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**A DEVELOPMENT CHALLENGE IN A CRISIS STATE-
'HIV AND AIDS PREVENTION IN ZIMBABWE'
: A CASE OF HARARE RESIDENTS'.**

A dissertation submitted in partial satisfaction of the requirements
for the degree **Master of Philosophy**
in International Development Studies

By

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DEDICATION

To:

My husband, *Enias Gramu*, the love of my life, my three beautiful children who were all born during my studies *Mayamiko, Tarab and Munashe*, to *VaChivare* (my late father), who passed away during the course of this MPhil from kidney failure. May your soul rest in peace, and thank you so much for the sacrifices you made, to be whom I am today. To my mother, *Gogo Chivare*, my brothers (*Victor, Simbarashe, Blessing*) and my sisters (*Unity, Ratidzo and Gloria*) and to my family, the *Gramu* family. *Ebenezer*, thus far the Lord has taken us!

SOME IMPORTANT QUOTES ON THE EPIDEMIC

‘The economic crisis has come on top of the existing food and AIDS crises that have already stretched families to the breaking point ‘

(Dr Rachel Yates, Senior Adviser on Children and HIV at UNICEF, 2009)

‘Until political figures and respected community leaders speak out and break the wall of silence, there is little hope of mounting a vigorous broad-based effort against the epidemic.’

(UNAIDS, 2000)

‘The first battle must be to break the conspiracy of silence at every level ... in too many countries; an official conspiracy of silence about AIDS has denied people information that could have saved their lives’.

(UN Secretary- General Kofi Annan: 1999)

Silence Kills, breaking the silence is a powerful way that people at all levels of society can combat the disease. I do not minimize the courage it can take to come forward challenge taboos and challenge traditions. But, that kind of courage is needed or more people will die’

(Colin L. Powell in Messer: 2004)

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ABSTRACT

Background: This thesis critically examines the prevailing socio-economic and political conditions and how they impact on health behaviour change for Harare residents. The study examines the effectiveness of Behavioural Change Programmes (BC) as a Human immunodeficiency virus (HIV) prevention strategy when a country is in a crisis¹. Zimbabwe is one of the 189 countries that have committed themselves to a comprehensive programme of national commitment and action to fight the HIV and AIDS epidemic by adopting the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS of June 2001. The Declaration of Commitment established a number of goals for the achievement of specific quantifiable and time-bound targets, including reductions in HIV infection among infants and young adults; improvement in HIV and AIDS education; health care and treatment; improvement in orphan support. In recent years, the Government of Zimbabwe (GoZ) has credited its HIV and the Acquired Immunodeficiency Syndrome (AIDS²) prevention strategies, in particular the BC programmes as the main driver of the significant decline in HIV prevalence rates³ from as high as 23.7% in 2001 to just 14.3 % in 2010⁴. This exceptional

¹ A Crisis in this thesis is defined as an event that leads to an unstable and dangerous situation affecting an individual, group, community or the whole society. It is negative changes in the security, economic, political, societal or environmental affairs, especially when they occur abruptly, with little or no warning. (Borodzicz, 2005).

² A disease of the human immune system caused by the HIV. This condition progressively reduces the effectiveness of the immune system and leaves individuals susceptible to infections, (Weiss, 1993).

³ The number of people living with HIV in a defined population within a specified period.

decline occurred in the midst of economic meltdown, social breakdown, disorganisation, and an intolerable political environment in the country.

Method: In attempting to analyse the dynamics between HIV and AIDS prevention programmes and Behavioural Change (BC) in a crisis state, this thesis is based upon fieldwork that was conducted in Harare, the capital city of Zimbabwe from March to December 2007. The methodologies used include a structured questionnaire, a series of in-depth interviews with selected key informants, participatory observations and secondary data collection. This was followed by inputting and critically analysing the data using computer software. However some of the statistics have since been up-dated to reflect new realities on the ground.

Theoretically, the study was based on the Health Belief Model (HBM) in attempting to predict sexual behavioural change in Harare . The HBM provided a deeper understanding of how people think about the risks of contracting a disease and how they make decisions regarding those risks. Other variables outside the HBM such as socio-economic factors, social norms and peer- influence on people's decisions regarding their health behaviours were also incorporated. The thesis is not entirely a comparative study per se; however a comparative analysis between different variables such as age, sex, income and levels of education was conducted to contribute to the theoretical formation of effective prevention models.

⁴ Ministry of Health and Child Welfare, Zimbabwe National HIV Estimates 2009

Results and Conclusion: Key research findings and the principal conclusion is that certainly, HIV prevalence rates in Zimbabwe have significantly declined. However, there needs to be favourable conditions that enable behavioural change to occur within a given population, and Zimbabwe does not seem to demonstrate these conditions. There are numerous other factors that have contributed to this decline, factors that conflict with the sole explanation by the Government that it is through their HIV and AIDS prevention strategies. The study concludes by arguing that declining HIV prevalence rates do not necessarily occur as a result of a successful intervention, in fact, a failure in HIV prevention strategies can also result in the decline in prevalence rates.

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LIST OF ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral Therapy
BC	Behavioral Change
CHRA	Combined Harare Residents' Association
CIO	Central Intelligence Organisation
CSW	Commercial Sex Workers
DRC	Democratic Republic of Congo
ESAP	Economic Structural Adjustment Programme
FGD	Focus Group Discussions
GPA	Global Programme for AIDS
GDP	Gross Domestic Product
GoZ	Government of Zimbabwe
HBM	Health Belief Model
HDA	High Density Areas
HIV	Human immunodeficiency virus
ICT	Information Communication Technology
IMF	International Monetary Fund
LDA	Low Density Areas
MARPs	Most-at-risk populations
MDGs	Millennium Development Goals
MIPA	Meaningful Involvement of People openly living with HIV and AIDS
MoH	Ministry of Health
MMPZ	Media Monitoring Project in Zimbabwe
MOHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NAP	National AIDS Programme
NGOs	Non Governmental Organisations
NSSA	National Social Security Authority
ODI	Overseas Development Institute
PGHQ	Police General Headquarters

PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
POSA	Public Order and Security Act
PSI	Population Service International
RCZ	Research Council of Zimbabwe
SAFAIDS	Southern Africa HIV and AIDS Information Dissemination Service
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation
ZAN	Zimbabwe AIDS Network
ZANU	Zimbabwe African National Union
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council
ZNNP+	Zimbabwe National Network of People Living with HIV and AIDS
ZHDR	Zimbabwe Human Development Report
ZIMCDD	Zimbabwe Coalition on Debt and Development
ZIMPREST	Zimbabwe Programme for Economic and Social Transformation
ZHNGO	Zimbabwe Human Rights NGO Forum
ZNVAC	Zimbabwe National Vulnerability Assessment Committee

CHAPTER 1

INTRODUCTION

1.1 A Global Economic Crisis and HIV Prevention.

These are extraordinarily challenging times for global development. The financial crisis that began in 2007 has resulted in the collapse of large financial institutions, the bailout of banks by national Governments and downturns in stock markets around the world. It is considered by many economists to be the worst financial crisis since the Great Depression of the 1930s⁵. In 2009, global Gross Domestic Product (GDP) growth, after a robust eight-year stretch, was set to shrink by 1.7% , an historic contraction with world output set to decline for the first time since World War II⁶.

Some developing countries that had seen strong economic growth saw significant slowdowns. For example, growth forecasts in Cambodia show a fall from more than 10% in 2007 to close to zero in 2009, and Kenya was set to achieve only 3-4% growth in 2009, down from 7% in 2007⁷. According to the research by the Overseas Development Institute

⁵ Reuters.2009. *Three top economists agree 2009 worst financial crisis since great depression; risks increase if right steps are not taken.*

⁶ World Bank. 2009. 'Averting a Human Crisis During the Global Downturn; Policy Options from the World Bank'. World Bank Human Development Network.

⁷ International Monetary Fund.2009.*World Economic Outlook: Crisisand Recovery*. IMF. Washington.

(ODI), reductions in growth can be attributed to falls in trade, commodity prices, investment and remittances sent from migrant workers (which reached a record \$251 billion in 2007, but have fallen in many countries since). This has led to a dramatic rise in the number of households living below the poverty line, be it 300,000 in Bangladesh or 230,000 in Ghana⁸. This evidence suggests that the current global financial crisis is exacerbating an already precarious situation for many countries.

