not sure 3</p>
Q504	<p>Do you know if any of the methods you have mentioned above can be used to avoid getting AIDS?</p> <p>Kuletindlela lose utibalile ngitulu tikhona yini letingasetjentiswa kuvikela kutfolala i AIDS?</p>	<p>Yes 1 No 2- Do not know, not sure 3- -Q506</p>
Q505	<p>Which ones? (Probe and circle all methods)</p> <p>Ngutlphi (Probe)</p>	<p>Condom 1 Diaphragm 2 Jelly 4 Withdrawal 5 Abstinence 6 Other (Specify)_____ 7 Do not know not sure 3</p>

No	Questions and filters	Coding Categories						
Q506	Do you know of any place or person where you could get condoms? If Yes where would you go if you wanted to get some? Kukhona yini indzawo noma umuntfu lomatiko, lapha ungatfola khona emajazi emkhwenyana (condoms) (If Yes) ungawatfola kuphi uma uwafuna	Shop 1 Chemist/Pharmacist/Drugstore 2 Health centre/Hospital 4 Family planning office 5 Other (Specify)_____ 6 ----- Do not know no known place 3- -Q508						
Q507	How long would it take you to go to this place or person to get condoms? Kungakutsatsa sikhatsi lesingakanani kuyofika kulenzawo nome kulomuntfu kuyotfola lamajazi (condoms)?	Minutes ---- OR ---- Hours ---- (if you do not know enter 99 hours)						
<p>People say many things about condoms. I am going to read some of the things they say. Listen carefully and tell me whether you agree or disagree with each of the statements I read out. (Read out each and ask do you agree or disagree?)</p> <p>Bantu basho tintfo letinyeti nge majazi emkhwenyana (condoms) ngitawutandza usho kutsi uyavumelana nome awuvumelani nalemiqondvo leshiwo bantfu Laleka -K ;-</p>								
		<table border="1"> <thead> <tr> <th>Agree</th> <th>Disagree</th> <th>Uncertain Do not Know</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> </tr> </tbody> </table>	Agree	Disagree	Uncertain Do not Know	1	2	3
Agree	Disagree	Uncertain Do not Know						
1	2	3						
Q508	Condoms make sex less enjoyable? Lijazi lenta kulalana kunga jabulisa kahle							
Q509	Condoms are most appropriate for use with casual partners Lijazi lilunge uma ulalane muntfu lomfole nje kwangalelo langa.							
Q510	Condom use is against my religion. Inkolo yami ayivumi ngsebentisa lijazi.							

No	Questions and filters	Coding Categories		
		Agree	Disagree	Uncertain Do not know
Q511	Condoms can climb up into the womb or stomach. Lijazi liyahamba lingene esinyeni nome esiswini se wesifazane.	1	2	3
Q512	The price of condoms is too high to use regularly Adulile amajazi kuti siwasebentise sonkesikatsi.	1	2	3
Q513	Condoms are offensive to husbands/wives/regular sex partners. amajazi abanga kungatsembani kwemadvodza nebafati nome tingani.	1	2	3
Q514	Condoms are good at preventing pregnancy if used properly. Lijazi likahle ekuvikeleni kwemitsa uma ulisebentise kahle.	1	2	3
Q515	Condoms can prevent venereal diseases if used properly. Lijazi lingavikela gcunsula uma lisebentiseke kahle.	1	2	3
Q516	Condoms are most appropriate for use with spouse or a regular partner. Lijazi likahle uma ulisebentisa nawu, newakakho nome singani sakho.	1	2	3
Q517	Condoms are easy to use. Lijazi kumalula kulisebentisa	1	2	3

SECTION 8: SEXUAL PRACTICES (OPTIONAL)

Now I am going to ask you a few questions about sex.
Nyalo-ke ngitakubuta imibuto maqondzana nekulalana.

No	Questions and filters	Coding Categories
Q601	How long is it since the last time you had sex? Wagcina nini kulalana nemuntfu	Days ago ----- OR ----- weeks ago ----- OR ----- Months ago ----- OR ----- Years ago ----- ----- (if never had sex enter- 00 in all 4 boxes and.. -Q701
Q602	*Have you had sex with someone other than your spouse/regular partner in the last 12 months, that is since. (Quote name of month)? Uke walala yini nalomunye umuntfu ngaphandle kwe wakakho nome singani sakho kuletinyanga letilishumi nambili letengcile.	Yes 1 No 2-Q607
Q603	Altogether how many different men or women have you had sex with in the last 12 months? Bangakhi sebabonkhe bantfu ^{labu} dvuna nome labasikati lotse walala nabo kuletinyanga letilishumi nambili letengcile.	Number of men ---- Number of women ----
Q604	Have you given anyone money, gifts or favours in return for sex in the last 12 months. Uke wapha umuntfu i mali nome tiph uncenga kutsi nilale, kuletinyanga letilishumi nambili letengcile	Yes 1 No 2-Q606
Q605	How often have you paid money, given gifts or favours in return for sex in the last 12 months? Always, sometimes, or rarely/ Ukwente kangakhi ^{lokupha} tiph nome imali uncenga kulala kuletinyanga letilishumi nambili letengcile.	Always 1 Sometimes 2 Rarely 3

No	Questions and filters	Coding Categories
Q606	<p>Did you ever use a condom/rubber on these occasions? I Yes, was it each time or sometimes?</p> <p>Bowulisebentisa yini lijazi lemkhwenyana ngaletotikhatsi, (If Yes) Bowulisebentisa ngaso sonkhe sikhatsi nome ngalesinye sikhatsi?</p>	<p>Yes each time 1 Yes Sometimes 2 Never 3</p>
Q607	<p>* In the last 4 weeks i.e since last (quote day and month) have you had sex with your spouse/regular partner?</p> <p>Kulamaviki lamane (4) lengcile uke walala yini newakakho nome nesingani sakho.</p>	<p>Yes 1 - No 2-Q610</p>
Q608	<p>How many times?</p> <p>Kangakhi</p>	<p>Number of times --- ---</p>

No	Questions and filters	Coding Categories
Q609	<p>Did you use a condom in any of occasions? If Yes, was it each time or sometimes?</p> <p>Bowulisebentisa yini lijazi lemkhwenyana (If Yes) ngaso sonke sikhatsi nome ngalesinye sikhatsi</p>	<p>Yes, each time 1 Yes, sometimes 2 Never 3</p>
Q610	<p>In the last 4 weeks, have you had sex with anyone other than your spouse/regular partner?</p> <p>Kulamaviki lamane lendlulile uke walala yini nalomunye umuntfu ngaphandle kwe wa kakho nome singani sakho</p>	<p>Yes 1 No 2-Q701</p>
Q611	<p>With how many different men or women, apart from your spouse/regular partner have you had sex in the last 4 weeks?</p> <p>Kulamaviki lamane lengcile ma ngakhi emadvodza lehlukene nome bafati nome tingani, ngaphandle kwe wakakho nome singani sakho lolele nabo.</p>	<p>Number -----</p>
Q612	<p>In the last 4 weeks how many times have you had sex with a man or a woman apart from your spouse/regular partner?</p> <p>Kulamaviki lamane lengcile ulele kangakhi nendvodza nome umfati ngaphandle kwe wakakho nome singani sakho</p>	<p>Number -----</p>
Q613	<p>Did you use a condom on any of these occasions? If Yes, was it each time or sometimes?</p> <p>Bowulisebentisa yini lijazi kuleto tikhatsi (If Yes) Ngaso sonkhe sikhatsi? Ngalesinye sikhatsi</p>	<p>Yes each time 1 Yes sometimes 2 Never 3- -Q701</p>

Q705	Who actually gave the injection? Ngubani lowakujova?					
	A qualified doctor? Ngabe ngudokotela?	--	--	--	--	--
	A doctor's assistant umsiti wadokotela	--	--	--	--	--
	A nurse/midwife Ngu Nesi	--	--	--	--	--
	A pharmacist Ngulosebenta ekhemisi	--	--	--	--	--
	An injectionist Umuntfu lojovako	--	--	--	--	--
	* A Traditional Healer Inyanga	--	--	--	--	--
	Someone else? (Specify) ----- Kulomunye-nje (Chaza)	--	--	--	--	--

Q706	When you were given injections was the needle and syringe taken from a jar or a tray or was it taken from a sealed plastic or paper container?	Jar or tray	1
		Sealed container	2
		Other (Specify)	4

		Do not know not sure	3
	Lemijova bowuyitfola bekujova ngetinyalitsi letitsatfwa emathileyini nome emabhadleleni nome takhishwa emaphepheni noma epulastikini?		

Q707	(If taken from a jar or a tray) Was the needle or syringe boiled in water or passed over a flame before being used on you?	Yes	1
		No	2
		Do not know, not sure	3
	Uma betitsatfwa ethileyini, betibilisiwe yini noma beba tihashula elangabini banga kakujovi?		

Q708	Was the needle and syringe thrown away after it was used or was it put back in a jar or a tray?	Thrown away	1
		Put back in a jar or a tray	2
		Other (Specify)	4

		Do not know, not sure	3
	Betilahlwa yini letinyalitsi nase baqedzile kukujova nome betibuyiselwa ethileyini nome ebhadleleni		

SECTION 10: LOCUS OF CONTROL (OPTIONAL)

No	Questions and Filters	Coding Categories		
		Agree	Disagree	Uncertain
Q801	If it is meant to be I will stay healthy. Nakudaliwe ngitahlala ngiphilile	1	2	3
Q802	When I get sick, I am to blame. Uma ngigula ngitisola mine.	1	2	3
Q803	Luck plays a big part in determining how soon I will recover from a illness Kusindza ekuguleni kuya ngenhlanhla	1	2	3
Q804	If I take care myself, I can avoid illness. * nangitinakekela kahle nginga-kuvikela kugula	1	2	3
Q805	I tend to think about the future and make plans. Ngivamisile kulungiselela likusasa	1	2	3
Q806	Everybody has to go sometime, so why worry about getting sick? Wonkhe muntfu utawukufa kepha sikuncenekele lani kugula?	1	2	3
Q807	If something good happens to me in everyday life I feel as if I am the one who caused it. Nangivelelwa yintfo lenhle ngiyaye ngive sengatsi kwentiwe ngimi	1	2	3
Q808	I usually do not believe in what doctors say regarding illness and health. Angikavamisi kukholwa tintfo letishiwo bodokotela ngetifo nange mphilo	1	2	3
Q809	If something bad happens to me in everyday life I feel as if it wasn't my fault, that is just the way things are. Uma tintfo letimbi tenteka kimi, ngiyaye ngitsi akubangua ngimi kepha bokuvele tintfo titobanjalo nje	1	2	3
Q810	I can usually keep myself from eating foods or doing things that are harmful for my health. Ngingatibamba kutsi ngingakudli kudla nome ngente tintfo letiyin-goti emphilweni yami	1	2	3

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SECTION 11: IV DRUG ABUSE (OPTIONAL)

No	Questions and filters	Coding Categories	
Q901	Do you know anyone in this community/place who takes drugs, like heroin, cocaine morphine etc. Bakhona yini bantfu lobatiko kulommango labasebentisi imitsi emaphilisi etidzakamizwa, insangu mankanjane nome emaganu	Yes No	1 2--Q903
Q902	Do any of them inject these drugs to themselves? Ngabe labantfu bayati jova yini leti dzakwamizwa	Yes No Do not know not sure	1 2 3
Q903	Have you ever used drugs like heroin, cocaine, morphine etc. Wake watisebentisa yini letidzakwamizwa	Yes No	1 2--Q910
Q904	How did you use them? Was it by sniffing, snorting, smoking, or injecting? Wawutisebentisa kanjani, bowu-hosha, ubhema, ujova, unatsa.	Sniffing Snorting Smoking Injecting	1-Q910 2-Q910 3-Q910 4
Q905	How many times in the last 6 months. That is since..(Quote name of month) have you injected one of these drugs. Kuletinyanga letisitfupha letengcile, utijove kangakhi ngaletinye taletidzakamizwa.?	Days ago OR Weeks ago OR Months ago	--- --- --- --- ---
Q906	When was the last time that you injected yourself with any of these drugs? Wagcina nini kutijova ngale tidzakwamizwa?	Days ago OR Weeks ago OR Months ago	---- ---- ---- ---- ----
Q907	Where did you do this? (Probe and then code)	Own home A friends home Street Corner A drug pushers home shooting gallery Other (Specify)	1 2 3 4 5 6

No	Questions and filters	Coding and Categories	
Q908	The last time you had an injection of one of these drugs who injected it? Kugcina kwakho kujova letidzakwamizwa wajovwa ngubani	Myself Spouse/partner Boy(girl)friend A friend Another drug user Other (Specify)_____	1 2 3 4 5 6
Q909	Were there any other people who used the same syringe/needle to inject themselves? Babkhona yini labanye batfu benibolekana nabo lemijovu	Yes No	1 2
Q910	Have you ever had sexual intercourse with a man or woman who you know uses drugs? Wake walala yini nemuntfu losebentisa tidzakamizwa?	Yes No	1 2
Q911	In the last 6 months how many times have you had sexual intercourse with a man or a woman who injects drugs? Kulentinyanga letisitfupha letengcile uke walala yini nemuntfu lojova tidzakwamizwa?	Yes No	1 2
Q912	Did you use a condom on any of these occasions when you had sexual intercourse with a drug injector? Would you say that you used a condom on all occasions, most occasions, some occasions or never? Bewulisebentisa yini lijaza lemkhwenyama ngalesikhatsi ulala nalomuntfu lojova tidzakwamizwa? (If Yes) Ungatsi bowulisebentisa ngaso sonkhe sikhatsi, imvamisa yesikhatsi, ngalesinye sikhatsi, angizange.	Always Often Sometimes Never	1 2 3 4

APPENDIX 3

NON-SCHOOL-GOING YOUTHS FOCUS GROUP DISCUSSION INSTRUMENT

Appendix 3
FOCUS GROUP INTERVIEW SCHEDULE (YOUTH)

INTRODUCTION

My name is _____ an employee of Project HOPE The Family Life Association of Swaziland and Project HOPE are developing a course for Youth Leaders concerning the prevention of the spread of HIV/AIDS in Swaziland The Youth Leaders will then use the information to teach youth how to protect themselves from getting the virus

Mr/Miss/Mrs/Rev _____ the chairman/President/Secretary has kindly arranged for you to meet with me to discuss aspects of AIDS prevention so that we can find out what young people like you know or need to know about how to protect yourself

In the discussion there are no right or wrong answers, so it is alright to disagree with each other, but do not judge or "put down" the one with whom you disagree The information you share will help us to plan the course for your youth leaders No one will be told what you have said to us, so please free to discuss anything Do you have any questions so far ?

Because there will be a lot of discussion it will be difficult to write notes, so we will tape record the discussion After the information is used to develop the course the tapes will be destroyed

Since the information is confidential you don't have to tell me your real names if you prefer not to, but please give names so that I don't have to call you "you" or point at you.

First let me introduce myself again. I am _____ Each of you please tell me the name you want to use

I will now ask you a few general questions before moving on to the Topic of AIDS.

TOPIC GUIDE AND QUESTIONS

GENERAL INFORMATION

INTERVIEWER HAVE EACH MEMBER COMPLETE ATTACHED FORM

- 1 What has it like for you now that you do not go to school ?
- 2 How do you spend your time when you are not working ?
If some individual is not working go to Question (4)
3. How would you prefer to spend your time ?
- 4 Since you are not working how do you spend your time ?

*

MEDIA EXPOSURE

Ask these questions if the answers did not come out earlier.

1. Do you listen to music ? (PROBE)
Where ?
What stations ?
What time of day ?
2. Who are your favorite Swazi artists ?
3. Who are your favorite radio announcers ?
4. What about newspapers do you read them ?
Which ones ?
What is your favorite sections ?
5. Who are your favorite soccer heroes ?
- 6 Which person in Swaziland do you admire most ? Why ?