What is interesting is that the financial crisis started in the most developed economies, but its impact has been felt in virtually all nations, leading to fears that international donor assistance will remain flat or be cut, the budgetary revenues of developing countries will fall and worker remittances will decline. It is predicted that many households may experience increased mortality and morbidity if the commitments made by Governments and the international community to sustain and increase the Human Immunodeficiency Virus (HIV⁹) prevention programmes and treatment are not honored. This crisis therefore threatens to undermine fundamental rights to health, survival and a decent standard of living for citizens across the globe.

⁸ Velde. D. W. 2009. *The global financial crisis and developing countries: taking stock, taking action*. A Briefing Paper, 54. London: Overseas Development Institute

⁹ A virus that causes AIDS. It is a condition in humans in which the immune system begins to fail, leading to life-threatening infections. Infection with HIV occurs by the transfer of blood, semen, vaginal fluid, pre-ejaculate, or breast milk. The four major routes of transmission are unsafe sex, contaminated needles, breast milk, and transmission from an infected mother to her baby at birth, (Douek et al, 2009 and Sepkowitz, 2001).

A joint World Bank/UNAIDS report¹⁰ looks at the potential impact of the global financial crisis on HIV prevention and treatment programmes worldwide. Using data collected in March 2009 from 71 countries, the analysis looks at how the crisis could affect the nearly 4 million people living with HIV on treatment, and the 7 million who need treatment but do not have access to it. The potential effects on prevention activities were also investigated. The report suggests that the well-being of millions of people could be put at risk and notes that an important lesson learned during previous crises is that cuts in core social development spending have long-term negative effects.

With regards to HIV and AIDS, what is key to understand and is the fact that preventing new infections is key to responding to the epidemic and less investment in such programmes results in more new infections with greater future treatment needs, and large cost implications. It is estimated that for every two people accessing HIV treatment, another five people are becoming infected as will be detailed in the next section.

1.2 Global HIV and AIDS Trends.

The HIV and AIDS epidemic is one of the most complex and perhaps the most perplexing social problems faced by modern society specially in developing countries. Since it began, 25 million people have died of HIV related causes and the number of people living with HIV worldwide continued to grow in 2008, reaching an estimated 33.4 million. This resulted in the total number of people living with the virus in 2008 to be more than 20%

¹⁰ UNAIDS/World Bank. 2009. *The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact*. UNAIDS/World Bank. Geneva

higher than the number in 2000, and the prevalence roughly threefold higher than in 1990¹¹.

The region that remains the most affected by the HIV and AIDS epidemic is Sub-Saharan Africa where an estimated 22.9 million adults and children are said to be living with HIV, and about 1.2 million have died from AIDS-related deaths. This corresponds to 68% of the total number of HIV cases in the world and 72% of all deaths attributable to the epidemic.

However, there are signs of major progress in HIV response evidenced in recent years. The UNAIDS 2008 report confirms that the world is at last, to some extent making some real progress in its response to AIDS. Some Governments are acting on their promises they made at the 2006 United Nations High Level Meeting on HIV and AIDS to scale up towards universal access to HIV prevention, treatment, care and support by 2010. In 33 countries globally, HIV incidence has fallen by more than 25% between 2001 and 2009. Of these countries 22 are in sub-Saharan Africa. The biggest epidemics in sub-Saharan Africa—Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe have either stabilized or are showing signs of decline¹². According to new data in the 2009 AIDS epidemic update, new HIV infections have been reduced by 17% over the past eight years. Since 2001, when the United Nations Declaration of Commitment on HIV and AIDS was signed, the number of new infections in sub-Saharan Africa is approximately 15% lower, with about 400,000 fewer infections in 2008¹³.

¹¹ Joint United Nations Programme on HIV and AIDS (UNAIDS) and World Health Organization (WHO) 2009, '2009 AIDS Epidemic Update'. UNAIDS, Geneva.

¹² UNAIDS. 2010. Global Report: UNAIDS Report on the Global AIDS Epidemic.

¹³ UNAIDS 2009 AIDS Epidemic update

However, this is not consistent within and between regions as infections are on the rise in a number of countries including China, Germany, Indonesia, Mozambique, Papua Guinea, Russia, Ukraine, United Kingdom and Vietnam (UNAIDS, 2008). While no disease in history has required strong political, financial, human resources and strong levels of leadership and ownership by communities, it is fundamental to question the HIV and AIDS agenda's position on the priority list of countries witnessing socio- economic and political crisis. Zimbabwe is amongst the countries in this category, once the bread basket of Africa, now a basket case. The next sections explore the prosperous years and factors that contributed to its turmoil.

1.3 The Prosperous Years – The Corporatist Policy Regime

When it attained its independence in 1980, Zimbabwe's position as a regional power was set to become a wealthy state. It was amongst the top industrialized countries in Sub-Saharan Africa, possessed a more diversified economy than most countries and a better human resource base than most, with the middle-income status. The country possessed two-thirds of the world's known reserves of metallurgical grade chromite and ranked top three in the production of chrysolite asbestos. It was the second largest producer of chrome and fifth largest producer of gold.

The Mugabe Government moved cautiously in its stated socialist ideology and goal of bringing about national transformation promised by the liberation struggle. Most of its activities were directed toward repairing the damaged and destruction caused by the long war and redressing the vast income and status disparities that exist between the whites and blacks by increasing minimum wages. There were considerable investments in social

development, characterised by massive expansion in the education and social sectors. It quickly became the regional breadbasket. At the beginning of the 1990s, the urban population of Zimbabwe was less poor, and generally more economically and social secure than probably any other African urban population in Sub-Saharan Africa. The proportion of the population below the poverty line had decreased between 1980 and 1990 from about 60% to 25-30%¹⁴.

Social services functioned relatively well and were free for many of those on low incomes. The vast majority of the urban population, whether poor or rich had access to potable water and electricity as the urban infrastructure functioned. Spending on education almost trebled from ZW\$227.6m to ZW\$628m, as did spending on health from ZW\$66.4m to ZW\$188.6m between 1979 and 1990 (Nziramasanga and Lee, 2002). Rural communities received substantial food relief during droughts. Discrimination against commercial agriculture in the Communal Areas ended, and there was positive pricing, better access to marketing services, credit, and inputs.

As a result, Jeffrey Herbst in, *'The consequences of ideology in Zimbabwe'* (1992, p54-55) wrote;

'The tremendous communal farmer supply response especially for maize and cotton made them the largest producers of these crops in the country, within a relatively short period. Thus the agricultural control regime served producer interests reasonably well such that for several years, Zimbabwe was considered one of Africa's agricultural success stories at a time when Africa was facing its most serious food crises.'

¹⁴ Potts, 2006.

During the Corporatist¹⁵ Policy Regime, the new ZANU Government maintained most of the existing controls over prices, resource allocations and investment. According to Mudziviri and Lee (2002), the Government introduced minimum wage and virtually removed the right to dismiss workers, increased expenditure on health and education by 10%, public sector employment by 60% and expenditure on civil service by 12% per annum over the decade. Central Government expenditure tripled and increased its share from 32.5% of GDP in 1979 to 44.6% in 1989. State ownership of utilities and agricultural marketing agencies continued and a number of private companies were bought by the Government. This system operated far more efficiently than they did in most African States.

1.4 Events that led to the deterioration of Zimbabwe

Zimbabwe among other several countries, presents a stark example of the combined effects of external shocks and domestic policy failures. Following the post- independence decade of robust growth, per capita incomes started to fall, followed by a series of structural adjustment programmes. Sachikonye (2002) in his paper, '*Whither Zimbabwe? Crisis & Democratisation*' in the *Review of African Political Economy*, points out that by the 1990s, the economy instead of expanding, began to contract from being a breadbasket to a basket case. This period turned out to be the 'wasted decade'. The economic downturn

¹⁵A system of economic, political, or social organization that involves association of the people of society into corporate groups, such as agricultural, business, ethnic, labor, military, patronage, or scientific affiliations, on the basis of common interests. It is theoretically based upon the interpretation of a community as an organic body (Wiarda 1997).

intensified an unfolding social crisis. The proportion of Zimbabweans living below the poverty line had significantly increased to over 75% by 1999 (Zimbabwe Human Development Report, 2000). Urban infrastructure such as water and electricity supplies were increasingly sporadic and urban health and education services increasingly expensive. Soon after independence, the first half of the decade was spent implementing a programme crafted in conjunction with the World Bank (WB) and the International Monetary Fund (IMF). Poor sequencing of the programme contributed to a significant erosion of the export competitiveness to domestic industry.