SEXUAL BEHAVIORS ALCOHOL DRUGS

There is a lot of talk about youth's behavior concerning sex, alcohol and drug taking

- 1 What do adults say about Youths
having sexual intercourse ?
using alcohol ?
using drugs like dagga ?
- 2 What do youths think about
having sexual intercourse ?
using alcohol ?
using drugs like dagga ?
- 3 What do you think about this statement ? "having a baby proves you are a man/woman"
4. Complete these statements
 - a) it is easier for a boy to abstain from sex because .
 - b) it is easier for a girl to abstain from sex because .

KNOWLEDGE OF STDs

Now I'd like to ask you some questions about STDs

1. What are STDs ?
- 2 Name any STDs that you know
- 3 What causes STDs ?
- 4 How are STDs passed from one person to the other ?
- 5 How can one tell if he/she has STDs ?
- 6 How can you tell the difference between the STDs that you have mentioned ?
- 7 How can STDs be treated ?

KNOWLEDGE OF HIV/AIDS

- 1 Recently a Swazi Newspaper printed an article stating that school kids aged 16-19 years have AIDS
 - a) What did you think about this statement ?
 - b) Did anyone you know talk about the article ?
 - c) What did they say ?
2. What is AIDS ?
- 3 What do you think causes AIDS ?
4. How do you think the virus is passed on ?
- 5 How can a person tell that he has the germ ?
6. How can you tell the difference between a person who is infected with the virus and one who has the disease ?
- 7 How can AIDS be prevented ?
8. Have you ever known anyone who had AIDS ?
- 9 What do you think can cure AIDS ?

ATTITUDES TO AIDS OR PEOPLE WITH AIDS

- 1 What do you think should be done with people who have the virus or those who have AIDS ?
2. How would you feel about having a friend or person with AIDS in your organization ?
- 3 How much of a threat do you think AIDS is to the health of the Swazi Youth ?
- 4 What are the chances that you yourself might catch the AIDS virus ?

BELIEFS ABOUT CONDOMS AND AIDS

1. Which people do you think are most likely to get this virus/AIDS ?
2. What do you think should be done with people who have the virus/AIDS ?
3. What were some of the things that you believed about HIV/AIDS when you first heard about it, which you found out later were not correct ?
4. How do you think the threat of AIDS is going to affect the future of the Swazi Youth ?
5. How will AIDS threat influence Swazi marriages and sexual practices ?
6. Some people say that "HIV/AIDS is a disease which only affect whites and foreigners " What do you think about this statement ?
7. People also say that "Camps or special hospitals should be built for HIV/AIDS people" What do you think about this statement ?

BEHAVIORS THAT AFFECT TRANSMISSION OF THE VIRUS

1. How would drinking and drug abuse contribute to the spread of the AIDS virus ?
2. How would receiving identification marks or pledges such as tatooes contribute to the spread of the AIDS virus ?
3. What change in their behaviours have you noticed among some Swazi Youth since they started hearing about AIDS ?
4. What could help others to change their behaviour ?
5. How should the Swazi youth change their sexual behavior to help to control the spread of the AIDS virus ? (Ask this if not answered in number 4)
6. If you were to plan a course to tell youths about AIDS and how to prevent it, what would you include ?

CLOSING

What else would anyone like to say about AIDS or any of the topics that we talked about ? Do you have any questions for me ?

Thank you so much for spending the time with me and sharing so much information

1

FOCUS GROUP INTERVIEW SCHEDULE

Interviewer Please complete this section for each group

COMMUNITY CHARACTERISTICS

REGION _____

NAML OI ARLA _____

DESCRIPTION OF AREA

- Rural Remote
- Rural Not remote
- Peri Urban (low income)
- Urban (low income)
- Urban (Middle income)
- Company Town

Please ask each candidate to complete this section

GROUP CHARACTERISTICS

AGE _____ SEX M F RELIGION _____

- MARITAL STATUS
- Single (Never married)
 - Married
 - Single (Living with man/woman)

- EDUCATION
- No formal education
 - SEBENTA
 - Primary (Grade 1 & 2)
 - Primary (Standard 1 - 5)
 - Secondary (Form 1 - 2)
 - Secondary (Form 3)
 - Secondary (Form 5)
 - Other _____

- EMPLOYMENT
- Full time
 - Part time
 - Seasonal
 - Unemployed

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OCCUPATION

- Handicraft
- Farm worker
- Mechanic
- Dressmaker
- Maid/Cleaner
- Housewife
- Gardener
- Guard
- Youth Leader
- Other _____

APPENDIX 4

TRADITIONAL HEALERS FOCUS GROUP DISCUSSION INSTRUMENT

Appendix 4

Project HOPE HIV/AIDS Prevention Project
In collaboration with
The Traditional Healers Organization

FOCUS GROUP DISCUSSION GUIDE

Introduction

The major objective of this programme is to save the lives of Swazis, by teaching Traditional Healers how to protect themselves and their patients from contracting the Human Immunodeficient Virus (HIV), and it's subsequent disease, Acquired Immune Deficiency Syndrome (AIDS)

TDr D. Nhlavana Maseko, President of the Traditional Healers Organization, has kindly arranged for you to meet with us to discuss aspects of HIV/AIDS prevention, especially as it relates to Traditional Healers.

We will record and write down everything you say so that we can plan the best training program for you. Please assist us by providing us with the most complete and accurate information and opinions that you have

First let us all introduce ourselves I am _____.
I would kindly request that each person introduce himself/herself

Project HOPE HIV/AIDS Prevention Project with THO

1 Personal Information

1 1 Full Name. _____ Marital Status
M / FM / NM

1 2 Chief _____ Induna _____

1 3 Address. _____

1 4 Main type of health practitioner. _____
(Possessed=1; Not possessed=2; Holy Spiritualist=3)

1.5 Area of Specialization: _____
(1=STDs, 5=Blood Sucker,
2=Uncurable STDs, 6=Delivering babies,
3=Wound Specialist, 7=Other _____,
4=Bone Setter, 9=No Specialty.)

* 1 6 THO Qualification level: Senior / Intermediate / Junior

1 7 Average no of patients you treat in one week ___ Code. ___

1 8 Which of the following facilities do you have? Codes ___

- (1=Traditional Healers Institute,
- 2=Traditional Healers Training College,
- 3=Master Healers Training School,
- 4=Faith Healers Church Service,
- 5=Traditional Healers Hospital,
- 6=Traditional Healers Maternity Hospital,
- 7=Traditional Healers Mental Hospital,
- 8=Herbalism Health Unit,
- 9=Alternative Medical Shop,
- 10=Traditional Clinic,
- 11=Traditional Mobile Clinic,
- 12=Traditional Mobile Clinic,
- 13=None of the above.

2. THO Agent Information THO Reg No _____

2 1 Promoter: _____

2 2 Regional Promoter: _____

2 3 Official Representative _____

2 4 Area _____ THO Code: _____

2 5 Region: _____ THO Code: _____

3. Information on Health Issues

3.1 How do you get information on health issues?

<u>Source</u>	<u>Type of Information</u>
1=Radio _____	_____
2=Newspaper _____	_____
3=THO Meetings _____	_____
4=MOH Services _____	_____
5=RHMs _____	_____
6=Other: _____	_____

3.2 How do you get patients?

- 1=Come to TH's homestead (1 e Reputation) _____
- 2=TH moves from place to place (mobile) _____
- 3=TH responds to calls _____
- 4=Referred: _____ By whom? _____
- 5=Other _____

3.3 Where do you treat patients? _____

- * 1=In Homestead where TH lives _____
- 2=In more than one of TH's Homesteads _____
- 3=In homes of the sick people _____
- 4=In a special TH facility _____

4. Information on Sexually Transmitted Diseases (STDs)

4.1 What do you know about sexually transmitted diseases?

(If AIDS is mentioned, say that it is an STD, but that it will be covered later on in the discussion on its own. Therefore, Q 5.1 through Q 5.5 should not include AIDS.)

Definition _____

People most likely to have STDs _____

Transmission modes: _____

Causes _____

Beliefs _____

(1=Likubalo lenja _____ 2=Likubalo: _____)

Types

- | | | |
|-------------------|-------|------------------|
| 1= Lugola | _____ | |
| 2= Sifuba sengati | _____ | |
| 3= Lufu lwendlu | _____ | |
| 4= Hlulizinyanga | _____ | |
| 5= Intjovela/Drop | _____ | (Gonorrhoea) |
| 6= Gqusula | _____ | (Syphilis) |
| 7= Tintfwala | _____ | (Pubic lice) |
| 8= "Cornflower" | _____ | (Genital ulcers) |
| 9= Sinkantshameti | _____ | (Paraphimosis) |
| 10= Ngqulaza | _____ | |
| 11= Tfishi | _____ | |
| 12= Timbilapho | _____ | (Lg Inguinale) |
| 13= Indere | _____ | |
| 14= Other | _____ | |

4.2 What are the signs and symptoms of the STDs you have mentioned?

- 1. Lugola _____
- 2 Sifuba sengati: _____
- 3 Lufu lwendlu _____
- 4. Hlulizinyanga. _____
- 5. Intjovela/Drop. _____
- 6 Gqusula. _____
- 7. Tintfwala: _____
- 8. "Cornflower": _____
- 9 Sinkantshameti: _____
- 10 Ngqulaza _____
- 11. Tfishi: _____

12 Timbilapho _____

13 Indere _____

14 Other _____

4.3 How can you tell the difference between a carrier and a person having the symptoms?

4.4 What methods do you use for treating the STDs that you have mentioned?

1. Lugola: _____

2. Sifuba sengati' _____

3. Lufu lwendlu _____

4 Hluzinyanga _____

5. Intjovela/Drop. _____

6. Gqusula: _____

7. Tintfwala _____

8. "Cornflower" _____

9. Sinkantshameti _____

10 Ngqulaza _____

11. Tfishi: _____

12 Timbilapho _____

13 Indere _____

14. Other _____

4.5 How can the STDs you have mentioned be prevented?

1 Lugola _____

2. Sifuba sengati _____

3 Lufu lwendlu _____

4. Hluzinyanga _____

5. Intjovela/Drop _____

6. Gqusula _____

7 Tintfwala _____

8 "Cornflower" _____

9 Sinkantshameti. _____

10 Ngqulaza: _____

11 Tfishi _____

* 12 Timbilapho. _____

13. Indere. _____

14 Other. _____

5. Information on AIDS

5.1 What do you know about AIDS?

Definition: _____

People most likely to have AIDS. _____

Transmission modes: _____

Causes. (Probe for HIV, AIDS germ, etc) _____

Beliefs _____

5.2 What are the signs and symptoms of AIDS?
(Probe to find out if they know the difference between an asymptomatic HIV carrier and a symptomatic person with AIDS)

Symptoms		Total
1= ARC	_____	_____
2= Weight loss	_____	_____
3= Face sores	_____	_____
4= Body sores	_____	_____
5= Persistent cough	_____	_____
6= Diarrhoea	_____	_____
7= No response to Rx	_____	_____
8= Thin hair	_____	_____
9= Sexual desires increased	_____	_____
10= Other	_____	_____

Incubation period _____

Difference between carrier and person with AIDS _____

5.3 How is AIDS treated/cured?
Complications and prognosis (for those who believe AIDS cannot be treated): _____

Traditional Healers treatment: _____

5.4 Have you ever known anyone with AIDS? Yes _____ No _____
1= Heard of one. _____
2= Seen one: _____
3= Treated one: _____

5.5 How did you know that person had AIDS?
(Probe for the source of AIDS diagnosis/information.)

5.6 How would you feel about having a person with AIDS under your care?

5.7 What do you think society should do about people who have AIDS? _____

(1=Be isolated _____ 3=Be sent to TH _____
2=Find cure _____ 4=Be sent to hospital _____)

6 Information on Traditional Healers equipment and practices

6.1 What kinds of equipment do you use in your work when treating patients? _____

- 1= Sucking horns _____
- 2= Enema horns _____
- 3= Razor blades _____
- 4= Knives _____
- 5= Broken glass _____
- 6= Assega1/spear _____
- 7= Reeds _____
- 8= Porcupine quill _____
- 9= Syringe _____
- 10= Needles _____
- 11= Sharp objects _____
- 12= Other _____

6.2 How and where do you get your equipment supply? _____

	<u>Source</u>	<u>Type of Equipment</u>
1	Shop _____	_____
2	THO Office _____	_____
3	Inherited _____	_____
4	Self-provided _____	_____
5	Other _____	_____

6.3 How do you care for each equipment or instrument before and/or after use? _____

	<u>Instrument</u>	<u>Care Procedure</u>	<u>Before/After</u>
1	Sucking horns _____	_____	_____/_____
2	Enema horns _____	_____	_____/_____
3	Razor blades _____	_____	_____/_____
4	Knives _____	_____	_____/_____
5	Broken glass _____	_____	_____/_____
6	Assega1/spear _____	_____	_____/_____
7	Reeds _____	_____	_____/_____
8	Porcupine quill _____	_____	_____/_____
9	Syringe _____	_____	_____/_____
10	Needles _____	_____	_____/_____
11	Sharp objects _____	_____	_____/_____
12	Other: _____	_____	_____/_____

6.4 When treating your patients, which body fluids do you ever come into contact with? _____

- 1= Blood _____ Often / Not often
- 2= Semen _____ Often / Not often
- 3= Vaginal fluid _____ Often / Not often
- 4= Saliva: _____ Often / Not often
- 5= Pus: _____ Often / Not often
- 6= Urine _____ Often / Not often
- 7= Stools: _____ Often / Not often
- 8= Birth water. _____ Often / Not often
- 9. None _____

6.6 What do you do with the body fluids after you come into contact with them?

- 1. Blood _____
- 2. Semen _____
- 3. Vaginal fluid _____
- 4. Saliva. _____
- 5. Pus _____
- 6. Urine _____
- 7. Stools _____
- 8. Birth water _____
- 9. None _____

7. Information on THs role and training in HIV/AIDS Prevention

7.1 How can the TH help in the prevention of HIV transmission in themselves?

- 1= Make TH practices AIDS-safe by* _____

- 2= Use condoms _____
- 3= Improve personal behavior by. _____

- 4= Learn more about AIDS _____
- 5=Other: _____

7.2 How can the TH help in the prevention of HIV transmission in their patients?

- 1. Make TH practices AIDS-safe by: _____

- 2. Promote condom use _____
- 3. Promote low-risk behavior, e.g.: _____

- 4. Teach my patients about AIDS: _____
- 5. Other: _____

7.3 What information would you want included in training in relation to AIDS and/or STDs?

APPENDIX 5
PROJECT ACTION PLAN

APPENDIX 5

ACTION PLAN

AFR/TR/HPN HIV/AIDS PREVENTION IN AFRICA

(HAPA) GRANTS PROGRAM

SWAZILAND, AFRICA

PVO HIV/AIDS PREVENTION IN AFRICA, FY 1989

September 20, 1989 to September 20, 1991

by

THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC.
(PROJECT HOPF)
Health Sciences Education Center
Millwood, Virginia 22646

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RATIONALE FOR DELETIONS

CLIENTS AT SEXUALLY TRANSMITTED DISEASE CLINICS
RURAL HEALTH MOTIVATORS
THE POLICE
CLIENTS OF BARS AND SHEBEENS
COLLEGE AND UNIVERSITY STUDENTS
THE ARMED FORCES

SUMMARY OF PERSONNEL RESOURCE ALLOCATION

IMPLEMENTATION TIMELINE

ACTION PLAN
Page 2

DELETED TARGET GROUPS The five target groups listed in the DIP but not chosen for focused activity in the Action Plan are:

Clients at STD Clinics,
Rural Health Motivators,
the Police,
Bars and Shebeen clients, (The Shebeens in the Siphofaneni area will be retained for pilot research purposes), and
the Armed Forces

Deletion of these five target groups is based on an estimation of limited resources and anticipated difficulties in implementing activities that would reach these groups. Responsibility for HIV/AIDS IEC directed toward these groups might be reassigned by the National AIDS Control Program (NACP) or scheduled for a follow-on project. Rationale for the deletion of each of these five target groups is included in Appendix A.

3.0. ACTIVITY NARRATIVE

3.1 MATERIAL DEVELOPMENT

RATIONALE Each of the following IEC activities is supported by the distribution of selected educational materials. The number and type of these materials are specified for each activity.

STRATEGY: Development of these materials will be undertaken with the assistance of IEC technical assistance. Materials will be designed in conjunction with counterpart institutions and pre-tested prior to printing.

RESOURCES REQUIRED.

HOPE AIDS Coordinator	40 days
IEC Consultant	30 days

3.2 NON-SCHOOL-GOING YOUTH

RATIONALE: Preliminary and unpublished findings from the Caribbean suggest that a significant portion of HIV/AIDS cases can be traced to contraction of the virus at early teen ages. The economic and social impact of HIV/AIDS among the young make this group a target of particular concern.

STRATEGY: The following groups have existing programs that serve non-school-going youth:

Manzini Youth Centre
Mbabane Church Youth Centre
Masibambisane Maize Youth Club
Swaziland Arts and Music Association

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Swaziland Youth Brigade Association
Swaziland Youth Relief Association
Swaziland Work Camps Association
Ngwane Park Youth Centre
The Our Spear Self Development Club
Manzini Youth Care

A total of 30 group leaders will be trained in two one week Training of Trainers (TOT) sessions of 15 participants each

The Project HOPE AIDS Coordinator will develop objectives, strategies, and curriculum. The curriculum will require participants to practice presentation of the curriculum content during the TOT training. Participants will leave the TOT training with the following teaching aids:

- 5 posters
- 100 condom instruction leaflets
- 100 AIDS information leaflets

Each participant will in turn conduct an average of two training sessions for an average of 20 participants each. The two HOPE/FLAS AIDS Educators will assist in the training and will monitor the replication of this training through 30 site visits.

3.3 FLAS FAMILY PLANNING CLINIC CLIENTS

RATIONALE The Family Life Association of Swaziland (FLAS) supports three family planning (FP) clinics. The association of Project HOPE Staff with FLAS makes the project particularly well-positioned to assure the competency of FLAS clinic staff to provide HIV/AIDS education to family planning acceptors, MCH clients, and STD clients.

STRATEGY: The FLAS FP clinics employ 10 services delivery staff: 4 sisters-in-charge, 3 nurse assistants, and 3 office assistants. These staff will be trained in three separate sessions corresponding to their level of responsibility. Curricula will be designed for each of the three levels.

The Project HOPE AIDS Coordinator will lead workshops in which FLAS staff will join in developing HIV/AIDS counseling techniques appropriate for clients of FLAS clinics.

The Project HOPE AIDS Coordinator will consult with the FLAS Clinic Supervisor in the development of the curriculum for the training of the clinic personnel. The Project HOPE AIDS

Coordinator and FLAS Clinic Supervisor will collaborate in the training.

ACTION PLAN

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Participants will be presented with a total of:

9 posters
27,000 AIDS education leaflets

The FLAS IEC Unit Educators will incorporate HIV/AIDS IEC in-service training into the periodic FLAS training sessions

MONITORING The number of condoms distributed before and after this training will be compared as an indirect indicator of the success of this training.

In addition, discussions with FLAS will consider the possibility of reporting the number of HIV/AIDS counseling sessions conducted

3.4 SEBENTA

RATIONALE. SEBENTA groups serve high priority target groups young to middle-aged adults with limited education. Access to this group is facilitated by the fact that participants meet regularly to receive instruction according to an established curriculum

STRATEGY. The SEBENTA program includes 15 staff officers. These staff officers will be trained in a single TOT session and they will, in turn, teach an estimated 600 volunteer workers who will incorporate HIV/AIDS education into their curriculum. The volunteer workers, located in the nine SEBENTA regions scattered throughout the country, are responsible for the instruction of twelve students. Quarterly refresher courses given throughout the regions will assist the volunteer leaders to maintain their skills.

The Project HOPE AIDS Coordinator will develop objectives, strategies, and curriculum appropriate for SEBENTA students. After pre-testing, this curriculum will be incorporated into SEBENTA teaching procedures

The Project HOPE/FLAS AIDS Educators will conduct 15 monitoring site visits to assess the performance of the SEBENTA staff officers and 15 monitoring site-visits to training sessions conducted by the field volunteers. In addition, the project staff will attend the quarterly refresher courses for volunteers and offer additional assistance in developing program content and materials.

ACTION PLAN

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The curriculum will require SFBFNTA instructors to practice teaching this material during the training. Each participant will leave the training with the following HIV/AIDS IEC materials:

- 40 posters
- 7,200 condom instruction leaflets
- 7,200 AIDS information leaflets

3.4 FIREMEN

RATIONALE: The duties of firemen often require the provision of emergency first aid and, consequently, the risk of HIV infection is high.

STRATEGY: There are five fire stations in the country. Each station will be visited three times in order to cover the three work shifts.

The Project HOPE AIDS Coordinator will develop objectives, strategies, and curriculum appropriate for firemen. At the completion of each visit, the following material will be left with the firemen:

- 5 posters
- 210 condom instruction leaflets
- 210 AIDS information leaflets
- 210 HIV Hepatitis B leaflets

3.6 TRADITIONAL HEALERS

RATIONALE: The Traditional Healers Organization (THO) has formally requested assistance from Project HOPE in the training of field officers (FOs) and leading traditional healers in the topic of HIV/AIDS prevention.

Available information suggests that Swazis consult the estimated 8,000 traditional healers regarding a variety of health and personal concerns. For many Swazis, traditional healers provide the first line of consultation regarding HIV/AIDS.

STRATEGY: HIV/AIDS IEC for Traditional Healers will use a TOT format that follows a field officer organizational structure favored by the president of the THO. Since this is the most innovative of the Project HOPP interventions, and presents perhaps the highest risk, extensive monitoring will be assigned to this activity.

TOT training will be provided to the fifteen field officers and promoters already designated by the president of the THO. The Project HOPE AIDS Coordinator will develop objectives,

strategies, and curriculum appropriate for traditional healers

The two Project HOPE/FLAS AIDS Educators will assist in curriculum development, the TOT training, facilitate training conducted by participant THO field officers, and selectively monitor the training conducted by 120 Traditional Healer Promoters and the presentation of this material by Traditional Healers in the course of their normal practice

The curriculum will require traditional healers to practice replication of this training during the TOT training. Each participant will leave the training with the following HIV/AIDS IEC materials

- 2 posters
- 100 condom instruction leaflets
- 100 AIDS information leaflets
- 100 condoms

3.7 KAPB SURVEY

RATIONALE: The Knowledge, Attitudes, Beliefs, and Practices (KAPB) questionnaire developed specifically for Africa by the World Health Organization was approved for project use by the HAPA Support Program. The central purpose of the WHO AIDS-related KAPB survey is to develop a body of country and region-specific information patterns of knowledge, attitudes, beliefs, and practices in relation to the AIDS epidemic and to factors associated with them. The project will, of course, use this information to assist with the planning of the HIV/AIDS initiatives.

The KAPB survey sample of 2,000 was originally specified in Swaziland's Medium Term Plan (MTP). An April 24, 1989 cable from USAID/Swaziland to USAID/Washington indicated the selection of 2,000 persons.

STRATEGY: The conduct of the KAPB survey has been subcontracted to the Social Sciences Research Unit of the University of Swaziland. Project HOPE staff anticipate considerable supervisory time may be required from project staff to assure the quality of the implementation and analysis of this survey.

3.8 HIV/AIDS COUNSELING

RATIONALE: The MOH has requested, in the Medium Term Plan, 60 HIV/AIDS counselors be trained. When this request was not met at the April, 1989 Resource Mobilization Meeting, it was added to the HOPE project. USAID concurrence was indicated in the revised proposal dated April, 1989.

ACTION PLAN

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STRATEGY Project HOPE has assumed responsibility for the establishment of a HIV/AIDS counseling center within a FLAS facility. In addition, Project HOPE will provide support for the training of 60 HIV/AIDS counselors during 3 sessions of 20 each lasting 5 days. Two months of external technical assistance will be provided at this time for the purpose of training and follow-up supervision and problem-solving in the counseling workplace.

4.0 MONITORING AND EVALUATION

4.1 OUTPUT OBJECTIVES: PROCESS INDICATORS

The nature and extent of the project suggests that both monitoring and evaluation will be limited to process indicators such as

FOR NON-SCHOOL-GOING YOUTH:

- 30 organization staff completing TOT training by 12/90
- post-test results from TOT training

- * 60 training sessions conducted by TOT participants by 6/91
- 1,200 non-school-going youth receiving such training by 6/91
- sample survey on non-school-going youth trained by 6/91

FAMILY PLANNING CLINICS:

- 10 FLAS service delivery staff completing training by 10/90
- post-test results from participants

- 11 monthly in-service sessions conducted by FLAS IEC Unit staff starting 6/90

- 25% increase in number of condoms distributed within 6 months after training

- 30% increase in clients receiving AIDS counseling sessions

SEBENTA

- 15 instructors completing TOT training by 1/91
- post-test results from TOT training

- 600 field volunteer workers trained by 8/91

- 3,600 literacy students educated by 8/91

- sample survey of students completed by 9/91

FIREMEN:

- 225 firemen receiving training by 4/90

- sample survey completed by 8/90

TRADITIONAL HEALERS:

- 15 field officers completing TOT training by 9/90
- post-test results from TOT training

- 6 training sessions conducted by TOT participants by 4/91

- 120 traditional healers receiving such training by 4/91

- post-test results from traditional healers trained

- sample survey of traditional healers by 5/91

ACTION PLAN

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SHIBBETH PILOT PROJECT

25 shebeen owners informed about HIV/AIDS at sessions by 4/90
12 shebeens distributing condoms by 7/90
1,000 condoms distributed by Siphofaneni shebeens monthly by 9/90
survey of shebeen owners by 9/90

COUNSELLORS

60 participants completing counselor training by 7/90
post-test results from participants
number of clients counseled by participants following training
one FLAS counseling center established following training by 7/90
25% of FLAS clients counseled concerning STD/HIV/AIDS by 11/90

4.2 IMPACT INDICATORS

Assessment of behavioral change, much less comparative HIV infection rates, would require resources far exceeding the extent of the project. However, a KAPB survey tool will have been tested during the course of this project and could serve as the basis for a follow-up survey in subsequent years if additional resources can be identified.

4.3 OUTCOME OBJECTIVES SHORTER TERM IMPACT INDICATORS

Pre-testing of target groups would provide a baseline which could be compared to post-test results to establish changes in knowledge and attitudes. Measurement of outcome objectives achieved by this project with the target groups of non-school-going youth, Sebenta, traditional healers, shebeen owners, and trained counselors will be conducted through various sample surveys by the Information Manager.

4.4 PROCESSING OF INDICATORS

Project HOPE has purchased appropriate hardware and software for the processing of anticipated process indicators.

An information Manager has been hired and a training schedule finalized.

Draft data collection instruments, data entry screens, and periodic project monitoring reports are in preparation.

APPENDIX

RATIONALE FOR DELETIONS

CLINICS AT SEXUALLY TRANSMITTED DISEASE (STD) CLINICS Earlier involvement by the European Economic Community and AIDSIECH had led project design staff to anticipate the establishment of STD clinics in Swaziland. Currently, as the Action Plan is being composed, plans for these STD clinics have not progressed sufficiently to justify inclusion of STD clinics in the Project HOPE program. Under existing STD service delivery schemes, access to STD clients via outpatient departments (OPDs) would require resources beyond those available under the Project HOPE program.

Selected STD clients, though, will be served through project IEC assistance to FLAS clinics.

RURAL HEALTH MOTIVATORS (RHMs) RHMs have been deleted from the Project HOPE program for the following reasons:

- o the number of RHMs make this a resource-intensive task,
- o there is little information on the effectiveness of RHM activities,
- o RHMs currently receive insufficient supervision by trained health workers,
- o monitoring the impact of training of RHMs would prove impossible given resources available to Project HOPE, and
- o RHMs are not a focus of FLAS educational efforts.

There is also indication from the Red Cross of their intent to do HIV/AIDS education work with RHMs.

THE POLICE The duties of firemen often require the provision of emergency first aid and, consequently, the risk of HIV infection is high.

This activity has, nevertheless, been deleted in the interest of assuring adequate resources for other high priority interventions.

CLIENTS OF BARS AND SHEBEENS
COLLEGE AND UNIVERSITY STUDENTS
THE ARMED FORCES

Although these three target groups represent important high risk groups, the logistical difficulty of presenting HIV/AIDS IEC to this target group suggest the elimination of this target group from the project.

Selected clients of Bars and Shebeens will continue to be served through follow-through activities of an existing trial CBD condom distribution program at Siphofaneni.

College and University students, in part, are scheduled to receive HIV/AIDS IEC from the MOH Health Education Unit and the Man Talk project

The Health Education Unit has also expressed an intent to serve the Armed Forces.

APPENDIX 6
CURRICULUM VITAE FOR PROJECT COORDINATOR

LINDA M. PEREZ



EDUCATION

M.H S , The Johns Hopkins School of Hygiene and Public Health,
Department of International Health, Baltimore, MD May 1983.

P C E , London University and University of Zambia, Department
of Education, Lusaka, Zambia. December 1967

B A. , The University of Texas, Austin, Texas January 1967

ADDITIONAL EDUCATION/TRAINING

Documentary film-making, Massachusetts Institute of
Technology, Film Section, Cambridge, MA 1977-1978

Post-graduate Science Teaching Course, The University of
California, Lawrence Hall of Science, Berkeley, CA 1970

PROFESSIONAL EXPERIENCE IN INTERNATIONAL HEALTH

HIV/AIDS Prevention in Africa Technical Consultant

Johns Hopkins University, Institute for International
Programs, Baltimore, MD.

Served as resource person at the 1990 HAPA Meeting for the
Technical Review of Project Detailed Implementation Plans

Provided technical assistance to two HAPA funded projects in
Zimbabwe Duties included: review baseline data and Detailed
Implementation Plan progress, assess technical assistance
needs, and orient project staff in available HIV/AIDS
prevention resources; meet with National AIDS Committee
representatives and USAID Mission staff to review AIDS
prevention activities in Zimbabwe and to discuss the
collaborative role and activities for PVOs and NGOs to best
support the AIDS prevention plan; identify and meet with other
NGOs and individuals currently, or potentially, involved with
AIDS prevention activities in Zimbabwe. November 1989.

Served as Proposal Review Coordinator for the HIV/AIDS
Prevention in Africa (HAPA) Grants Support Project. Duties
included assisting the HAPA Support Program Director to
identify screening criteria and conduct initial screening and
processing of PVO proposals; develop technical criteria for
judging the proposals, assist in forming the Technical
Advisory Group; organize the review of proposals, and draft
the final report for the technical review. March-May 1989

Organized the Orientation Meeting for U.S.-based PVO recipients of HAPA grants held in Arlington, VA on 6/23/89

Child Survival Technical Consultant

Automation Research Systems, Alexandria, VA, and PRITECH, Arlington, VA for USAID FVA/PVC, Washington, D C

Served as External Technical Reviewer in FY 1988, 1989, and 1990 Child Survival Proposal Reviews. Duties included assessing the strengths and weaknesses of PVO project proposals, and making recommendations for technical strengthening of the proposals. Intervention areas of specialization for review included nutrition, ORT, and EPI. Assigned geographic areas were Africa and Latin America.