Zimbabwe's Economic Structural Adjustment Programme (ESAP) was launched at the beginning of 1991 with a primary objective of improving living conditions through rapid and sustainable economic growth. To achieve this, the economy was to become more competitive and productive which was expected to occur as liberation led to recovery of investments and more efficient resource allocation (Government of Zimbabwe, 1992). This process generated a major restructuring, involving significant costs and losses and by 1997, senior business leaders were confident the economy had grown by 7.3% in 1996, exports had increased from 23.9% of the GDP in 1991 to 36.1% in 1996. Foreign exchange reserves were high and employment was beginning to recover after a sustained period of downsizing (Zimbabwe Ministry of Labour, 1996). The ESAP involved the removal of many restrictions on trade, credit, foreign exchange, investment and labour. The policy was largely home-made, and was designed to encourage job creating growth by transferring the control over prices from the state to the market, improving access to foreign exchange, reducing administrative controls over investment and employment decisions, and reducing the fiscal deficit (Gunning et al, 2002). It had wide local support, and was introduced before the economic problems had gone out of control.

However, by the end of the ESAP programme, the economy was in a much weaker rather than stronger position. Even the World Bank itself admitted in its audit that the programme, based as it was on orthodox conditionalities, had been flawed from the beginning (Allen, 1999). Since then, the economic policy has changed considerably as the old import-substitution regime which emphasised development through Government interventions and control, was replaced by a market oriented development strategy

In the book *From Crisis to Growth in Africa?* Durevell (2001) highlights the fact that good governance in general, and adequate policy responses to external shocks are essential for the maintenance of a high level of investments. The improvement in fiscal policies and the budget presented for 1997/8 persuaded the World Bank that the economy was on the right track and the IMF decided to release the second tranche of the second structural adjustment credit in mid 1997. In June 1998, the IMF approved a Stand-By credit of US\$175 million in response to promises that the Government would adopt a 'package of corrective policy measures' (IMF, 1998).

However, just before the agreement was signed a series of counter-productive political decisions were taken and President Mugabe announced that liberation war veterans were to receive compensation and pensions. Against more prudent advice, President Mugabe authorised huge unbudgeted pay-offs of about ZW\$5 billion for war veterans who sought a payback for their struggle. The pay offs sparked the Zimbabwe dollar to plummet by more than 50% of its value in November 1997 (Sachikonye, 2002). This unexpected and unplanned increase in public expenditures made it impossible for the World Bank to release the money. Other events that contributed to the decline were as follows:

1. During the late 1996 and early 1997, there were adverse developments in export volume prices and rapid increase in imports. This led to a large trade deficit and the downward pressure on the exchange rate. By defending the value of the currency, the authorities reduced foreign reserves sharply.
2. In an attempt to boost its popularity after the agreement over compensation of the war veterans, the Government announced that close to 1 500 out of 4 000 mainly white-owned farms would be nationalised during 1998. This was done without clarifying how the nationalisation would be financed or to what extent farmers would receive compensation for their property.
3. Due to the El Nino¹⁶, fears were created of a serious drought in 1998, which raised food prices and reduced export income.
4. The military intervention in the Democratic Republic of Congo (DRC) in the mid 1998 to shore up the Kabila Government, with an annual expenditure of US\$ 360 million.
5. Corporatists' controls over the exchange rate and many other prices were re-established and that destroyed the viability of many firms and reduced the incentive to invest.

During the same period in 1998, the Zimbabwe Programme for Economic and Social Transformation (ZIMPREST) was another factor that caused the crisis. Zimbabwe was unable to secure funding from the Bretton Woods Institutions which was supposed to run from 1996 to 2000 but remained a dead letter while the economy began to shrink. In addition, there was hyperinflation which climbed above 110% in the first quarter of 2002,

¹⁶ Extreme weather pattern.

while domestic debt levels shot to US\$3.5 billion, foreign debt to US\$4.5 billion during the last quarter of 2001 (ZIMCDD, 2001¹⁷).

The political violence which accompanied the electioneering process in 2000 elections diminished investment flows further. The GDP fell by about 26% between 2000 and 2002, and inflation was more than 600% by the beginning of 2004. Food production was less than 50% of a normal year in 2003¹⁸.

There was an upsurge of corruption at high levels. One estimation was that up to ZW\$17 billion may have been wasted through corruption between 1997 and 1998 (ZHDR, 2000). To curb the crisis, the Reserve Bank ordered all companies to liquidate their foreign currency accounts, and the discount rate was increased by 5 %age points to 28.5 per cent. Shortly after, the Government announced tax increases to continue financing the war veterans, but the party conference held a few days later anonymously rejected this measure and a wave of strikes hit the country.

By 2003, the urban situation in Zimbabwe was extremely different from the previous decade. The Zimbabwe National Vulnerability Assessment Committee (ZNVAC, 2003) reports that 72% of the urban household were defined as poor, this included 51% deemed to be 'very poor', meaning that they could not afford to buy enough food. The proportion of the urban population living below the poverty datum line thus trebled in twelve years.

¹⁷ Zimbabwe Coalition on Debt and Development

¹⁸ European Union Report, 2003.

By 2005, the purchasing power of the average Zimbabwean had dropped to the same levels in real terms as 1953¹⁹. Inflation rose from an annual rate of 32% in 1998, to an official estimated high of 11,200,000% in August 2008 according to the country's Central Statistical Office²⁰. This represented a state of hyperinflation, and the central bank introduced a new 100 billion dollar note. By 2009, Zimbabwe's inflation crisis was the second worst inflation spike in history, behind the hyperinflationary crisis of Hungary in 1946, in which prices doubled every 15.6 hours²¹.

Zimbabwe resorted to the introduction of a new ZW\$100 trillion banknote in January 2009. The situation remained unchanged resulting in the then acting Finance Minister Patrick Chinamasa announcing that Zimbabweans will be permitted to use other, more stable currencies such as the Sterling, Euro, South African Rand and the United States Dollar to do business, alongside the Zimbabwe dollar. During the same year, on 2 February 2009, the RBZ announced that a further 12 zeros were to be taken off the currency, with 1,000,000,000,000 Zimbabwe dollars being exchanged for 1 new dollar. New banknotes were introduced with a face value of ZW\$1, ZW\$5, ZW\$10, ZW\$20, ZW\$50, ZW\$100 and ZW\$500. The country was therefore not on track to achieving most of the Millennium Development Goals (MDGs²²) due to a profound economic crisis,

¹⁹ Clemens, Michael et al (2005). Costs and Causes of Zimbabwe's Crisis. Center for Global Development. <http://www.cgdev.org/content/publications/detail/2918/>.

²⁰ <http://edition.cnn.com/2008/BUSINESS/08/19/zimbabwe.inflation/index.html>.

²¹ Berger, Sebastian (13 November 2009). "[Zimbabwe hyperinflation 'will set world record within six weeks'](http://www.telegraph.co.uk/news/worldnews/africaandindianocean/zimbabwe/3453540/Zimbabwe-hyperinflation-will-set-world-record-within-six-weeks.html)". *The Daily Telegraph* (London). <http://www.telegraph.co.uk/news/worldnews/africaandindianocean/zimbabwe/3453540/Zimbabwe-hyperinflation-will-set-world-record-within-six-weeks.html>.

²² These are international development goals that all 193 United Nations member states and at least 23 international organizations have agreed to achieve by the year 2015. The goals are (1) eradicating extreme poverty and hunger, (2) achieving universal primary education, (3) promoting gender equality and empowering women, (4) reducing child mortality rates, (5) improving maternal health, (6) combating HIV/AIDS, malaria, and other diseases, (7) ensuring environmental sustainability, and (8) developing a global partnership for development.

which has devastated the livelihoods of most of its rural and urban populations. To this day, the country's development is being substantially undermined by the mutually reinforcing 'triple threat' of high HIV and AIDS prevalence, chronic and acute food insecurity and poverty and weak governance.

It is fundamental to note that corporatist regimes²³ and their neo-liberal²⁴ alternatives have been competing policy regimes that have dominated the development theory since its nineteenth century beginnings and unsurprisingly have also played a significant part in the successes and failures of Zimbabwe. The former were used to justify extensive state interventions and a high level of political authoritarianism, whilst the latter, demanded for market competition and liberal democracy. Corporatists assumed that the new professional elites would use state institutions to deliver modern services to a 'traditional' and dependent citizenry. On the other hand, liberals assumed that a rational citizenry would use its political authority to control the potentially predatory instincts of the political class, and its economic skills to provide cost effective services in response to rational market-determined incentives. However, both regimes assume that the outcome of any development strategy will be determined by the adequacy of the rules and incentives that govern resource allocation²⁵.