PRITECH for JHU/IIP Child Survival Support Program

Served as External Evaluator in the Final Evaluation of the CARE North Kordofan Child Health Project in Sudan. The main interventions of the Child Survival FY 1986 funded project were immunization and ORT. Responsibilities included drafting the Final Evaluation Report. September 1989

Served as Mid-Term Evaluator of the Helen Keller International Regional Technical Assistance Africa Project for provision of technical assistance in vitamin A programming to U.S.-based PVOs with Child Survival Projects in Africa. The consultancy was performed in New York and Washington, D C. December 1988

Catholic Relief Services, Baltimore, MD

Evaluated the CRS Children's Survival Assistance Program (CSAP) implemented in Nicaragua and Costa Rica from 1988 to 1989. The purpose of the project was to procure and distribute medical drugs and supplies to approximately 100 church clinics. February 1990

Project Planning and Design Advisor

Johns Hopkins University, Institute for International Programs, Baltimore, MD

Consultancy performed in Mozambique to assess the existing MOH delivery of health services in four rural districts in Zambesia Province and to identify strategies for improved implementation and coverage of primary health care programs. The project is a multi-party effort headed by the Mozambican Ministry of Health and USAID/Mozambique. October-December 1989

Food and Agriculture Organization (FAO) of the United Nations, Rome, Italy

Consultancy performed in Lusaka, Ndola, and Luapula Province, Zambia to work with the MOH, UNICEF, WHO, and the National Food and Nutrition Commission in developing a national plan for the reduction of blindness and eye disease and to plan a project on behalf of FAO for the reduction of eye disease and improved nutrition in the Luapula area. February-March, 1988

German Agency for Technical Cooperation (GTZ, GmbH), Eschborn, Federal Republic of Germany.

Consultancy performed at the University of Nairobi to design a survey for identifying those persons in governmental and non-governmental agencies in eastern Africa for whom a post-graduate course in nutrition for policy and programme planning purposes should be targeted. Responsibilities included carrying out the survey in Tanzania. July 1984

Consultancy performed in Zambia to assess the nutrition situation and to develop a proposal for a project to improve the nutritional status, to be funded by the governments of Zambia and West Germany. September 1983-July 1984

German Agency for Technical Cooperation and Dirección Regional de Salud, Cusco, Peru.

Designed and administered a nutritional status survey in three health districts, Cusco, Apurímac, and Madre de Dios, in Peru to establish baseline data for identifying PHC priorities with which to plan interventions. Activities included selection of anthropometric indicators, sampling method and sample size, training and supervision of survey team members, and analysis of data. The sample was 3,800 children. Sept. 1982 - May 1983

Programme Coordinator

German Agency for Technical Cooperation (GTZ, GmbH), Eschborn, Federal Republic of Germany.

Developed, implemented, and supervised a community-based, rural nutrition programme in Kawambwa District, Zambia, integrating health, agriculture, education, and small-scale industries development. District level activities included establishing a growth monitoring and nutrition surveillance program throughout the district, improving the health information system, training health and agriculture field staff, establishing a transportation system for field workers, and feedback of project progress to the communities through the District Council. Community level activities included

assisting villages to organize and implement self-help projects, including health centres, agricultural storage depots, village industries of sunflower oil production, soap production, and mattress production, and extension of roads. Responsibilities included administration of project, supervision of staff, coordination and collaboration of activities with government and non-government institutions and agencies, evaluating and reporting of activities, and accounting of budget expenditures August 1984 - August 1987

ADDITIONAL PROFESSIONAL EXPERIENCE

Laboratory Manager and Research Assistant

The Johns Hopkins University, School of Medicine, Department of Cell Biology and Anatomy, Baltimore, Maryland. 1978-1981
Harvard University, School of Medicine, Department of Anatomy, Boston, Massachusetts. 1976-1978

Managed the laboratory of Dr. A C Walker, first at Harvard then at Hopkins, and assisted in research to determine the diet of early hominids. Responsibilities included developing the methodology and techniques to be used, operation and maintenance of a scanning electron microscope and other equipment, and assisting in writing grant proposals and scientific papers for publication. Summers were spent in Nairobi assisting R E. Leakey in hominid fossils preparation.

Researcher/Project Designer 1975 to 1976

University of Nairobi, Department of Zoology, Nairobi, Kenya.

Researched and designed a project to study the seasonality of reproduction of several species of large tropical mammals in order to identify those factors influencing synchronicity of births

Secondary School Teacher

Teachers Service Commission, Nairobi, Kenya.

Taught general science, mathematics, and art to students in Forms I through IV at Nyakach Girls Secondary School, Nyanza Province, Kenya. 1971-1973

Ministry of Education, Lusaka, Zambia.

Taught biology, agricultural science, general science, mathematics, and physical education to Forms I through V at Samfya Secondary School, Luapula Province. Responsibilities included being in charge of girl's boarding, the Biology Department, and the Young Farmers' Club. 1968-1969

Juvenile Programme Coordinator

1970 to 1971

Oakland Economic Development Council, Inc , Oakland, CA

Designed, developed, and implemented a Juvenile Justice Program Responsibilities included soliciting voluntary legal representation by lawyers in the San Francisco Bay area for juveniles in court cases; community and student organizing through the Oakland Public Schools, carrying out a juveniles rights information campaign; and liaising with the Oakland Legal Aid Society.

PUBLICATIONS/REPORTS

- Perez, L M., "Report for the Zambesia Child Survival Pilot Project - Mozambique", Johns Hopkins University, Institute for International Programs, Baltimore, December 1989.
- Perez, L.M , "HIV/AIDS Prevention in Africa Support Program Zimbabwe Projects", JHU/IIP, Baltimore, November 1989.
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Walker, A C , Hoeck, H , and L.M. Perez (1978) "Microwear as an Indicator of Diet", Science, 201. 908-910.

LANGUAGES

Fluent - English

Secondary - Spanish, German, Kiswahili

REFERENCES

Furnished upon request.

APPENDIX 7
CONSULTANT'S REPORT

APPENDIX 7
CONSULTANT'S REPORT

PROJECT MONITORING
HIV/AIDS INFORMATION SYSTEMS

PREVENTION OF HIV/AIDS INFECTION IN SWAZILAND
(AFR/TR/HPN HIV/AIDS PREVENTION IN AFRICA)
HAPA GRANTS PROGRAM

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GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
CAFS	Centre for African Family Planning
ESAMI	East and South African Management Institute
FLAS	Family Life Association of Swaziland
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HOPE	Health Opportunities for People Everywhere
HPNO	Health, Population, and Nutrition Officer
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
KAPB	Knowledge, Attitudes, Practices, and Beliefs
MOH	Ministry of Health
NACP	National AIDS Control Programme
RFA	Request for Assistance
SEBENTA	(Adult Literacy Groups)
SSR	Social Sciences Research Unit University of Swaziland
TOT	Training of Trainers
USAID	United States Agency for International Development

ACKNOWLEDGEMENTS

This consultancy coincided with the visit to Swaziland of Dr Marjorie Souder, the HOPE Center HIV/AIDS Coordinator. The Action Plan and most of the material included in this report has been developed by the ad hoc on-site team, that included Dr Souder, in addition to Dr Tom Kenyon, the Project HOPE Regional Programme Director based in Swaziland, and Ms Agatha Lowe, the AIDS Coordinator and Senior Project HOPE staff assigned exclusively to this project.

All computer company and Information Manager candidate interviews were conducted together with Dr Kenyon.

Particular appreciation is expressed to these Project HOPE staff who gave generously of their time and expertise.

In addition, Mrs Nomcebo Manzini, the FLAS Program Director, and Mr Jay Anderson, the USAID Acting HPNO, were kind enough to review drafts of the Action Plan, Position Description, Request for Assistance, and this report prior to finalization.

Mr. E Hlope, the Under-Secretary for Evaluation at the MOH and Mr. Rudolph Maziya, the Programme Manager for the National AIDS Committee, were both particularly helpful.

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EXECUTIVE SUMMARY

The Prevention of HIV/AIDS Infection in Swaziland project supports FLAS HIV/AIDS IEC activities for six selected target groups. It also provides funding for the conduct of a KAPB AIDS survey conducted by the Social Sciences Research Unit of the University of Swaziland.

During this consultancy, a Project HOPE team composed an Action Plan which specifies rationales and strategies for Project HOPE participation in the provision of training for these target groups. The Action Plan includes estimates of the cost of these activities, measured in person weeks and financial cost, and predicts an implementation timeline.

Although specific activities vary for each target group, the common approach includes:

- o identification of participants,
- o the conduct of focus groups or interviews to determine IEC messages,
- o the development of learning goals, objectives, and strategies,
- o curriculum and material development, and the pre-testing of both,
- o provision of Training of Trainers (TOT),
- o replication of this training by participants for targeted number of participants, and
- o monitoring of process and impact indicators to determine the message deterioration and the effect of training.

The specifics of the monitoring process are developed in this report. Monitoring includes the comparison of pre- and post-tests to assess success in transmitting the selected messages, and sample surveys to assess impact over time.

This report also discusses the selection of an Information Manager, the selection of commercial computer support, and the design of the computer processing to support the monitoring process.

1.0 BACKGROUND

Through the Prevention of HIV/AIDS Infection in Swaziland project, USAID has contracted with Project HOPE to provide a range of services that will accelerate Swazi efforts to prevent and control the spread of the HIV infection and AIDS disease in the spread of the HIV infection and AIDS disease in the country.

The April 1989 project proposal, the February 1990 Detailed Implementation Plan, and the Action Plan developed concurrently with this consultancy describe services to be provided under the contract to include

- o The conduct of an HIV/AIDS Knowledge, Attitudes, Practices, and Beliefs (KAPB) survey,
- o educational campaigns conducted in conjunction with the Family Life Association of Swaziland (FLAS) and directed at specifically defined target groups, and
- o the provision of counseling services to persons pre- and post-HIV testing.

Project documents make repeated references to the importance of information systems which will monitor both project implementation and the impact of project activities.

The purpose of this consultancy is to expand the definition of information management activities to more specifically delineate how this will be achieved.

2.0 MONITORING PROJECT INTERVENTIONS

The Action Plan identifies six groups targeted for training. These are:

Non-school-going youth,
Clients at Flas Clinics,
SEBENTA (Adult Literacy Group),
Firemen,
Traditional Healers, and
Counselors.

For each target group, the Action Plan delineates training objectives and strategies at a level of specificity that CONS.

predicts:

- o process indicators (output objectives) that assess successful implementation of project activities,
- o outcome objectives that measure short term impact, and, wherever possible,
- o impact indicators that measure longer term effects

2.1 PROCESS INDICATORS (OUTCOME OBJECTIVES)

For each target group, the information system will record:

- o NUMBERS OF TRAINING OF TRAINERS (TOT) PARTICIPANTS TRAINED. The number trained will be compared to the numbers identified for training in the Action Plan.
- o NUMBERS OF SESSIONS CONDUCTED BY TOT PARTICIPANTS. With non-school-going youth, a total of thirty participants (two groups of 15 each) will receive TOT training. These thirty TOT participants will replicate the training twice each. The actual number of training sessions conducted by TOT graduates for each target group will be recorded and compared with the number predicted in the Action Plan.

2.2 OUTCOME OBJECTIVES (SHORT TERM IMPACT)

Results of the KAPB survey, and results of focus groups, conducted when appropriate, will enable project staff to select specific learning objectives for each target group.

These learning objectives produce learning activities which are intended to alter knowledge, attitudes, practices, and beliefs about HIV/AIDS. During the training event, it is possible to measure knowledge, attitudes, and beliefs, but not practices.

- o LEARNING OBJECTIVES ACHIEVED. Each learning objective will produce a question or questions, which together will form pre- and post-tests completed by training participants. Scores from post-tests will be compared

to scores on pre-tests to establish the success of each objective and document changes in knowledge, attitudes, and beliefs.

- o PARTICIPANT TRAINING COMPETENCY By comparing these documented changes at the TOT level with documented changes at the level of replicated training, it will be possible to assess success in making TOT participants competent trainers.

2 3 LONG TERM IMPACT

Retention, over time, of changes in knowledge, attitudes, and beliefs - and changes in practice - are more difficult to measure within the constraints of project resources. Nevertheless, the following activities and indicators will produce indirect indicators of long-term impact.

- o DIAGNOSED CASES OF AIDS. The National AIDS Prevention and Control Programme (NACP) has designed a diagnostic reporting form which will be submitted directly to the NACP office.
- o CONDOM UTILIZATION. With the exception of pharmacies and private physicians all condoms distributed in Swaziland are currently ordered through the Research Unit of FLAS because of USAID/Swaziland's bilateral project with FLAS, and distributed by the MOH Central Stores. Once the expatriate technical advisor in the Research Unit has completed his contract, FLAS will resume condom procurement through its own Supplies Office. Bin Cards record the name of the facility and the number of condoms collected. This will allow the comparison of condom distribution across time and between regions

Also, FLAS clinics report number of condoms issued. Since FLAS clinic staff will be trained under the project, condom use among FLAS clients is an indicator of behavioral change in this target group.

2 4 SAMPLE SURVEYS

The Information Manager has been chosen to assure the

capacity to design sample surveys. These surveys will be conducted by IEC Unit AIDS Educators on an occasional basis. Particular attention will be given to those target groups, such as Traditional Healers and SEBENTA, where:

- o the number of levels of training would suggest greater risk of message deterioration, or
- o unusual characteristics of the target group require specialized training materials.

2.5 KAPB SURVEY SUPPORT

The instrument chosen for the KAPB survey is the WHO GPA survey. The selection of this format reflects the origin of this activity from a request by the National AIDS Prevention and Control Programme. Results of the survey will contribute to the selection of messages for Target Group training.

Time did not permit a visit to the staff of the Social Sciences Research Unit. Following this consultancy, Project HOPE staff will meet with SSR staff to assure adequate software for processing, and accurate and timely reporting of results.

3.0 INSTITUTION BUILDING

This project design calls for Project HOPE to collaborate with FLAS in order to expand the institutional capacity of FLAS to provide HIV/AIDS IEC services beyond the duration of the project.

This can be achieved in the area of information management through technical collaboration with the Research Unit at FLAS. This unit includes two positions, a Research Officer and an Assistant Research Officer. Recent attempts to fill these positions have proved unsuccessful.

Instead, the work of this unit is currently accomplished by two expatriate advisors provided by a USAID-funded Pathfinder project and by Lutheran World Federation.

The successful staffing of this unit is essential to both the success of the Project HOPE project and to the continuing HIV/AIDS activities of FLAS. The monitoring and assessment of Project HOPE/FLAS HIV/AIDS target group activities would be most appropriately undertaken by the Research Unit through the analysis of process indicators, service delivery statistics and through sample surveys.

In addition, appropriate staffing of the Research Unit would enable FLAS to attract additional donor funds. In other countries in the region, Family Planning Associations (FPAs) affiliated with the International Planned Parenthood Federation (IPPF) have used donor funds attracted by their research departments to support institutional expansion.

The project will support FLAS efforts to establish a Counseling Center within at least one of its current clinic facilities. Tacking of counseling services will be included in the information system.

3.1 THE INFORMATION MANAGER

The Project Proposal calls for a full-time, local-hire Information Manager. In discussion with the project team, a Position Description was drafted for this position. A copy was given to the USAID HPNO for comment.

The full position description is included in the Appendix. In the summary, however, it calls for the following activities:

- o support for the monitoring of target group activities as described above and including not only computer processing, but also assuring the timely and accurate submission of data,
- o collaboration with the FLAS Research Unit in order to expand capacity for production of impact indicators and for the conduct of sample surveys, and
- o support for project administrative requirements including the generation of periodic statistics required for reporting purposes.

This position description was distributed to a number of persons who might be expected to know of appropriate candidates. This

process proved successful and five candidates were interviewed. Four of these proved acceptable. One, in particular, met the criteria.

TRAINING FOR THE INFORMATION MANAGER

Interviewing conducted during the consultancy suggests that the consultancy suggests that the anticipated Information Manager will be equipped with adequate training and experience to assume responsibility for the computer processing activities.

The Information Manager, though, will have little or no background in Health, Family Planning, and related fields. Competency in such topical areas will facilitate the Information Manager's ability to serve both the objectives of Project HOPE, and the continuing role of the Research Unit of FLAS.

The Centre for African Family Studies (CAFS) in Nairobi offers a course in Family Planning Research and Evaluation. ESAMI offers similar courses. Participation in such coursework will enhance the contribution of the Information Manager. The CAFS course costs US\$ 4,000, including room and board, and exclusive of air travel.

3.2 COMMERCIAL BACKUP

It is unreasonable to expect that in any country, much less developing countries, a single person will have the full range of skills required to support a computer installation without backup and support.

The most essential skills have been included in the position description for the Information Manager. Other services, such as:

- o hardware support,
- o occasional software and design support, and
- o standardized training

can be provided in the most cost-effective manner through contractual arrangements with local computer support firms.