Zimbabwe adopted a highly corporatist programme between 1980 and 1990, before making a rapid switch to a liberal one that began in 1991 and terminated in disaster in the final years of the decade. In 1980, the new Zimbabwe African National Union (ZANU)

²⁴ A label for economic liberalizations, free trade and open markets. Neoliberalism supports the privatization of nationalized industries, deregulation, and enhancing the role of the private sector in modern society (Taylor, 2009).

²⁵ Brett, 2005

Government took over a corporatists policy regime that had been created by its settler based predecessor and added some redistributive elements to it. It then made a rapid shift to liberalisation in 1991 that was effectively dismantled again in 1998/9²⁶.

In just three decades after independence, Zimbabwe's capacity to maintain its political, economic and social institutions and to provide for its people is in absolute crisis. The shift by the Zimbabwean Government from a corporatist to liberal economic policy regimes has led to profound economic and political crisis in Zimbabwe which has exposed its populations to main shocks that have devastated their livelihoods and created conditions of extreme poverty and desperation. The country demonstrates an extraordinary rapid decline in living standards which are no longer remarkable when compared to other African states.

As a result, political and economic pressures tend to lower policy commitment on the social development and health service delivery systems for its citizens, threatens the high-priority goals of the decision making unit and restricts the amount of time available for response before the situation is transformed. According to Chabal and Daloz (1998), citizens are now governed by predatory political and economic elites that ignore the public interest in order to maximise their returns in the state of confusion, uncertainty and sometimes even chaos. Chabal and Daloz's (1998) attribution of such ideas where people exploit a 'political economy of disorder' for personal or group benefit provides us with important insights into the reality of countries locked into processes of cumulative breakdown like Zimbabwe.

²⁶ Brett, 2005

1.5 Aim of the study

The practical aim of this study is to develop an operational understanding of the dynamics between the HIV and AIDS epidemic and Behavioural Change (BC) prevention strategies when a country plunges into a crisis state. There are favourable conditions that should be met for behavioural change to occur which Zimbabwe, arguably, does not seem to demonstrate. This research thus attempts to provide a picture of how residents in Harare have dealt with HIV and AIDS issues during a crisis time and where future efforts might be focussed. This is because developing effective prevention strategies requires a deeper understanding of how people think about the risks of AIDS and how such risk perceptions influence their behavioural decision making.

HIV and AIDS is the most explicitly politicised of medical conditions therefore; the research will try to understand the relationship between the HIV and AIDS and attitudinal and behavioural factors, socio-demographic, economic, political and other characteristics such as migration during a crisis.

1.6 Research Objectives

1. Critically analyse the prevailing socio-economic situation/conditions and how they impact on health behaviour change for Harare residents
2. To determine if awareness and knowledge on HIV and AIDS in Harare is linked to changes in sexual behaviours and HIV infection rates.
3. To examine if perceptions of HIV vulnerability that motivate risk reduction
4. To assess attitudes towards the HIV and AIDS prevention strategies during crisis periods.

5. To examine the factors that has lead to the significant reduction in HIV infection rates in Zimbabwe in the midst of both economic and political crisis.

1.7 Research Questions

1. What are the dynamics between the crisis conditions in Harare and HIV and AIDS prevention?
2. What is the relationship between one's economic status and attitudes towards sexual behavioural change?
3. What are the dynamics between knowledge of the disease and sexual behavioural attitudes towards the epidemic?
4. How effective is the implementation of 'one-size fits all' prevention programmes to groups with varying socio—economic status within a given population?
5. What are the reasons for the decline in HIV prevalence rates in Zimbabwe during a crisis period.

1.8 Statement of Argument (Hypothesis)

The general hypothesis of this study is that in a given population, the socio-economic and political conditions in the country determine the perceptions of risk, susceptibility, benefits and barriers to the effectiveness of HIV and AIDS behavioural change strategies. Based on the Health Belief Model (HBM) predictions for perceived threat, this thesis hypothesis that *the higher the perceived threat of contracting the HIV virus, the higher the likelihood of engaging in*

prevention behaviour. If an individual does not believe that he or she can carry out preventive measures to avoid contracting the virus, there is little motivation to engage in that behaviour. Therefore, there is a direct relationship between self-efficacy and prevention behaviour. If perceived self-efficacy is high, the likelihood of engaging in prevention behaviour will also be high.

I agree that the HIV prevalence rates have declined in recent years. However the decline is not entirely as a result of the success of the Zimbabwean Government's HIV and AIDS prevention strategy through sexual Behaviour Change (BC) programmes . This thesis argues that several factors might have contributed to this decline, factors that have resulted from the state's collapsing systems. There need to be an understanding of tensions between the socio-economic welfare of individuals to survive during crisis times and health prevention strategies.

There is therefore the need to look at the possibilities of being open-minded about the potentialities of alternative policy implementation strategies that are relevant at any given time. HIV prevention strategies' effectiveness and sustainability depends on political stability, and the state's ability to sustain an economic process that can generate better standards of living for the people. There must be a harmonised approach between the socio- economic status of any given population and the type of health prevention strategies implemented to them. There are five obstacles referred to as five lacks which are, commitment, conceptualisation, capacity, infrastructure and accountability²⁷, which undermine the fight against HIV and AIDS. Each of these represents a different dimension

²⁷ Campbell, 2003.

of failure of political will to bring about the behavioural changes necessary to create health-enabling community contexts

There is also a generalized assumption in HIV and AIDS prevention policies that the approach is if people know, people will change. The net effect is that there are mixed cues leading to simple, one-size-fit-all programmes, geographically haphazard with no regard for HIV prevalence or vulnerability and poorly coordinated responses whose effectiveness is never fully evaluated because of limited capacity to do operational research (Institute of Development Studies in Zimbabwe, 2003). Evidence still shows that most of the responses on the ground are purposely or otherwise still being largely driven by this health perception. The ABC²⁸ prevention package is a typical example. While this prevention package has its role to play and is one of the easiest to propagate to the nation, the overall HIV and AIDS challenge is much more complex and rooted much deeper in how the population perceives the risk of contracting the virus during various socio, economic and political phases in their lives. Information and knowledge should be positively associated with prevention behaviour, because as information and knowledge increase the person has stronger tools to engage in prevention.

This thesis supports the hypotheses developed from the Health Belief Model, which will be discussed in the next chapter, which argues self-efficacy, perceived threat, perceived knowledge quantity, and information receptivity influence health prevention behaviours change. Behavioural patterns have multi-layered determinants with culture, individual actions and socio – political factors having differing degrees of importance on the spread of disease at different places at different times. This investigation of the transmission of

²⁸ Abstain, Be faithful and use Condoms

HIV in Harare between different groups would yield a complex list of reasons for that particular unprotected sexual act.

Zimbabwe, apparently without any intervention whatsoever, experienced a declining HIV incidence due to lack of transport, money, food which are contributing factors to the number of sexual partners one can have. There is currently no evidence of a decline in infection rates in other relatively stable regional countries which had incidences as high as Zimbabwe such as Swaziland, Botswana and South Africa's KwaZulu-Natal province. The survival strategies of many in Zimbabwe at present entail giving higher priority to obtaining food, clothing and shelter than concerns with healthy living issues or safe sexual practices. Yet it is an oversimplification of the Zimbabwean Government in having the same prevention programmes to all its people. In theory, every citizen makes up his mind on public questions and matters of private conduct.

My hypothesis therefore argues that the Zimbabwean Government has the ability to succeed in fighting HIV and AIDS in its critical economic meltdown. Due to variations of the impact of HIV and AIDS amongst different countries, the strategic approaches to combat this disease must be designed to respond to the epidemiology of the disease in individual countries. This can be achieved by borrowing some, but not all international ideas, and formulate its own relevant and achievable indigenous prevention theories, tailoring them to specific relevant populations than basing prevention messages on any one generalised approach to behaviour change. What is clear is the fact that different individuals and groups will require different motivations, information, or structural change to sustain sexual behaviour change.

1.9 – Thesis Rationale and choice of Zimbabwe

Disease prevention is important to societal welfare and sustainability, especially when a disease has reached epidemic proportions hence the results in this research will help guide development of effective prevention strategies. It is now widely known that the principal ways in which HIV is transmitted, perinatally by intimate sexual contact or by exposure to contaminated blood, hence the need to involve more social and behavioural scientists given that the behaviour change is presently the only way to prevent the spread of the epidemic. Currently, there is no proven vaccine to prevent HIV infection. Curative therapies for those infected with HIV are still in the experimental stages and clearly, preventive programs still offer the best chance to combat HIV and AIDS and the nature of the main transmission models highlights the need for effective behavioural change interventions.

Health is a critical factor in the development of any country for two reasons. First, health status is a key indicator of the population's welfare (Sen, 1985) and second, improving the health status of the population leads to greater economic productivity (Strauss and Thomas, 1995). As sex can be arguably regarded as the only cheap commodity on the market in Zimbabwe at present, there is a danger that it might be the only commodity that the population will resort to, without any protection, as a means of curing their stress.

The failure of the medical community to provide an answer to HIV and AIDS cure has placed an unprecedented emphasis on the social sciences to address what is now the most studied disease in history (Webb, 1997). As the AIDS epidemic is now in its third decade, there is an abundance of scientific research on the disease in Sub-Saharan Africa and yet as Boone and Batsell (2001) argue, political scientists have been noticeably absent from much

of the analysis of AIDS in Africa. It is fundamental to note that, because power, resources, ideology and institutions shape policy making on HIV and AIDS, any responses to the epidemic are intensively political.

The HIV and AIDS epidemic has raised policy dilemmas of a magnitude that are yet to be fully recognized or understood and Governmental responses sometimes lack a sense of urgency or purpose. Allen (2004) argues that given the continuing rise in rates of infection and mortality, it would be fair to conclude that HIV and AIDS public health policies have been seriously inadequate hence the reason for pursuing this research based on the fact that there is a continuing importance of a focus upon implementation processes. African governance institutions are not in a good position or shape to face these challenges. In this context, the epidemic is likely to further undermine the effectiveness of bureaucracies and the bureaucratic norms.

I hope to contribute in the reduction of new infections. Prevention messages are crucial, but so too are the ways in which they are passed on and the relevance to the targeted populations at any given time. Zimbabwe does not have shocking adverts on the issue of HIV and AIDS. As Terry (2006) puts it across, imagine every week the World Trade Centre Twin Towers collapse with 3 800 of Zimbabwe's young people inside. What is more, it is so commonplace it does not make the news. There continues to be a narrow understanding of the epidemic in Zimbabwe, with much research focusing on both the causes and consequences of the epidemic and the relationship of the epidemic with several socio-economic variables.

The dominant approach to public policy and HIV and AIDS has focussed on medical aspects of the epidemic and Waal (2003) notes that the policies have developed in parallel to and sometimes in isolation from broader development frameworks²⁹. There is also a common tendency for HIV and AIDS to become an add-on or any other agenda to other 'more urgent' demands. This shows that public policy makers and their actions can shape the impact of this disease. There is a need to highlight the ways in which HIV prevention theories and practices need to be modified to allow for the varieties and realities of a Zimbabwean existence. Although, one can argue that there is not much direct political gain in helping to stop the numbers from multiplying, there is no justification, whatsoever, to why people are still dying in the 21st Century for simple lack of effective policy implementation and total interventions that can see a change in peoples beliefs, perceptions and behaviours towards HIV and AIDS.

My thesis rationale also comes from arguing that it is fundamental to conduct research on the effects of the AIDS epidemic, AIDS care and AIDS cure research, but in the long term, it is even more important to ensure that more people do not become infected hence the importance of the prevention strategies research, otherwise there will never be a stop to this epidemic.

In doing this research, I hope to contribute to the growing body of work on how the HIV and AIDS epidemic prevalence rates can be significantly reduced in Zimbabwe. The study will increase our understanding of how relevant the policies implemented are, prioritisation

²⁹ For example, HIV and AIDS is notably marginal within the New Partnership for Africa's Development (NEPAD). Major issues still remain controversial and there is scant reference to this epidemic as a public health problem and none at all to the NEPAD's development impact.

of the health by Zimbabweans and general attitudes in their role in fighting this epidemic. This change in research focus will also hopefully prove heuristic and make a positive contribution to this field. I believe that social science perspectives, which only recently have been applied broadly to AIDS research, have the potential for productively refocusing the investigation of AIDS to reveal the complex, yet powerful linkages between individuals and their social- economic structures, and to suggest how such changes can inspire individual behavioural changes

1.10 – Structure of the Thesis

Chapter 1 gives an overview of the HIV epidemic including an analysis of the deterioration of Zimbabwe into a crisis state. Chapter 2 looks at HIV trends in the and its developmental impacts. The Health Belief Model is also discussed in depth in this chapter. Chapter 3 is the Methodology chapter where the researcher gives an account of how the research was achieved. From Chapter 4 onwards, the research provides the research findings where an overview of the crisis in Harare is discussed in Chapter 4, collapsing health delivery service in Chapter 5, components of the Health Belief Model in Chapter 6 and perceptions of the city's policy makers and implementers on behavioural change strategies in Chapter 7. The final Chapter 8 provided the discussion from the research findings, conclusions and recommendations. This is followed by the Bibliography and Appendix sections.

CHAPTER 2

HIV AND AIDS: A DEVELOPMENTAL CRISIS IN AFRICA

2.1 HIV trends in Africa and developmental impacts

The impact of HIV and AIDS varies considerably amongst African countries where most countries have generalized epidemics. Heterosexual sex is the primary form of transmission in Africa, although in countries with more concentrated epidemics, other forms of transmission can play a significant role, including sex work, migration, men having sex with men, and mother-to-child transmission. Adult prevalence exceeds 20 % in some countries, including Botswana (24.8%), Lesotho (23.6%), and Swaziland (25.9%)³⁰ while others have concentrated epidemics with disease hotspots, such as Burundi, where the prevalence of 38% among sex workers is 16 times higher than that of the general adult population (UNAIDS, 2009).

In Southern Africa, prevalence has stabilized at high levels in most countries, while prevalence in East Africa has declined since 2000 and stabilized at lower levels than in Southern Africa. In West Africa, prevalence rates are markedly lower than on the rest of the subcontinent, at under 2 % across the region, except in Cameroon (5.3 %), Côte d'Ivoire (3.4 %), Gabon (5.2 %), and Nigeria (3.6 %).

³⁰ UNAIDS, 2010

Sub-Saharan Africa continues to bear an inordinate share of the global HIV burden: 23 million people living with HIV and AIDS have their homes in the region. . UNAIDS estimates 40 % of all HIV-positive women in the world live in the subregion³¹. Globally, more than one in five PLWHA live in Botswana, South Africa, and Zimbabwe, where 5.6 million PLWHA live in South Africa alone. Swaziland has the highest prevalence of any country in the world: Approximately one in every four citizens is HIV positive. Further decreasing the number of new HIV infections in Southern Africa is a continuing challenge. Compared to other countries in the subregion, Angola has a remarkably low HIV prevalence (2 %), in part due to the limited cross-country travel during its protracted civil war (1975–2002), which impeded the spread of the virus. Fig 2.1 below provides a summary of prevalence rates in Sub-Saharan Africa;

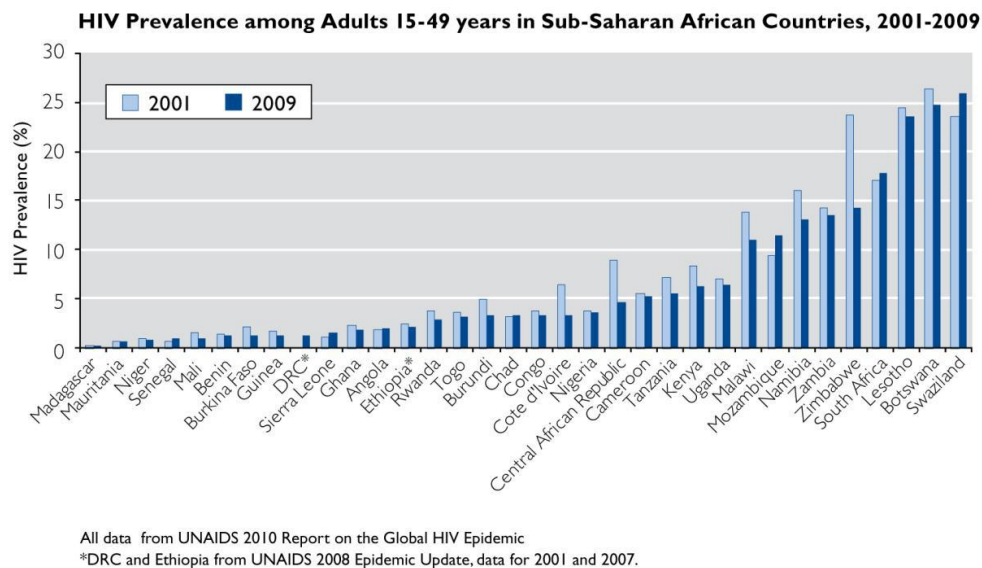


Figure 2.1 HIV Prevalence in Sub- Saharan Africa
 (Source : UNAIDS 2009)

³¹ UNAIDS, 2009.