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In discussion with the project team, a Request for Assistance (RFA) was drafted. The full RFA is included in the appendix. A copy was given to the USAID HPNO for comment.

Three local firms have agreed to submit proposals delineating the nature and cost of providing such service. These were:

Computer Systems Support, Ltd ,
Eseveni Computers, Ltd , and
Computronics Ltd. (Manzini office).

These proposals will be reviewed by the team and a decision made concerning which firm to contract with.

3.3 COMPUTER TRAINING

Proper monitoring of training activities and the design of sample surveys will depend, in part, on the ability of the Project HOPE staff to communicate requirements to the computer-oriented Information Manager. Two firms in Manzini, Eseveni Computers, Ltd., and Computronics, Ltd., offer short courses in orientation to computers, PD DOS, Wordperfect, Lotus, and DBASE. These courses are inexpensive. The cost per course is approximately E300.

Such costs are more than justified by the expected benefits in quality of work and productivity.

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APPENDICES

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APPENDIX PERSONS CONTACTED

Rudolph Maziya	AIDS Committee Programme Manager	NAC
E. Hlope	Under-Secretary for Evaluation	MOH
Mrs. Khetsiwe Dlamini	Executive Director	FLAS
Mrs. Nomcebo Manzini	Programme Director	FLAS
Domique Mayiga	Asst. Research Officer	FLAS
T. Dr D. Maseko	President	THO
Tom Fen	Res. Advisor, FHS project, Pathfinder	
Mary	Acting Director	USAID
Alan Foose	HPNO	USAID
Jay Anderson	Asst. HPNO	USAID
Vivian Harmon Watkins	Sr System Analyst	Comm Supp.
Tracey Harmon	Sr Programmer/Trainer	Consultant
David Van Vuuren	Manager	Computronics
Jonna J. Kruijer	Instructor/DBASE Programmer	"
Lura Xaba	Director	Eseven1
Marjorie A. Souder	AIDS/HIV COORDINATOR	Project HOPE
Tom Kenyon	Program Director	Project HOPE
Agatha Lowe	Coordinator, AIDS Control	Project HOPE

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Programme, (annual activities 1 October 1989 through 30 September, 1990), 14 December 1989.

Project HOPE, PROPOSAL, PREVENTION OF HIV/AIDS INFECTION IN SWAZILAND, July 1989 through June 1991. April 20, 1989.

USAID, Cable re Project HOPE AIDS Program, 8 March, 1990.

USAID, Cable re Project HOPE AIDS Program, Detailed Implementation Plan, 5 March, 1990.

MOH, A THREE-YEAR MEDIUM TERM PLAN FOR THE PREVENTION AND CONTROL OF AIDS IN SWAZILAND (1989-1991), September, 1989

MOH, Swaziland, 1988 FAMILY HEALTH SURVEY, June, 1989

APPENDIX 8

CURRICULUM VITAE OF DR. GUGULETHU ZAMAKHOSI GULE

CURRICULUM VITAE

A. PERSONAL DATA

Name Gugulethu Zamakhosi Gule
[REDACTED]
Position Held Demography Lecturer

Address University of Swaziland
Private Bag No. 4
Kwaluseni
Swaziland

Phone Number 84011 ext. 266
Fax Number 55270

B. *EDUCATIONAL BACKGROUND

Ph.d Demography, University of Pennsylvania,
Philadelphia, U.S.A. (1990)

M.A. Demography, University of Pennsylvania,
Philadelphia, U.S.A. (1984)

Dpl. Public Health, Boston University, Boston,
U.S.A. (1987)

B.A. Statistics and Mathematics, University College
of Swaziland, Kwaluseni, Swaziland, 1982

C. PROFESSIONAL EXPERIENCE

1. Consultant:
 - a) Studied the needs and problems facing youth in Swaziland, 1985, International Planned Parenthood Federation, Nairobi, Kenya
 - b) Taught basic demographic techniques to middle-level personnel, 1985-86, Swaziland Ministry of Health and Ministry of Education
 - c) Analysis of 1988 Family Health Survey data, 1989, Centers for Disease Control, Atlanta, U.S.A.
2. 1986 Population Census Technical Advisor, 1985-86, Central Statistics Office
3. Demography lecturer, first appointment, 1982, University of Swaziland
4. Statistics Lecturer (Full-time and Part-time), 1984-86, University of Swaziland

D. MEMBERSHIP OF ACADEMIC AND/OR PROFESSIONAL INSTITUTIONS

1. Population Association of America
2. Swaziland Economics Association
3. Family Life Association of Swaziland
4. Swaziland Red Cross

E. FELLOWSHIP OR SCHOLARSHIP AWARDS

1. Population Council, 1989-90
2. African American American Institute (USAID), 1986-89
3. Rockefeller Foundation, 1983-84
4. Swaziland Government, 1978-82

F. RESEARCH INTERESTS

1. Infant and childhood mortality and health
2. Fertility and family planning
3. Population and development

G. COMPUTER EXPERIENCE

- a) Types of Computers Used:
- Main Frame
 - Micro Computers IBM, Beltron and other IMB Compatibles, and Zenith
- b) Software Packages Familiar With:
- Lotus - Spreadsheet
 - SAS - Statistical Package
 - SPSS - Statistical Package
 - Chart - Graphics
 - Pascal - Programming
 - PC-Write - Word Processing
 - Word Star - Word Processing
 - Mortpak - Demographic Package

I. RESEARCH PAPERS AND PUBLICATIONS

- "Local Newspaper Readership", Prepared at the request of Times of Swaziland, 1982
- "Education and Labour Force Participation", University of Pennsylvania, M.A. Requirement, 1983
- "Internal Migration Patterns in Swaziland", University of Pennsylvania, M.A. Requirement, 1984
- "Fertility Differentials in Swaziland", University of Pennsylvania, M.A. Requirement, 1984

"Fertility and Family Planning in Swaziland",
Prepared for Presentation at a Seminar on
Population in Swaziland, June, 1984

"Implications of Swaziland's Population Structure
on the Economy of Swaziland", Prepared for
Presentation at a Seminar for Peace Corps, Mountain
Inn, Mbabane, 6-8 August, 1985

"Family Life and Health Situation Analysis for the
Youth in Swaziland", International Planned
Parenthood Federation, Nairobi, Kenya, 1985

"Fertility in Swaziland", Prepared for Presentation
at a Conference on Population and Development in
Swaziland, Yen San, 1986

"Childhood Mortality in Swaziland. Levels, Trends and
Differentials", Ph.d Thesis, University of
Pennsylvania, May 1990

"Socio-Cultural Factors Affecting Family Planning
Programmes in Africa", Prepared for Presentation at
a Conference on Socio-Cultural Factors Affecting
Family Planning in Developing Countries, United
Nations, New York, 20-22 June, 1990

"Population Dynamics in Swaziland", Prepared for
Presentation at a Seminar on Population and
Development, Nhlangano Sun, August, 1990

SIGNED

Gule

Gugulethu Z. Gule

APPENDIX 9
STD/AIDS HELPLINE PILOT PROJECT REPORT

APPENDIX 9

PROJECT HOPE/FIAS HIV AIDS PREVENTION PROGRAM

SIDs and AIDS HELPLINE Pilot Project Report

Introduction

The telephone SIDs and AIDS Helpline Service was proposed by Project Hope and FIAS IEC staff to be piloted at the FLAS/Project Hope stand at the 1990 Swaziland International Trade Fair held in Manzini from 31st August - 9th October. An application for the installation of the telephone was made and approved by the Post and Telecommunications staff.

The telephone service was designed to answer questions and provide information on SIDs and HIV/AIDS to the public during the 10-day Trade Fair period, as a pilot for determining whether or not a permanent AIDS Helpline should be established in the near future. Such a service could appeal to people who wished to be anonymous and to have intimate and highly sensitive questions asked in an atmosphere of guaranteed confidentiality. A press release statement announcing and explaining the service was given to the local TV and Newspapers on the 27th August 1990 with a follow-up Press Release sent on 5/9/90. (Press Releases annexed)

A roster of counsellors who would operate the Helpline was drawn up. Three counsellors (two Project HOPE staff - Thandi Shongwe and Thandv Nhlengethwa and one nurse Jillian Zwane from King Sobhuza Clinic) manned the Helpline. At first it was felt that two-hour shifts would be optimal but experience quickly proved that three hour shifts were adequate and manageable. There were two shifts per day to cover the operating hours of 10 00 am to 4 00 pm.

A short questionnaire was designed to collect basic information about callers using the Helpline service and about types of questions and concerns they had about AIDS and SIDs. (See questionnaire annexed to this report.) The project staff felt the information to be collected should be brief and impersonal in order to support confidentiality and not to subject the caller to time-consuming and interest-reducing enquiry. The counsellors operating the Helpline felt that the callers were cooperative and did not mind answering the few questions asked of them.

Response and results

The service received a good response from all four regions of the country from both males and females in spite of having only two days to publicize the service. Twenty eight (28) of the calls received were recorded. However calls received outside the 10am - 4pm operating time of the Helpline were not recorded. Some of these were answered by non-Helpline staff who had not been informed of the recording procedure. The second Press Release to update information on the AIDS Helpline and the response it was receiving sent to all mass media on 5th September 1990 resulted in an increase in calls received over the following days.

- 1 -

RECORDED CALLS BY SEX AND AGE

Age Group	Females	Males	Total
10 years	3 (11%)	4 (14%)	7 (25%)
20-40 years	8 (29%)	13 (46%)	21 (75%)
Total	11 (40%)	17 (60%)	28 (100%)

As data in the table above shows 40% of the calls were from females and 60% of the calls were from males. The main age group of the callers was approximately 19-25 years. This is known because callers often stated their exact age to the counsellor instead of keeping to the broader age groups of the Caller Questionnaire, mentioned above.

In addition several people came to the stand seeking advice and information on AIDS from the counsellors. Some representatives of companies, schools, women's development groups and church groups also came to the stand to request that we educate their groups about AIDS.

Most calls came from the regions of Mhohho and Manzini which is to be expected since these regions contain the main urban centres, the greatest population and best general access to telephones. However, Shiselweni had an unexpectedly high response in spite of low population, poor phone links and less access to phones, while Lubombo, with good phone links and better access than Shiselweni was the region with the lowest response.

Questions asked by Callers

1. Sexually Transmitted Diseases:

Seven (7) questions were from callers who, previously having had STD infections such as gonorrhoea, syphilis, and pubic lice were worried of being at risk of HIV/AIDS.

2. Condom Use

Seven (7) questions were asked about the reasons for using a condom, effectiveness of the condom in preventing AIDS and advice on how to help partners accept condoms.

3. Pregnancy.

Three (3) questions were related to pregnancy in an HIV carrier, specifically whether the virus affects fertility. There was also a question of whether pregnancy can take place just immediately after menses.

4. General Basic Information about HIV/AIDS.

Five (5) callers needed information about HIV/AIDS e.g. what AIDS is how it is transmitted its treatment and prevention

5. Symptoms of HIV/AIDS.

Five (5) questions were asked about symptoms a person would feel or should expect when if he has caught the HIV infection

6. HIV Test

Three (3) callers wanted to know if it would be possible for them to be tested for HIV

7. Presence of HIV/AIDS in Swaziland.

One (1) wanted to know if AIDS really is in Swaziland

Caller Response on Questions of Future Use of HELPLINE Service

Twenty six (93%) out of the twenty eight callers said they themselves would use the service again in the future and that they would recommend it to friends. One person was undecided. Only one person did not intend to use the service in the future. These results could be interpreted as user satisfaction with the service and as an expression of the continuing need for the service

Additional Observations and Opinions of the Helpline Counsellors

Many callers expressed serious personal concerns and seemed to have been worried for a long time about their symptoms without seeking advice or treatment from existing health services. The Helpline service seemed to be a relief to them. Some of the callers were quite tense and nervous when they started asking their questions but gradually relaxed as the conversation continued. Two of the callers asked for letters from the counsellors to follow up on the advice given them by the counsellor. One had not been able to face a doctor and explain his need and STD symptoms for treatment, but felt a letter from the counsellor would help him to seek medical care. The other wanted to be tested for HIV and was willing to have pre-test counselling first but wanted a letter of referral by the Helpline Counsellor.

Referral of Helpline Callers to Established Counselling Network

The AIDS counsellors, trained in 1990 by the project and now established in all regions and most areas proved to be an excellent resource for the AIDS Helpline. Callers who had had the ice broken by discussing their concerns with the Helpline counsellors could be referred to a counsellor near to where they lived for any additional counselling needed e.g. pre-test

counselling. A list of names and addresses of the trained AIDS counsellors in Swaziland was kept next to the Helpline telephone for easy referral. These referrals also will assist the newly trained counsellors to become better established and known in their areas.

Conclusion

The AIDS Helpline piloted by the project at the Trade Fair was considered by all to be very successful and well worth starting on a permanent basis in the future. The National AIDS Programme (NAP) and the IEC AIDS Committee, at a meeting on 19/9/90, expressed complete support for an AIDS Helpline in Swaziland. The NAP would like to have the Helpline in its office and wants a full-time counsellor to be employed for that purpose. The problem at the moment is that all NAP staff positions are presently unfilled including a permanent Programme Manager. The logistics and cost for a permanent Helpline need to be determined and a feasible interim plan needs to be drafted. This will be done in the near future by staff from FLAS Project HOPE, and the Acting Programme Manager of the NAP.

APPENDIX 10
SEBENTA TRAINING COURSE CURRICULUM

COURSE CONTENTOBJECTIVESUnit 1 Introduction and Orientation

- | | | |
|---|--|--|
| 1 | Collaboration plan for Project HOPE/FLAS HIV/AIDS Prevention Project and Sebenta | Explain the plan |
| 2 | Course format and Training Expectations
1 1 Expectations of participants
1 2 Outline of training course
(Topics, methodology, and evaluation) | Explain Course expectations and format |

Unit 2 The National AIDS Programme in Swaziland

- | | | |
|---|--|---|
| 1 | The Medium Term Plan | Describe the NAP the MTP, and the H I V / A I D S prevention role and activities of some NGOs |
| 2 | The Role of NGOs in the Medium Term Plan | |
| 3 | Government collaboration with specific NGOs, e g
* Project HOPE/FLAS
* CARE International
* Man Talk
* Red Cross | |

Unit 3 Overview of HIV/AIDS in Swaziland

- | | | |
|---|--|---|
| 1 | Definition of Terms
+ AIDS
+ HIV
+ STDs
+ Carrier
+ Incubation period | Define the main terms used in discussion of HIV/AIDS to facilitate understanding of them |
| 2 | Demographic Information re HIV/AIDS
2 1 HIV/AIDS in Southern Africa
2 2 HIV/AIDS in Swaziland Studies and their Results
+ Studies cited in Maziya Paper
+ KABP Baseline Survey | to know the incidence/prevalence of AIDS as a regional and local threat also local KABP |
| 3 | High Risk Behaviours in Swaziland
+ Multiple sex partners
* Unprotected sex with unknown partner
* Alcohol abuse leading to unprotected sex
+ Handling blood and other body fluids without gloves
+ Improper care and disposal of body fluids and sharp objects that come into contact with body fluids | To identify those behaviours which could/do expose an individual to a greater risk of contracting the HIV |

- | | | |
|---|---|--|
| 4 | Relationship between Sexually Transmitted Diseases (STDs) and the risk of contracting the HIV | to explain the relationship between other STDs and risk of contracting HIV |
|---|---|--|

Unit 1 IEC Activities in Swaziland

- | | | |
|---|---|--|
| 1 | AIDS IEC Action Group | To explain the present structure for coordination of AIDS IEC and those IEC activities being implemented |
| | 1 1 Purpose | |
| | 1 2 Activities | |
| | 1 3 Member organizations and activities | |
| | * Health Education Unit MOH | |
| | * Curriculum Development MOE | |
| | * Council of Swaziland Churches | |
| | * WHO | |
| | * Local NGOs | |
| | * International NGOs | |