The epidemics vary considerably from country to country across the continent, with prevalence estimates ranging from 0.1 % in Madagascar to more than 15 % in some of the countries in the southern region. Deaths from HIV and AIDS continue to decline as antiretroviral therapy (ART³²) and prevention of mother-to-child transmission of HIV (PMTCT³³) coverage increase. In countries most heavily affected, HIV has reduced life expectancy by more than 20 years, slowed economic growth and deepened household poverty. In this geographic region alone, it has orphaned³⁴ nearly 12 million children aged under 18 years (UNAIDS, 2008).

Comprehensive knowledge of HIV and AIDS remains low in sub-Saharan Africa and is an obstacle to reducing incidence rates. For example, approximately 2 million PLWHA in South Africa do not know they are infected, believe they are not in danger of becoming infected, and are unaware they can transmit the virus to others³⁵. A review of Demographic and Health Surveys (DHS) from countries across West Africa from 2003 to 2008 estimated less than 50 % of the population between the ages of 15 and 49 years had adequate correct knowledge about the disease.

³² Antiretroviral therapy (ART) is treatment of people infected with human immunodeficiency virus (HIV) using anti-HIV drugs.

³³ The primary aim of the PMTCT programme was to decrease the number of HIV infected babies born to HIV positive mothers.

³⁴ UNAIDS uses orphan to describe a child who has lost either one or both parents. It also uses the terms 'maternal orphan', 'paternal orphan' and 'double orphan' to describe a child who has lost its mother, father or both parents respectively.

³⁵ www.avert.org

ART coverage has scaled up significantly over the past decade. From 2008 to 2009, sub-Saharan Africa had the greatest increase in the number of people receiving ART of any region. According to the World Health Organisation (2010), ART coverage rose from 2.95 million in December 2008 to 3.91 million one year later – an increase of approximately 33%. However, despite this increase, WHO/UNAIDS/UNICEF's 2010 *Towards Universal Access* report indicates only 37 % of PLWHA in Sub-Saharan Africa who are eligible for treatment currently receive treatment.

2.2 The Impact of AIDS on Development

The United Nations Development Programme (UNDP) argues that HIV has inflicted the single greatest reversal in human development in modern history (UNDP, 2005). The response to HIV is critical to progress of the Millennium Development Goals because health, which the World Health Organisation in 1946 defined not only as the absence of illness but of complete physical, mental and social well – being is a critical factor in the development of any country for two reasons. First, health status is a key indicator of a population's welfare (Sen, 1985) and second, improving the health status of the population leads to greater economic productivity (Strauss and Thomas, 1995).

The link between HIV and AIDS and development is evidenced by the multisectoral deterioration of the macroeconomic environment; rising poverty and the worsening debt crisis; declining real budgetary allocations to health, education and the social sector. Although the number of new infections on the continent seems to have peaked in the mid-1990s, the epidemic continues to be a major challenge to the health and development of many African nations. The disease is an immediate crisis requiring responsive health

systems and programs to address the health of PLWHA. Over the coming years and decades, the virus will create a systemic condition exacerbating existing struggles with poverty, development, and economic opportunity that must be addressed. Over time, HIV and AIDS deplete savings, reduces labour supplies, increases household vulnerability to shocks, reduces productivity in the public and private sectors, and negatively affects public finances and economic growth³⁶.

The vast majority of people in Africa who have HIV are between the ages of 15 and 49, thus, many adults are affected in their most economically productive years. According to the United Nations' (2010) *'The World's Women'* report, life expectancy at birth in the countries most affected by the epidemic in Southern Africa (South Africa, Namibia, Botswana, Swaziland, and Lesotho) was 64 years for women and 59 years for men from 1990–1995. Five years later (2000–2005), it had fallen to 51 for women and 49 for men as a consequence of the epidemic. More recent data (2005–2010) have shown a slight increase (52 for women, 51 for men) as a result of efforts to prevent new infections and provide life-prolonging ART.

The epidemic is also reversing progress in poverty reduction. AIDS tends to have an impact on the poor more than the rich, due to the costs associated with treatment and the loss of a productive labourer in a household; notably, in countries with larger epidemics. A study in Burkina Faso, Rwanda, and Uganda reported by the United Nations Development Program has calculated that AIDS will increase the %age of people living in extreme poverty from 45 % in 2000 to 51 % in 2015. Swaziland's Human Development Index has

³⁶ World Bank's *Commitment to HIV/AIDS in Africa* report, 2008

fallen considerably, with 69 % of the population living below the poverty line. Economic activity and social progress are set back as more of the labour force becomes ill or dies.

Agriculture, in particular, is neglected or abandoned due to household illness, adding to food insecurity in many areas. In Malawi, where the agriculture workforce is expected to shrink by 14 % by 2020, HIV and AIDS is the cause of the country's falling agricultural output³⁷.

The United Nations Food and Agriculture Organization (FAO) estimates AIDS has killed around 7 million agricultural workers since 1985 in the 25 hardest-hit countries in Sub-Saharan Africa. It further estimates an additional 16 million could die due to complications from HIV infection by 2020. This is of particular concern for many nations in Africa, where one-third of the gross national product from the most affected countries comes from agriculture.

Other sectors, particularly health and education, are affected by loss of skilled labour to HIV and AIDS. According to The World Bank, before the introduction of ART programs, Zambia lost approximately half as many teachers as it trained each year due to the epidemic³⁸. This depletion of trained human capital in the education sector made it difficult to train and educate future generations. HIV and AIDS poses increasingly heavy demands on Africa's health systems. As demand for services increases, countries are losing their

³⁷ World Food Programme, Facts and Figures, 2008.

³⁸ World Food Programme, Facts and Figures, 2008.

capacity to supply them. Most health systems in Africa already face labour shortages due to worker migration to other regions in pursuit of better pay and working conditions.

There is also an unparalleled orphan crisis as a result of the epidemic where Sub-Saharan Africa alone is now a home to approximately 90 % of children orphaned by HIV and AIDS globally³⁹. More than 10 % of all children (0 to 17 years of age) have lost one or both parents to HIV in Zimbabwe (16 %), Lesotho (13 %), Botswana (12 %), and Swaziland (12 %). Many of these children are raised by their grandparents or live in households headed by other children. Many children orphaned by HIV/AIDS lose their childhoods and are forced by circumstances to become producers of income or food, or caregivers for sick family members. They suffer their own increased health problems related to inadequate nutrition, housing, clothing, and basic care. They are also less able than other children to attend school regularly, and lower school attendance reduces the potential to develop human capital in future generations. There is therefore a growing recognition that because of the way HIV affects all other development issues, none of the MDGs are likely to be achieved unless the epidemic is curbed.

2.3 Various national responses to HIV and AIDS, a lesson for Zimbabwe.

There is virtually universal consensus that political leadership is the single most important element of any effective HIV and AIDS prevention strategy and has been critical in most of the outstanding success stories of the epidemic. Policy response to HIV and AIDS can fit into three overall categories, (1) Prevention, (2) Care and Support and (3) Treatment.

³⁹ UNAIDS, Report on Global AIDS Epidemic, 2010.

The nature of state-civil society relations illustrates one difference between countries reflecting the active participation model and those exhibiting the passive adhesion model. The nature of democracy affects the fight against this disease because formal implementation of national HIV and AIDS Programmes has often taken precedence over the mobilization of the concerned populations and the content of AIDS policies. The national responses have been evolving as people and countries learn from the past and from each other, although for many Governments in developing countries, they are often frog marched in some direction by donor incentives or conditionalities even when these choices do not meet the need of the local situation (Foster-Rothbart *et al*, 2002). Consequently, there is a risk that countries will develop comprehensive programmes on paper, which do not reflect the realities on the ground. Price *et al* (2004), argue that preliminary evidence suggests that the advocacy of prevention by endogenous political elites is extremely successful in HIV infection rates.