Unit 5 Strategy of the HIV Germ

- | | | |
|---|---|--|
| 1 | How the HIV affects the Immune System | To explain how |
| 2 | Phases of Infection with HIV | To outline and distinguish between the different phases of HIV infection |
| | 2 1 Acute response | |
| | 2 2 Antibody development | |
| | 2 3 Asymptomatic | |
| | 2 4 AIDS related diseases | |
| | 2 5 AIDS | |
| | 2 6 Death | |
| 3 | Difference between a healthy carrier and a person with AIDS | To point out and explain the difference |

Unit 6 Testing of blood for HIV in Swaziland

- | | | |
|---|---|---|
| 1 | The different tests for HIV antibodies | To explain the tests and methods for detecting HIV antibodies |
| | 1 1 Enzyme-Linked Immuno Absorbent Assay (ELISA) test | |
| | 1 2 Western Blot test | |
| 2 | The meaning and accuracy of the HIV tests | To identify test results accuracy |
| 3 | Candidates for testing in Swaziland | To identify who is presently tested for HIV in Swaziland |
| | * Blood donors | |
| | * Persons with signs and symptoms suggesting AIDS | |
| | * Others | |

4	Confidentiality and informed consent	To explain and discuss these important issues
5	Limitations to mass testing	
	† Expense	
	† False sense of security for those testing negative	To discuss some limitations to mass testing
	† Ethical and political considerations	
Unit 7	<u>Sexually Transmitted Diseases in Swaziland</u>	
1	STDs Common in Swaziland	To describe and distinguish between the STDs common in Swaziland
	† Gonorrhoea	
	† Syphilis	
	† Genital warts	
	† Pubic lice	
	† Trichomoniasis	
2	Signs and symptoms of those STDs common in Swaziland	To list signs and symptoms of STDs in Swaziland
3	Transmission of STDs	To explain how each disease can be transmitted
	3 1 Sexual intercourse (all)	
	3 2 Blood (Syphilis)	
	3 3 Mother to infant (Gonorrhoea and Syphilis)	
4	Treatment of STDs	To state how each disease is treated
	4 1 Antibiotics	
	4 2 Traditional Healers methods	
	4 3 Other	
5	Prevention of STDs	To explain how these diseases can be prevented
	5 1 During treatment	
	5 2 For the non-infected	
	5 3 From mother to infant	
Unit 8	<u>Transmission of the HIV Germ</u>	
1	Blood and body fluids	To explain how the HIV is and is not transmitted
2	Sexual	
3	Mother to infant	
4	Ways the HIV is NOT transmitted i e common misconceptions re transmission	
Unit 9	<u>Prevention of HIV/AIDS</u>	
1	Actions to reduce the risk of contracting the AIDS virus	To describe actions the individual could

1 1	Low risk sexual behaviours	take to decrease
1 2	Avoidance of alcohol and drug abuse	the risk of
1 3	Avoidance of unprotected contact with blood and other body fluids	contracting the
1 4	Avoidance of STDs	AIDS virus
1 5	Completing treatment for STDs	
1 6	Ensuring that treatment is received with new or sterile needles razors, etc	
2	Obstacles to preventing oneself from acquiring HIV/AIDS (Incl KABP results)	To identify possible
2 1	Lack of availability of preventive material measures, eg condoms etc	obstacles to
2 2	knowledge	preventing
2 3	Attitudes	oneself from
2 4	Peer pressure	acquiring
		HIV/AIDS
Unit 10	<u>Condom Demonstration and Discussion</u>	To become
		familiar with
		condoms and learn
		how to use them
Unit 11	<u>Psychosocial Issues of HIV/AIDS</u>	
1	Cultural and social factors which could contribute to the spread of AIDS	To identify
1 1	Beliefs and practices regarding sexual activity	cultural social
1 2	Marriage customs	and psychological
1 3	treatment practices	factors which
1 4	Fear of being tested/of learning HIV test results	could contribute
1 5	Dangerous responses to positive test results eg want to infect others	to the spread of
1 6	Others	A I D S in
		Swaziland
Unit 12	<u>Counselling in HIV/AIDS in Swaziland</u>	
1	Importance of confidentiality in counselling for HIV/AIDS clients	To explain the
1 1	Definition of confidentiality	importance, and
1 2	Role of confidentiality in promoting a productive counselor-client relationship	difficulty of
1 3	Associated constraints and problems	confidentiality
		in HIV/AIDS
		counseling in
		Swaziland
2	Difference between giving information and counseling	To explain the
		difference

- | | |
|--|---|
| <ul style="list-style-type: none"> 3- Characteristics of a good counselor <ul style="list-style-type: none"> * Listens * Empathetic * Respectful * Non-judgemental 4 strategies to encourage others to avoid acquiring the HIV <ul style="list-style-type: none"> 4 1 Values clarification 4 2 Decision-making models 5 Present HIV/AIDS counseling facilities and services in Swaziland <ul style="list-style-type: none"> 5 1 Trained counsellors and locations 5 2 AIDS Helpline Pilot 5 3 Growing need 5 4 Obstacles | <p>To describe the qualities and characteristics of a good counselor</p> <p>To describe some strategies which might be used to encourage others to avoid acquiring HIV/AIDS</p> <p>To describe the present HIV/AIDS counseling services available</p> |
| <p>Unit 13 <u>Sexually Transmitted Diseases and AIDS in Paediatrics in Swaziland</u></p> | |
| <ul style="list-style-type: none"> 1 Professional observations on paediatric STD and AIDS cases in Swaziland <ul style="list-style-type: none"> 1 1 Trends in incidence and prevalence of paediatric STD and AIDS cases 1 2 Probabilities and influencing factors of maternal transmission of these diseases 1 3 Prognosis for the infants with STDs and AIDS 1 4 Medical resources presently needed, and projected for these cases 1 5 Paediatric AIDS related problems for society and the nation, eg orphans 1 6 Suggestions and recommendations | <p>To describe the present situation regarding STDs and AIDS in paediatrics in Swaziland</p> |
| <p>Unit 14 <u>The Impact of AIDS on the Economy</u></p> | |
| <ul style="list-style-type: none"> 1 The present and potential threat of AIDS to the main sectors of the economy <ul style="list-style-type: none"> 1 1 In Swaziland 1 2 In Southern Africa | <p>To describe the economic damage attributed to AIDS</p> |
| <p>Unit 15 <u>The involvement and Role of Other Sectors in HIV/AIDS Prevention</u></p> | |
| <ul style="list-style-type: none"> 1 The Mass Media <ul style="list-style-type: none"> 1 1 present activities and involvement of the mass media in Swaziland related to HIV/AIDS prevention | <p>To show that AIDS Prevention is an effort not to be limited only to the Health sector</p> |

- | | |
|---|--|
| <ul style="list-style-type: none"> 1 2 Additional HIV/AIDS-related activities appropriate for mass media to consider adopting in the future 1 3 Constraints experienced | <p>To explain the role and involvement of mass media in AIDS prevention</p> |
| <ul style="list-style-type: none"> 2 The town Council: 2 2 Present HIV/AIDS prevention related activities being implemented or supported by Town Councils in Swaziland B Additional HIV/AIDS prevention related activities appropriate for Town Councils to consider adopting in the future | <p>To explain the role and involvement of the Town Council in AIDS prevention as another example of a different sector addressing AIDS</p> |
| <p>Unit 16 <u>Determining the Role of Sebenta in HIV/AIDS Prevention</u></p> <ul style="list-style-type: none"> 1 Review of Sebenta plan to collaborate with Project HOPE/FLAS HIV/AIDS Project 2 Identifying <ul style="list-style-type: none"> 1 roles and tasks of Sebenta staff especially Regional Officers 1 support and technical assistance tasks for the HOPE/FLAS Project. | <p>To have Sebenta staff now more knowledgeable about STDs and HIV/AIDS discuss and determine an appropriate realistic and effective role for Sebenta in HIV/AIDS Prevention</p> |

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APPENDIX 11

LIST OF PARTICIPANTS FOR SEBENTA TRAINING COURSE

APPENDIX 11

PROJECT HOPE/FLAS HIV/AIDS PREVENTION PROJECT
STDS AND HIV/AIDS TRAINING COURSE
81H-111H OCTOBER 1990

LIST OF PARTICIPANTS AND THEIR ADDRESSES

Sebenta Participants

- 1) Mr David Dlamini Executive Officer P O Box 64 Mbabane
- 2) Ms Emmah Dlamini, Publication Officer P O Box 64, Mbabane
- 3) Mr Michael Dlamini, Project Educator, P O Box 64 Mbabane
- 4) Mr Musa Dlamini Regional Officer, P O Box 112, Nhlanguano
- 5) Ms Sophie Dlamini, Regional Officer, P.O Box 64, Mbabane
- 6) Mr Dumisuni Gwebu Regional Officer, P O Box 64 Mbabane
- 7) Mr Jabulani Kondowe, Regional Officer, P O Box 188.
Sidvokodvo
- 8) Mr John Kubheka, Field Supervisor, P O Box 64, Mbabane
- 9) Mr Paul Lukhele, Materials Officer, P O Box 64, Mbabane
- 10) Mr Titus M Mabula, Regional Officer P O Box 64, Mbabane
- 11) Mr Hebrone Matsebula, Regional Officer, P.O Box 64, Mbabane
- 12) Mr Abel Mbingo, Regional Officer P O Box 64, Mbabane
- 13) Mr Amos Nkambule, Regional Officer, P O Box 64, Mbabane
- 14) Mr Jameson Shabangu, Regional Officer, P O Box 112
Nhlanguano
- 15) Mr Bhekisukati, Regional Officer, P O Box 64, Mbabane
- 16) Mr George M Thabede. Training Officer, P O Box 2424
Mbabane

Youth Organization Participants

Swaziland Girl Guides Association:

- 17) Ms Sibongile Simelane Trainer P O Box 112, Nhlanguano
- 18) Mrs M M Thwala, P.O Box 1699 Manzini

Swaziland Boy Scouts Association:

- 19) Mr Sibusiso Patrick Nxumalo, Assistant Trainer, P O Box 581,
Mbabane
- 20) Mr A G Dhladhla Field Commissioner, P O Box 1944, Manzini

Swaziland National Youth Council:

- 21) Ms Lungile Xaba, P O Box 22, Mbabane
- 22) Ms Nonhlanhla Nkambule, P O Box 22, Mbabane

Swaziland Youth Relief Association:

- 23) Mr Hezekiel Manana P O Box 2691, Manzini
- 24) Mr Boniface Ndlela P O Box 2691, Manzini

Siphila Nje Drama Society:

- 25) Ms Busie Msibi
- 26) Mr Siphiso Dlamini

Manzini Youth Brigade:

- 27) Mr Pius Ngoza, Field Officer, P O Box 558, Manzini
- 28) Mr Jerome Phiri, Brigadier, P O Box 558 Manzini

Swaziland Workcamps Association:

- 29) Ms Pinkie Neal

Church Organization Participants

Council of Swaziland Churches:

- 30) Ms. Thabani Motsa, Organizing Secretary, P O Box 1095, Manzini

Anglican Church:

- 31) Mrs J Gama, Matron, St Michaels School, P O Box 15, Manzini

Catholic Church.

- 32) Sister Jane Shongwe, St Julian's Clinic, P O Box 341, Manzini
- 33) Mr Patrick Nplangamandla, Teacher, Salesian Primary School P O Box 95, Manzini

Lutheran Church:

- 34) Mr Mafika Shabalala Youth Field Worker, P O Box 278, Manzini
- 35) Ms Susan Ndladla Youth Field Worker P O Box 278 Manzini
- 36) Rev Absalom Mnisi Manager of Ecumenical Movement

Other Organization Participants

- 37) Mr Thulani Mtetwa, Swazi Observer
- 38) Mrs Ntfombivenibuso Tfwala Educator, Family Life Association P O Box 1051, Manzini

Appendix 15

Newspaper articles related to expectations and roles of
Sebenta, youth organizations, and church organizations
in STDs and HIV/AIDS Education and Prevention

AIDS alarm



WHAT insect is this. Well for those who do not know, this is a prawn. However the fact remains that not many people have seen a giant prawn this size on their tables. Hence we are unable to say whether it is edible or not. These prawns were for sale at the Manzini Bus Station yesterday, at E18 per kilogram. Again we are unable to verify whether that is cheap or expensive. Suppose it depends on the prawn eaters.

Two out of every hundred people now have disease

BY VUSIE GININDZA

THE RATE at which AIDS is spreading is so fast in the country that it is doubling every half a year.

Speaking at the opening of a four day conference on sexually transmitted diseases the Director of the Department of Extra Mural Services at the University of Swaziland Mr Almon Mkhwanazi said at least two out of every 100 people are now infected with HIV the virus that gives rise to the disease AIDS.

This is compared to 1 out of every 200 last year.

He said: "At this rate it is doubling every six months it will be eight percent next year and 32 percent is one out of every three people by 1992."

Mr Mkhwanazi was officially opening a four day conference to discuss sexually transmitted diseases and HIV/AIDS. It is for Sebenta regional officers

instructors and other members of non governmental organisations.

Among the participants is the Council of Swaziland Churches, the Catholic Church, Anglican Church, Lutheran Church, National Youth Council, the Swaziland Boy Scouts Association, the Youth Brigade of Swaziland and the Swaziland Youth Relief Association.

He said: "Efforts to prevent the spread of AIDS must be intensified to reduce the impact of this disease which already is more devastating to human life and economic progress than any other disease in history."

"In this regard I encourage you to learn well about sexually transmitted diseases and AIDS so that you can return to your organisations and educate others there about these terrible diseases."

"I also encourage each of you as recommended in the national AIDS programme medium term plan to form an AIDS committee within your group for the purpose of developing and carrying out AIDS prevention activities for your groups," Mr Mkhwanazi said.

Granny held

BY MBU'SO MATSENJWA

THE alleged grandmother of Manzini band leader Senzo Nxumalo who was wanted by police in connection with a marathon trial at the High Court involving armed robbery has been arrested.

Senior Crown Counsel Mr Adinkrah Donkoh yesterday informed High Court Judge Mr Justice Ben Dunn that the woman said to be Marriam [Name obscured] has

TOUGH WAS NEVER THIS EASY TO OWN.



THE NEW MAZDA B-SERIES

from front page of Times of Swaziland 17/8/87, p. 10

rentals so VJR was proposed to fix and collect rentals on a five per cent commission fee. It now appears however that VJR have not provided an effective machinery for collection the report said.

VJR on the other hand put the blame for their ineffectiveness on the Council.

"The example of one

but still nothing has been done by the Council to facilitate the collection process or legal proceedings the report said.

On the whole most of the bus rank businesses were in arrears with their rentals for more than three months and the amount exceeded E2000 in each case. As at 30 June 1986 the position of arrears in

revenue accruing from this source and more particularly when remembering that the bus rank shopping complex was built out of improper expenditure.

"The Council had no good explanation for not acting in terms of the lease agreements against the lessees as soon as they were in ar

MEMBERS of Parliament have accused the inspectorate division of the Ministry of Health of laxity in checking rural butcheries.

One MP Mr Dzin gahwe Dlamini suggested that this laxity is

He said the inspectors who are responsible for visiting rural butcheries work on their own. As a result they wander off and do their own private business during working hours.

wait for five before they get an inspector to authorise them to slaughter cattle. The butchers claim that they have lost a lot of money this way.

Chief Siph Shongwe who stated in

AIDS action plan needed

BY VUSIB
CININDYA

THE Executive Director of Sebenta Mr David Dlamini has called for an AIDS action plan.

He said this could be done through a AIDS committee to stop the spread of sexually transmitted diseases and the dreaded Acquired Immune Deficiency Syndrome.

He also warned Swazis to be more responsible in their sexual behaviour as the lives of future generations could be at stake.

Mr Dlamini told about 30 participants during the official closing of a four day STDs and HIV/AIDS course

in Manzini yesterday that though the measures to be taken to fight AIDS are difficult Swazis need to make wise decisions about their actions.

The people of Swaziland are known for being strong and reliable when it comes to making difficult decisions. The time has come for those decisions to be made he said.

Mr Dlamini disclosed that Sebenta will hold a writers workshop in collaboration with the Project Hope/ELAS HIV/AIDS Prevention Project to draft a student primer and teacher's manual on STDs and HIV/AIDS prevention.