Across eastern and southern Africa, HIV and AIDS does not head the population's list of priorities. The *Afrobarometer* (2004) public opinion survey shows that AIDS is a concern to African publics but that it rarely ranks at or near the top. The findings are consistent. In 1999, the University of Cape Town began the first systematic attempt to poll public opinion in the African continent. What is most striking about the data is how low concern about AIDS ranked where few people named the epidemic as a priority for the Government's agenda. Instead, they ranked Government action on unemployment, poverty, crime, education and general health improvements as priorities. Similar rankings were found in 2002 where South Africans put unemployment at the head of the most important problems facing the country that the Government ought to address.

De Waal (2006) also notes that even Africa's leading AIDS activists are careful not to challenge their Government's legitimacy on the issue as it follows that AIDS will not head elected politicians' agendas either, no matter how much foreign AIDS ambassadors try to persuade them otherwise. Table 2.1 below shows the *Afrobarometer* data which shows diverging profiles of public opinion on AIDS in different countries as a %age when asked the most important problems they faced that the Government should address.

Table 2.1 Priority List for African publics⁴⁰

Botswana	Uganda	Malawi	Mozambique	South Africa
Unemployment	Poverty	Famine	Unemployment	Unemployment
Poverty	Health	Poverty	Health	Crime
AIDS	Unemployment	Farming	Education	Poverty
Education	Education	Economy	Poverty	AIDS
Farming	Water	Health	Famine	Education
Health	Farming	Unemployment	AIDS	Corruption
Crime	Economy	Water	Farming	Health
Economy	Crime	Education	Water	Famine
Famine	Corruption	Crime	Crime	Water
Water	Roads	Roads	Corruption	Economy
Corruption	AIDS	Corruption	Economy	Farming
Infrastructure	Famine	AIDS	Roads	Roads

Source: Afrobarometer (2002)

With the information on Table 2.1, it is reasonable for the communities to propose that Governments' intervention in Sub-Saharan Africa has had very little impact in trying to

⁴⁰ All variables are listed in order of priority with the top listed being of the outmost importance.

control the epidemic. In its 2002 Report of the Global HIV and AIDS epidemic, the Joint United Nations Programme on AIDS (UNAIDS), reports that it has been hoped that the epidemic may have reached its natural limit in the region, beyond which infections rates would stop increasing after reaching a plateau. Unfortunately, this appears not to be the case yet as HIV and AIDS is still a health and development crisis throughout much of Sub-Saharan Africa.

In the first years of the epidemic during the 1980s, there was denial of the existence of the disease resulting in policy makers and the public having difficulties in grasping the urgency of preventive measures. As Ainsworth (1998) notes, this denial robbed the society of precious time during which early and focussed action could have averted the epidemic. The silence was also made possible by the latency period⁴¹ of the disease contributing to the policy makers not taking control of the virus for nearly two decades. This extended latency period also contributed to large populations not worrying about the virus with the belief that they were likely to die of something else within the same period given the numerous misfortunes experienced by African countries. Awusabo-Asare *et al* (1999) notes some of the attitudes when he said, '*All die be die*'. The Nigerian attitude was also noted by Orubuloye and Oguntimehim (1999) when they said, '*Death...will come when it is due*', and in East Africa, Amuyunzu-Nyamongo *et al* (1999) used the phrase, '*Everyone will die anyway*'.

For AIDS to be rolled back, the right political incentives for HIV prevention need to be in place. Every Government intervenes in health sectors to some extent, but the nature and

⁴¹ The time between infection and the onset of symptoms of disease. HIV and AIDS theory postulates a **latent period** of roughly 10 years between infection by human immunodeficiency virus (HIV) and the appearance of symptoms of acquired immune deficiency syndrome (AIDS).

size of those interventions varies from country to country, but the bottom line is that they embark on measures that prevent transmission and lately the need to acquire life – prolonging therapy. Some of the most successful country programmes in the last decade include Uganda and Thailand, where political elites have used their power to educate the population and have encouraged an environment to support initiatives that control the spread of HIV without violating individual rights. A summary of the successful responses in Thailand, Uganda will be discussed below. The study will also explore how South Africa dealt with the epidemic followed by the responses in Zimbabwe.

2.2.1 Thailand

Although Thailand took longer to respond than many other countries, once catalysed, a comprehensive AIDS response flourished in a very short space of time. At this time, known as the '*Prague Spring for Thailand*', the Prime Minister took the chair of the National AIDS Committee, and the AIDS budget rocketed from \$2.5m in 1991 to \$48m in 1992, with most of its money being locally sourced rather than from external donors (Singhai and Rogers, 2003). In Thailand, civil society responses, aided by relatively progressive Government support, played a key role. In 1991, for instance, there was only one Thai support group for people living with HIV. By 2001, there were 400. Mechai Viravadiya, '*Mr Condom*' as he became known in Thailand started as a civil society activist and became an extremely effective Government Prime Minister helping to champion AIDS as a critical issue. The state media was also effectively utilised, both for information dissemination and as a catalyst for political change. The precursor to the Thai political leadership described above was the communication environment, including a relatively free and plural media, that helped Mechai and other civil society actors promote the AIDS agenda and become

such a powerful force for political advocacy. The intensity of the Thai fight against AIDS was such that each day, in the 1990s, there were 73 hours of AIDS messages on the radios, and two hours of TV coverage (Lyttleton, 1996).

The HIV epidemic was fuelled by an illegal yet thriving sex industry in Thailand. In the same year a change of Government heralded a new, pragmatic response to the problem. At its core was the world's first "*100 per cent condom use*" programme. Instead of trying to eliminate commercial sex, the Government chose to distribute tens of millions of free condoms to brothels and massage parlours, and to clamp down on those that failed to insist on condom use. Men were discouraged from visiting sex workers, and the rights of women were promoted. Following the start of this campaign, the number of Thai men paying for sex fell substantially, and reported condom use in brothels rose from 14% in 1989 to over 90% in 1994 (UNAIDS, 2005). The effect on the HIV epidemic was spectacular, with annual diagnoses plummeting from 143,000 in 1991 to around 19,000 in 2003, hence Thailand has rightly been praised for this success.

However in recently years, Thailand's record is not perfect. According to the International HIV/AIDS Alliance (2010), the country's funding for HIV prevention has fallen by two thirds and public concern has dwindled. The virus is widespread among injecting drug users and men who have sex with men, who have been largely neglected by prevention campaigns. Condom use has declined again among sex workers, who are increasingly working in non-brothel settings, where they are largely unaffected by the 100 per cent condom use programme.

2.2.2 Uganda's response

Uganda is most often credited as one African country that has demonstrated an ability to prevent HIV and reverse incidence rate and has received international acclaim as a role model. The involvement at all levels of leadership from top political officials to grassroots leaders was the key difference between Uganda and other African nations. It is continually held up as the African HIV and AIDS success story, and the Government response is seen as a model for other states to follow. One of the most remarkable aspects of the Ugandan response to the epidemic and the subsequent success achieved in lowering HIV rates is that it was undertaken in situations that would typically constrain state actions and policy effectiveness. The country had just emerged from a long period of civil war (UNAIDS, 2008).

Uganda was the first African nation to identify cases of AIDS when, in 1982, a number of traders who lived near the shores of Lake Victoria were seen to be suffering from an immune system breakdown and symptoms similar to those identified in the United States a year earlier (UNAIDS, 1999). It found itself labeled as one of the worst hit countries in the world by the early 1990s. It was said to be at the centre of an 'AIDS belt' in Eastern Africa with national prevalence rates estimated at between 10 and 20 % in the early 1990s. Uganda was the first nation in the world to develop a dedicated AIDS programme, which was launched in 1986 soon after President Yoweri Kaguta Museveni came into power, as an AIDS Control Programme (ACP) in the Ministry of Health. (Schoepf, 2003).

The response was characterized by strong political leadership, open communication and involvement of numerous grassroots organisations, as well as expanded condom distribution, HIV testing and treatment of sexually transmitted infections. However, since it was diagnosed in Uganda over two decades ago, one million people have died and

another 1.2 million are currently living with the virus (WHO, 2007). From a prevalence rate of 30 % in the early 1990s to about 6.7% in 2006, Uganda took a bold step to address the epidemic at a time when most countries feared to talk openly about HIV and AIDS.