After that Sebenta instructors will be trained to teach the new course on STDs and HIV/AIDS prevention and finally in 1991 the new course will be offered to Sebenta students all over the country he said.

Mr Dlamini commended the objectivity of the workshop in the light that it involved church youth and non governmental organisations.

He said that a solid foundation of information and knowledge about all key topics is essential in understanding STDs and AIDS in all the participants so that they can be a good resource in educating others in their respective groups.

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FAX 85069

OUR STAFF CLIFFORD BUSIE GE
WILL BE ONLY TO HAPPY IC

From Times of Swaziland
Saturday October 13, 1990

APPENDIX 12
SHEBEEN OWNERS REPORT

APPENDIX 13
SAMPLES OF HIV/AIDS EDUCATIONAL MATERIALS

**Published in the interest of
safer sex by**



**P.O. Box 86
Malkerns**

**a joint project of
Occupational Health Services
and
Population Services U.K.**

AIDS

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WHAT IS AIDS?

AIDS STANDS FOR

**ACQUIRED
IMMUNE
DEFICIENCY
SYNDROME**

When you get **AIDS** your body can't fight off illnesses so well and one of these illnesses could eventually kill you

WHAT CAUSES AIDS?

AIDS is caused by a virus which infects some of the white blood cells

This virus is called **HIV**
(**Human Immuno-Deficiency Virus**)

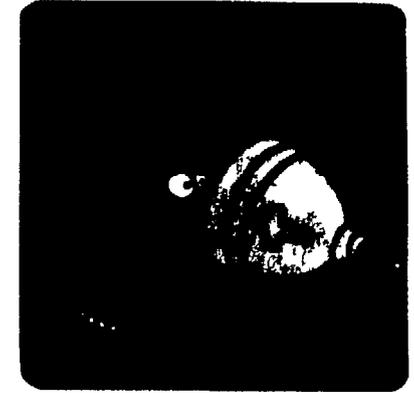
For a long time (often years) after being infected by **HIV**, people look and feel well, but can infect others

These people are said to be
"HIV POSITIVE"

Their blood contains antibodies to the virus, but these antibodies do not attack the virus



GIVING BLOOD



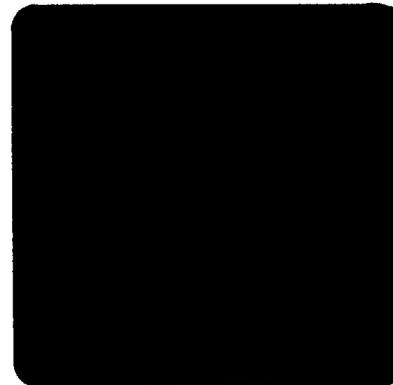
THE CHALICE



VISITING THE DENTIST



SNEEZING



TOWELS



MOSQUITOES

What is The Test?

When the body is infected by HIV (Human Immuno-deficiency Virus), it reacts by producing antibodies. The test looks for these antibodies.

It is not a test for AIDS.

It will only tell you whether or not you have been infected by HIV. The test will not tell you if you have AIDS, and cannot predict whether you will go on to develop AIDS.

What does the test involve?

A doctor or nurse will take a sample of blood usually from your arm and then send it to a laboratory for the HIV antibody test. Because the laboratory has to confirm the test, it will be two to three weeks before you get your results.

How to take the test?

If, after thinking and talking it over, you decide to take the test, you can ask your doctor to arrange it for you.

The result, and the fact you have been tested, is confidential between you and the doctor requesting the test and other staff immediately concerned with your care. It may be difficult to keep the result confidential if you tell friends you are having the test. They will want to know the result.

The result will not be given to anyone but you. You should make another appointment at the clinic because it is important to talk to someone about the result, whether or not your test shows that you have been infected with HIV.

The best defence against HIV and AIDS is information. Read this leaflet as many times as you need to and/or talk to your doctor, before you make a decision about having the test.

What does the result tell you?

If the test does not find antibodies to HIV in your blood, you have probably not been infected with the virus.

However, it can take 2 to 3 months for antibodies to develop after you have been infected with HIV. This means that you should wait up to 3 months after the last occasion when you think you might have been infected before you have the test. And of course, a negative result does not mean you cannot become infected in the future if you put yourself at risk.

If the test does find antibodies to HIV in your blood it means that you have the virus. It does not mean that you have AIDS, or that you will necessarily get AIDS.

It does mean that you are infectious and can pass the virus on to other people through sexual contact or blood even though you may look and feel well.

It does not mean that you can infect someone by normal, everyday contact. Working, eating, drinking or sharing a house with people are all quite safe.

REMEMBER

Safer sex for everyone

Stay with one partner. If this is not possible, reduce your number of sexual partners and always make sure a condom is used during sexual intercourse.

Don't mix blood

Injecting drugs with a needle and syringe, used by someone who has the virus, can give you the virus. 'Muti incisions' or 'gata' performed with unsterilised instruments can spread the virus.

Should I take The Test?

Only you can make that decision. Allow yourself plenty of time to think carefully about the consequences. Knowing that you have the virus can fundamentally affect your life. Here are some ideas to think about.

- Knowing that you do not have the virus may put your mind at ease and stop you worrying unduly about AIDS.
 - If you do have the virus and then develop symptoms of AIDS related disease, your doctor may be able to start treatment earlier, which may benefit you.
 - You may find it easier to practice safer sex if you know that you have the virus (but you should be doing this anyway).
 - If your partner has the virus your results may help you decide how to carry on your sex life.
- On the other hand
- No major life assurance company will give life assurance to someone who has the virus.
 - Your employment may be put at risk if it is known that you have the virus.
 - Some people with the virus have been rejected by their families and friends, and have been left to cope alone.

It may help you to write down a list of all the reasons why you are considering the test. Put it away somewhere private for a few days, then look at it again and ask yourself if you still feel the same.

AIDS JOB

 AIDS (Aquired Immune Deficiency Syndrome) is a frightening disease, but no one should be afraid of catching it at work. This leaflet explains the facts for workers in general, and includes some guidelines for workers in particular occupations.



What is AIDS?

AIDS is caused by a virus known as HIV (Human Immuno-deficiency Virus) that does not survive well outside the body. HIV is not spread by casual, non-sexual contact. This means that you can't catch AIDS from a cough, a sneeze, a handshake, or a hug. Nor can you catch it from the food you eat, no matter who prepared or served that food. You won't get AIDS by working closely with a co-worker who has the disease. Nor will you get it by having coffee, going to lunch, or sharing toilet facilities with that person.

Careful studies have shown that doctors, nurses, and medical technicians who have taken care of AIDS patients have not contracted the disease from them. Scientists have not found a single instance in which HIV has been spread through ordinary non sexual contact in a family, work, or social setting.

AIDS, in fact, is a very hard disease to catch. The purpose of this leaflet is to give you facts about AIDS - facts that can save you needless worry about catching AIDS from co-workers.

Published in the interest
of your safety by



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f AIDS is not spread by casual contact, how does it spread?

he virus is transmitted in three ways

By sexual contact, but only if one person has the virus

By blood Sharing needles or syringes with someone who has the virus 'Muti incisions' or 'gata' performed with unsterilised instruments can spread the virus

From an infected mother to her unborn child

In the past, a number of people were infected through blood or blood products This is now extremely unlikely in Swaziland where all donated blood is screened When donated blood is found to be HIV antibody positive, it is discarded

HIV and its effects

AIDS was first reported in the United States in 1981 since that time there have been cases reported from most every country in the world, but no one knows for sure where the virus first came from No one has recovered from the disease

HIV infects some of the white blood cells which are part of the body's defences and prevents them from working properly As a result, people may get illnesses which the body would normally be able to fight off quite easily Some of these illnesses can become serious or result in death

People who have been infected with HIV do not all have AIDS In fact most of them are still healthy and do not know they are infected From what is known about the condition at present, between a quarter and a third of these people will develop AIDS in about five to seven years time Others may have less severe illnesses due to the virus and some will remain well for long periods

AIDS and your job

Again, it should be emphasised that a fellow employee who has AIDS or who carries HIV does not pose a danger to you For workers in general, there is no need for worry or special precautions There follows some guidelines for workers in particular occupations

Food Handlers

Because HIV is not transmitted in food, people who work with food, such as cooks, caterers, waiters, bartenders, airline attendants, and others, should not be restricted from work because they have AIDS or have been infected with HIV

All food handlers, including those with AIDS, should of course observe good personal hygiene and sanitary food-handling procedures They should take particular care to avoid injury to their hands while preparing food Any food handler with open sores should be restricted from work, and any food that becomes contaminated with blood from a cut should be thrown away

Personal Service Workers

Beauticians, barbers, manicurists, and similar personal service workers routinely observe procedures that protect them and their clients from bacterial and viral infections The risk of spreading HIV in these settings is very low, but when instruments that could draw blood are used, sterilising equipment is important

- Instruments that penetrate the skin, such as ear piercing devices and needles used for electrolysis, tattooing and acupuncture, should be discarded after one use, or thoroughly cleaned and disinfected between uses with a chemical germicide

- The same procedure should be followed for other instruments, such as razors or cuticle scissors
- A personal service worker with open sores should refrain from direct client contact until the wound is healed

Workers With Jobs Requiring Special Precautions

Police, firemen, emergency medical workers, and prison staff may be exposed to blood or other body fluids of people with AIDS or AIDS related disorders because of accidents, fires or violence Fortunately, by observing a few simple rules, workers can avoid infection

- Avoid wounds from weapons and punctures from hypodermic needles used by drug abusers Blood on these articles could cause infection
- Use disposable gloves in handling contaminated articles
- Place contaminated articles in a cut proof evidence bag to be taken to a laboratory for examination or disposal
- Clean up blood spills promptly with freshly diluted bleach (Jik) 1 part bleach to 9 parts water
- Wash your hands after exposure to any possible source of infection Hand washing reduces the chance of spread of infection
- Wear protective masks, gloves gowns, and shoe coverings, if there is a chance of exposure to blood or other body fluids of someone with AIDS



If he says

You can reply

I love you! Would I give you an infection?

Not intentionally But many people don't know they're infected That's why this is best for both of us just now

Just this once

Once is all it takes

I don't have a condom with me

I do (Or) Then let's satisfy each other without intercourse

You carry a condom around with you?- Like a prostitute

I always carry one with me because I care about myself I have one with me tonight because I care about us both

I won't have sex with you if you insist I use a condom

So let's put it off until we can agree (Or) OK, then let's try some other things besides intercourse

Condoms are available from

- Man Talk, at the address on this pamphlet
- The Family Life Association
- Any clinic - just ask the nurse
- Any pharmacy

No one will be shocked, so don't feel that you need to wear a disguise when asking for some

Guidelines for safe and proper condom use

- Use a new condom every time you have sex
- Open the foil pack carefully so there is no danger of tearing the condom inside
- Put the condom on as soon as erection occurs
Do this before the penis touches your body as semen is often released prior to ejaculation

between the thumb and forefinger to expel air and unroll gently down the full length of the penis

Some partners do this as part as their lovemaking

- Although the condom is strong it can be torn by sharp fingernails or rings, so be careful
- If you wish to use an additional lubricant with the condom you should make sure that it is a water based lubricant, such as KY jelly Oil based lubricants, such as Vaseline, weaken the rubber
- After making love, the penis should be slowly withdrawn before it becomes soft, with the condom held firmly in position at the base of the penis Care should be taken not spill any semen
- Wrap the used condom in a tissue and dispose of it hygienically, (flush it down the toilet, or put it in the dustbin)
- Store condoms in a cool, dry place Heat can cause the latex to deteriorate

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A WORD TO THE LADIES



If you are prudish or embarrassed by talk of sexual matters, **DON'T READ THIS!** Then again, **YOU** really ought to read it, for you are the woman most likely to be caught with her skirt up and no condom in her bag.

This message is addressed to the average single woman. She is sexually active at one time or another. Let's dispense with pretences right from the start. Let's make no bones about the fact that single women do have sex. After all we happily accept as fact that single men have sex but balk at the thought that single women have the same habits. If you think about it, the two attitudes, taken together, just don't add up. If single women are so virginal, who do all those single men make love to? five naughty widows living somewhere east of Nhlanguano?

Right! Are you thinking straight? Let's start talking straight

You're in the pub having a quiet drink, or dancing the night away at the disco, when you meet him. Or perhaps he's just a new guy at the office who takes you out for a drink after work. One thing leads to another and before you know it you're back at his place or yours.

But hang on! Are you on the pill or loop or something? You are! **GREAT!** You are obviously a lady who has her life organised - no unplanned pregnancies for you. A carefree evening lies ahead.

Until another little devil starts whispering in your ear

'Heard of gonorrhoea? What about syphilis, chancroid, herpes? Heard of AIDS? - that one kills, and there is no cure!'

You are not the only woman who has ever found this man attractive. Whom did he sleep with last week or last month or last year?

Don't know? Don't care? Just shrug your shoulders and get on with having a good time? **DON'T!** If you unknowingly contract the AIDS virus, you may well transmit it to the children you plan to have in the future. On the other hand you can enjoy yourself and be careful at the same time.

A condom ('tube', 'rubber', 'sheath') is the answer. Be prepared - carry a supply of condoms with you at all times. You'll probably be more comfortable if they're in a case rather than loose.

This immediately poses the new question of how do you get your man to use one, without hurting his feelings, breaking the mood, or seeming 'unsafe' yourself. If he is as thoughtful and as careful as you, there is no problem. He will have his own condom and use it. So, give your new man a chance to broach the subject and use one of his own. Don't resent him for thinking you might not be 100% safe. You've met an intelligent man who is trying to protect both himself and you.

If your man avoids the subject of condoms, you must bring it up, but keep explanations brief and sexually enhancing. You could just hand the condom to him and say something like

'You're a great guy but I'm not ready to have your baby just yet, honey',

'A man as handsome as you must have a hundred girlfriends. Let's play it safe',

'I know that I'm OK and you probably know that you're OK, but I don't know that you're OK and you don't know that I'm OK, so let's be safe'

Emphasise how much protection means to you - and should to him - and that you'll enjoy sex more if you both feel safe. If he doesn't care whether you enjoy it or not, drop him.

But the best technique is direct action. Have the condom ready with the packet open - they can be tough to open when your hands are shaking. Above all, know what to do with it. Instead of saying, 'I hate these dreadful things, but what can one do with disease so rampant?' make the rolling on and off of a condom part of sexual fore and afterplay. Using a dab of KY jelly - not Vaseline, which quickly damages rubber - to help ease the condom on (plus excite your partner), then gently removing it after intercourse can make tender, loving gestures out of what is a sensible precaution.

In spite of all your tact and charm, your partner may remain resistant or defensive. Here are some suggestions to help you answer his objections.

If he says

I know I'm clean, I haven't had sex with anyone for ages

I can't feel a thing when I wear a condom

I'll lose my erection by the time I stop and put it on

It destroys the romantic atmosphere

Using a condom isn't Swazi

What other way?

You can reply

Thanks for telling me. As far as I know, I'm clean too. But I'd still like you to use a condom since either of us could have an infection and not know it.

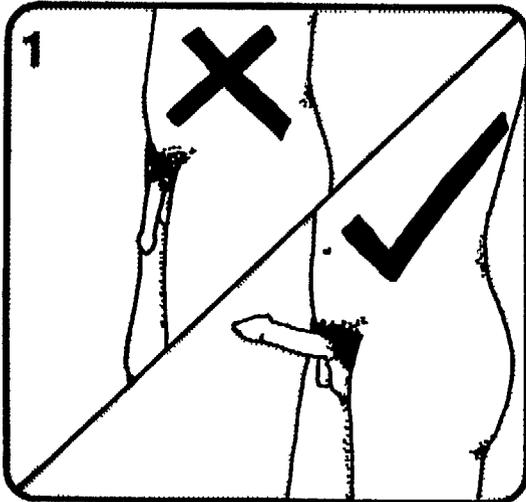
Even if you lose some sensation, you'll still have plenty left.

I'll help you put it on - that way you'll keep it.

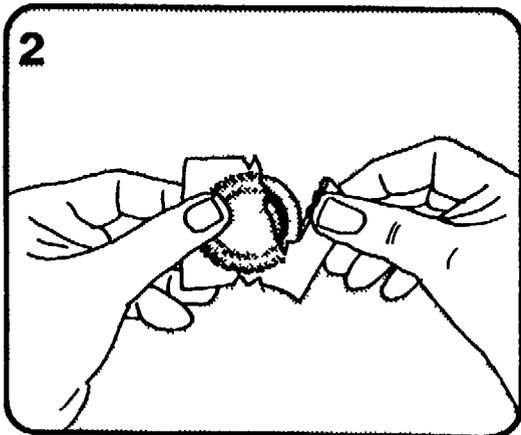
It doesn't have to be that way.

Neither is dying of AIDS - so let's give the condom a try. Or maybe we can look for another way.

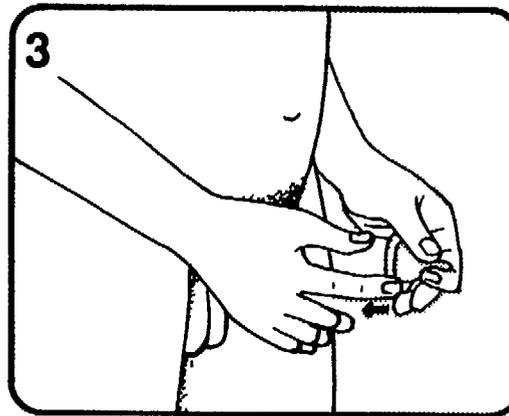
Maybe we'll just pet, or postpone sex for a while.



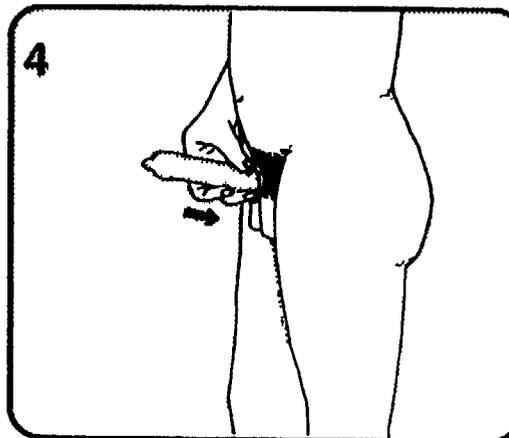
Wait for the penis to go hard



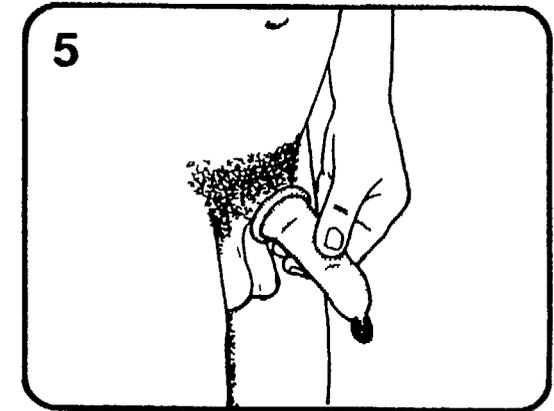
Tear the packet at one of the zig-zag ends, and take condom out of the packet with your hands



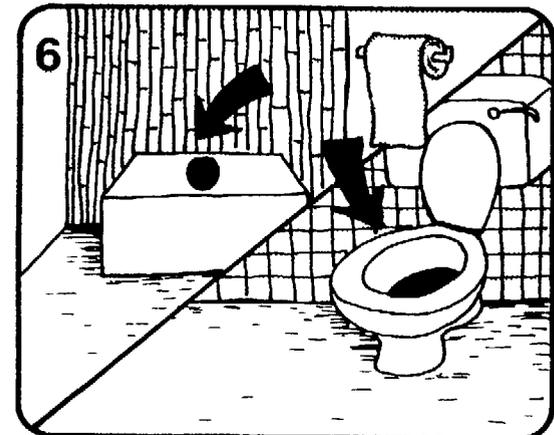
With one hand press the tip of the condom with the thumb and finger
With the other hand put the condom on the head of the penis



Roll it all the way down



Take the penis out of the vagina soon after you come, holding the condom on the penis Do not spill any sperm when you do this
Never use the same condom twice



Wrap the condom securely in toilet paper
Throw it away in the toilet

Condoms are available from

- Any Man Talk agent - look for the logo and you'll know whom to contact Or write to the address on this pamphlet
- The Family Life Association
- Any clinic - just ask the nurse
- Any pharmacy

Guidelines for safe and proper condom use

- Use a new condom every time you have sex.
- Open the foil pack carefully so there is no danger of tearing the condom inside
- Put the condom on as soon as erection occurs
Do this before your penis touches your partner's body as semen is often released prior to ejaculation
- To put on the condom, hold the teat or closed end between the thumb and forefinger to expel air and unroll gently down the full length of your penis
Some partners do this as part as their lovemaking
- Although the condom is strong it can be torn by sharp fingernails or rings, so be careful
- If you wish to use an additional lubricant with the condom you should make sure that it is a water-based lubricant, such as KY jelly Oil-based lubricants, such as Vaseline, weaken the rubber
- After making love, your penis should be slowly withdrawn before it becomes soft, with the condom held firmly in position at the base of the penis
Care should be taken not spill any semen
- Wrap the used condom in a tissue and dispose of it hygienically, (flush it down the toilet, or put it in the dustbin)
- Store condoms in a cool, dry place Heat can cause the latex to deteriorate

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IS THIS YOUR ATTITUDE TO



THE CONDOM?

This message is addressed to the modern male
If you want to keep your head in the sand, DON'T READ IT

Once upon a time your sex life was less complicated. Many a young man spent the night sowing wild oats, and the next few days praying for crop failure! VD was always a risk - but a small one - and treatable. Where the ladies started taking responsibility for contraception, the worry about unwanted pregnancy vanished. Unfortunately the number and variety of sexually transmitted diseases increased. In Swaziland today these diseases are spreading in an uncontrolled and alarming fashion.

Now you are faced with a new plague. AIDS kills, and there is no cure. Nor is there any way in which you can tell who is infected. You can catch this disease by having unprotected sex with a healthy carrier of the virus. This disease is in Swaziland and the number of healthy carriers is increasing all the time.

If you wish to avoid AIDS and stay alive you have to accept one of the following choices.

- Life long, total abstinence. This means no sex, ever. Hardly a realistic choice for a red-blooded male!
- A faithful sexual relationship with one partner, who is not infected, and who is faithful to you. This is the ideal, although it may not have wide appeal. The problem here is that although you may be faithful, there is no guarantee that your partner is.
- If you wish to sleep around, or if you are unsure of your partner, then you must use a condom ('tube', 'rubber', 'sheath')

The alternative could be death! Even if you are prepared to take the risk, are you prepared to risk your family? If you unknowingly contract the AIDS virus, you may well transmit it to your wife, and through her to the children you plan to have in the future.

So get your act together, man! The problem won't go away if you ignore it. Instead of saying, 'I hate these dreadful things, but what can one do with disease so rampant?' think positive. Remember the plus factors:

- The condom gives you the freedom to choose, without risking the consequences of a bad choice.
- The condom is your best protection against most of the other sexually transmitted diseases.
- The condom is your protection against unwanted pregnancy.
- Most important of all, the condom puts you in control.

If you are a sexually active male you should carry one or two at all times.

But how do you use one, without hurting her feelings, breaking the mood, or seeming 'unsafe' yourself? If she is as thoughtful and as careful as you, there is no problem. Emphasise how much protection means to you - and should to her - and that you'll enjoy sex more if you both feel safe. If she doesn't care whether you enjoy it or not, drop her. If in spite of all your tact and charm, your partner remains resistant or defensive, here are some suggestions to help you answer her objections.

If she says

I'm on the pill, you don't need a condom

I know I'm clean, I haven't had sex with anyone for ages

By the time you put it on, I'm out of the mood

You can reply

I'd like to use it anyway. We'll both be protected from infections we may not know we have.

Thanks for telling me. As far as I know, I'm clean too. But I'd still like to use a condom since either of us could have an infection and not know it.

Maybe so, but we feel strongly enough for each other to stay in the mood.

It destroys the romantic atmosphere.

Using a condom isn't Swazi.

What other way?

This is an insult. Do you think I'm some disease-ridden prostitute?

None of my other boyfriends uses a condom. A real man isn't afraid.

I love you! Would I give you an infection?

Just this once.

I don't have a condom with me.

You carry a condom around with you? You were planning to seduce me.

I won't have sex with you if you're going to use a condom.

It doesn't have to be that way.

Neither is dying of AIDS. So let's give the condom a try. Or maybe we can look for another way.

Maybe we'll just pet, or postpone sex for a while.

I didn't say or imply that I care for you, but in my opinion it's best to use a condom.

Please don't compare me to them. A real man cares about the woman he dates, himself, and about their relationship.

Not intentionally. But many people don't know they're infected. That's why this is best for both of us just now.

Once is all it takes.

I do. (Or) Then let's satisfy each other without intercourse.

I always carry one with me because I care about myself. I have one with me tonight because I care about us both.

So let's put it off until we can agree. (Or) OK, then let's try some other things besides intercourse.

What is AIDS?

AIDS is caused by a virus called HIV (Human Immuno-deficiency Virus). This virus infects some of the white blood cells which are part of the body's defences and prevents them from working properly. As a result, people may get illnesses which the body would normally be able to fight off quite easily. Some of these illnesses can become serious or result in death. HIV is not easily transmitted - you cannot become infected through everyday social contact.

In Africa AIDS affects men and women equally. The virus is transmitted in three ways:

- By sexual contact, but only if one person has the virus
- By blood. Sharing needles or syringes with someone who has the virus. 'Muti incisions' or 'gata' performed with unsterilised instruments can spread the virus
- From an infected mother to her unborn child

In the past a number of people were infected through blood or blood products. This is now extremely unlikely in Swaziland where all donated blood is screened.

People who have been infected with HIV do not all have AIDS. In fact most of them are still healthy and do not know they are infected. From what is known about the condition at present between a quarter and a third of these people will develop AIDS in about five to seven years time. Others may have less severe illnesses due to the virus and some will remain well for long periods.

Before you decide.

Before you make any decisions, here are some questions which may help you:

- Am I likely to be infected?
- If I know that I do not have HIV, will that stop me worrying?
- To whom, if anybody, should I tell my result? (my partner? doctor? family?)
- When I get my result, whatever it is, how should I change my sexual behaviour?
- What if my partner and I are planning to have a baby? A pregnant woman may pass on HIV to her child
- How would the result affect my employment situation?
- Do I need the result to help me make decisions?

Take your time before you decide about a test. Discuss it with your doctor.

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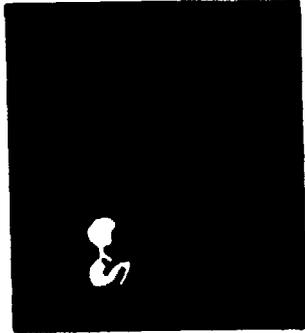
AIDS TEST

 This leaflet is
for anyone
who is
thinking of
having a

blood test called the HIV
antibody test. It tells you all
about the test and explains
what the results mean. It also
raises some of the issues you
might want to
think about
before you
decide
whether to
have the test.



who has the virus, can give you the virus
"Muti incisions" or "gata" performed with unsterilised instruments can spread the virus



If you have the virus and get pregnant, you may have an increased chance of developing AIDS

If you have the virus, you can pass the virus on to your unborn baby

The virus is not strong It does not live long outside the body and can be killed by bleach("JIK")



Wipe up spilled blood with a solution of 1 part bleach to 9 parts water



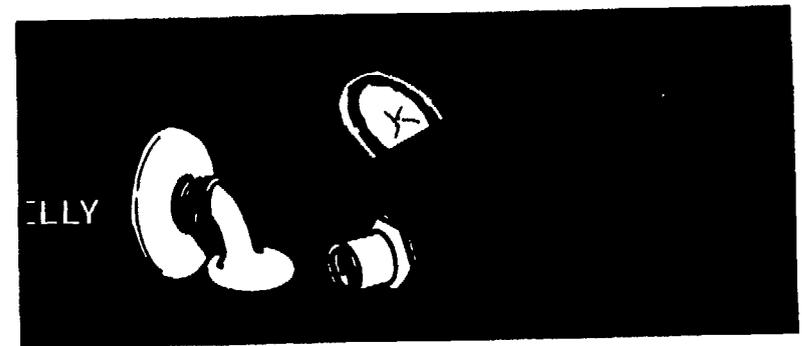
Do not share toothbrushes and razors, they may be soiled with blood

DO NOT have sexual intercourse without a condom

It is safer if you only have sex with one person and neither of you have other sexual partners

If neither of you have the virus you are safe

If you have sex with different people think about **safer sex**, you don't know if any of them have the virus



If you have sexual intercourse, make sure the man wears a condom (tube,rubber,sheath) over his penis every time

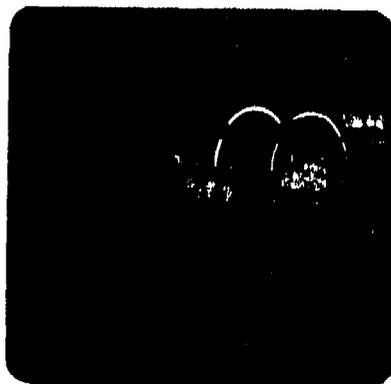
Don't use a condom with petroleum jelly (vaseline) as a lubricant, it weakens rubber and the condom could tear

If you have more than one sexual partner it is becoming too dangerous now for anyone to have sexual intercourse without a condom, if you don't catch the virus you could catch some other infection

YOU CAN'T



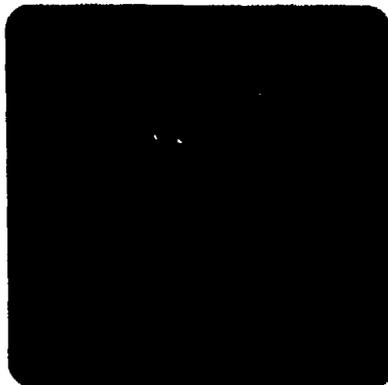
TOILET SEATS



SWIMMING POOLS



KISSING



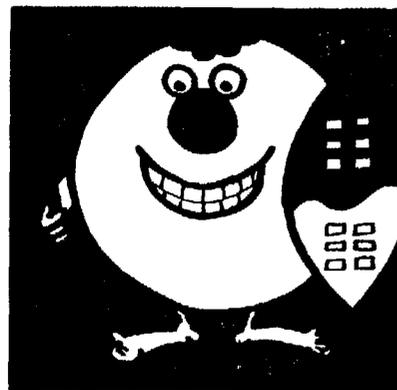
HUGGING



SHAKING HANDS



SHARING CUPS



For about three out of ten people their white blood cells may become weaker
Then the cells can't fight off some germs

When this happens a person is said to have **AIDS**

HOW CAN YOU CATCH THE VIRUS?

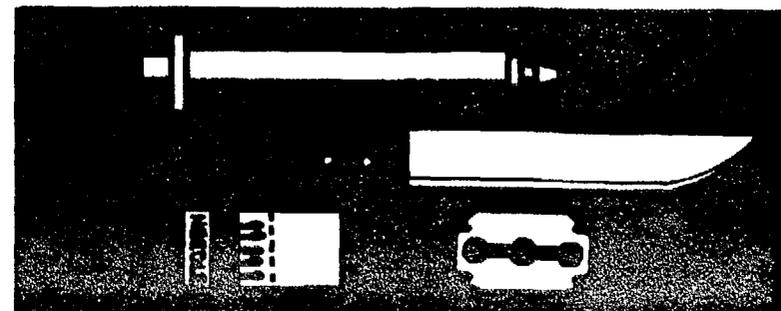
It is hard to catch the virus - there are only two ways

BY SEX

But only if one person has the virus

BY BLOOD

The virus has to get into your blood



BEST AVAILABLE COPY