The highly successful ‘ABC’ (Abstinence, Be faithful and Condom use) policy to HIV prevention is often said to have started in Uganda, and it is arguably the reason for the decline in prevalence rates. Uganda’s president was introduced by Chinua Akukwe in Washington D.C.⁴² with these words:

‘Ladies and gentlemen, Uganda beat back the deadly ravages of HIV and AIDS because of the courageous principles of one individual, Yoweri Museveni. This president more than 15 years ago decided to buck the traditional African proverb that a tree cannot make a forest. Mr Museveni became not only the proverbial tree in AIDS remedial efforts in Uganda but also constitute himself into a forest... Many of us will be happy to save one, two, three or ten lives in our lifetime due to our direct actions. President Museveni has literally saved millions of lives in Uganda. He has also saved millions more in other parts of Africa by his bold, courageous and principled fight against HIV and AIDS...President Museveni, you are without any doubt an icon and a living legend in the fight against HIV and AIDS in Africa’.

Low- Beer and Stoneburner (2004) also mention that part of the reason that Uganda’s anti-AIDS efforts were effective was because the Government provided a space in which local groups, faith-based groups, neighbours and friends could discuss the disease and educate one another. From 1986, President Museveni and his Government stressed the importance

⁴² This was at a luncheon organised for President Museveni by the Pharmaceutical Research and Manufacturers of America, Constituency for Africa, Africa Society of the National Summit of Africa and Church World Service, 12 June 2003, Washington DC.

of openness and early response to HIV and AIDS. In contrast to many other world leaders, Museveni publicly discussed HIV, called all members of society and politicians to fight it and encouraged Non Governmental Organisations and donors to become involved. The Government was to follow what has been termed an ‘inclusive’ or ‘open’ approach to HIV. The Government did not call for one particular method of dealing with the disease, but instead invited a wide range of stakeholders to partake in policy consultation. It established an enabling environment, which allowed for different actors to address HIV in their own unique ways.⁴³

Under new-found political freedoms in the mid-1980s, enabled by an effective political leadership, a strong credible and highly professional media began to emerge in Uganda. Daniel (2002) noted that reporting on HIV and AIDS was intense, sometimes sensational and inaccurate, but often pioneering. The Government launched an aggressive media campaign involving posters, radio messages and rallies; they trained teachers to begin effective HIV and AIDS education and most importantly, it mobilised community leaders, churches and the public in general. Emmanuel Katongole (2000) gave a narration of Uganda’s progression in awareness messages;

“ I remember in the early 1980s, when , at least in Uganda, billboards warning against the spread of HIV infection carried the picture of what was obviously a married couple with three young children, and bore the caption : ‘Love Faithfully to Avoid AIDS’. This was soon replaced by the

⁴³ There have been few attempts to understand the meaning of openness in HIV activities. For some government officials, openness referred to the early acceptance by the President and national government of the HIV problem. For representatives of religious groups, they saw the state as ‘open’ to alternative message of HIV prevention, including spiritual as well as secular ones. NGOs reliant on international donor support saw a key aspect of ‘openness’ to be a way the government was open to funding from outside (Parkhurst, 2001; 2002).

Uganda AIDS Commission with what was seen to be a more potent picture, two young lovers in embrace, with the caption, ‘Love Carefully’. This means that with AIDS even lovers cannot (or is it, should not) trust each other fully (love faithfully) but must learn the art of loving ‘carefully’, that is suspiciously. This involved regarding the partner as potential danger from which one had to ‘protect’ oneself. Thus by mid 1990s, the caption had changed again from ‘Love Carefully’ to ‘Use a Condom to Avoid AIDS’.

The Government worked alongside many independent organisations, using different messages to address different groups of people according to their needs as well as their ability to respond. Young people were encouraged to wait before having first sex, or to return to abstinence if they were not virgins. All sexually active people were given the message of "zero grazing", which meant staying with a regular partner and not having casual sex. Those who did not abstain were encouraged to use condoms, which were promoted to the population as a whole (Ministry of Health-Uganda, 2004). In order to encourage people to take up such strategies and to make them effective, action was taken to encourage candid discussions to reduce stigma, empower women, improve testing facilities, treat other sexually transmitted infections and to provide better care for those already infected. Fear avoidance was also a part of the strategy.

According to De Waal (2006), Uganda under Museveni is an odd mixture of liberalism and militarism, as is the country's AIDS efforts. The AIDS policy approaches in Uganda reflects the president's fondness for military metaphors emphasising the values of discipline, obedience, nationalism and masculinity. This combination of open and active Government response, popular changes to fight HIV and AIDS, and lower stigma levels, combined with epidemiological evidence of HIV reductions, has unsurprisingly led to Uganda's recognition as one of the world's success stories.

However, it is important to note that Uganda's success in reducing infection rates has been more celebrated than analysed. Some authors have suggested that Museveni may have prioritised HIV and AIDS for strategic reasons, with the often repeated tale that it was the Cuban President, Fidel Castro who informed him that many of his military leaders who went to Cuba for training were testing positive for HIV. Museveni, a guerrilla army leader, may, therefore have seen this as a threat to the security of his Government. Strategically, Museveni placed the Uganda AIDS Commission under the office of the President and not within the Ministry of Health.

Other critical analysts argue that Museveni's actual record on AIDS has some shortfalls. To start with, he has not been open with the figures. It is argued he overstated the decline in prevalence, claiming in 2000 that national prevalence had come down from 30% in 1991, a figure that is probably twice as high as the reality (De Waal 2006). If questioned, the Ugandan official response to any questioning of the figures was scathing and intimidating. The importance of the Ugandan experience has thus been compromised as conclusions were drawn out of context and statements made on the basis of oversimplified assessment of epidemiological data. Tumushabe (2005) argues that at the end of the 1990s, Museveni began to trumpet his success and use it for political credit, perhaps his military involvement in Congo was becoming politically costly and the country's long economic boom was coming to an end.

The Government strategically dealt with the concerns and demands of the international community, while at the same time managing to maintain control of a national response that would soon become the model for Africa and beyond. Uganda was one of the first countries to negotiate lower costs for antiretroviral drugs to treat those infected with HIV

(Health Action International, 2002). It also became one of the first countries to benefit from the debt forgiveness initiatives. Yet, in recent years, HIV prevalence in Uganda has failed to decline further, and perhaps has increased from 6.4% in 2005 to 7.3% in 2011⁴⁴. One of the contributing factors was the shift from HIV Prevention Programmes to treatment. The overall progress and gains made are now under threat and could see a reversal from the previously registered success.

2.2.3 South Africa's shortfalls in HIV prevention

Many activists believe that weak political leadership has severely hampered the response to HIV in South Africa, where an estimated 5.6 million people were living with HIV and AIDS in 2009, the highest number of people in any country. In the same year, it is estimated that 310,000 South Africans died of AIDS-related causes, reflecting the huge number of lives that the country has lost to AIDS over the last three decades. Prevalence is 17.8 % among those aged 15-49, with younger adults being particularly affected⁴⁵.

In particular, President Mbeki's Government was very slow to begin providing *nevirapine*⁴⁶ and other drugs for the Prevention of Mother-to-Child Transmission (PMTCT⁴⁷) programme. of the virus. The UNAIDS (2005) reports that only around 14.6% of pregnant women with HIV received preventive treatment although the Government's own estimate

⁴⁴ 2011 Uganda AIDS Indicator Survey (UAIS) Report

⁴⁵ UNAIDS (2010) '[UNAIDS report on the global AIDS epidemic](#)

⁴⁶ A drug used to treat HIV infection.

⁴⁷

is much higher. This rate is quite typical for an African country, but is surprisingly low given South Africa's relative wealth and resources.

African electors' low level of political concern over AIDS also allows us to explain why the Africa National Congress (ANC) seems unhurt electorally by the Thabo Mbeki's stand on HIV and AIDS of publicly adopting the extreme view that HIV is not the cause of AIDS and that anti-retroviral treatment is unnecessary and toxic. In the run up to South Africa's first democratic elections in 1994, Strand (2005) reports that Nelson Mandela⁴⁸ was reportedly advised not to make AIDS into a campaign issue for the fear of offending culturally conservative constituencies. Mandela said,

'I wanted to win...and I did not talk about AIDS'.

Mbeki's story is viewed differently by the African and Western media. The Western media generally crucified him but Africa had mixed feelings. It is therefore crucial to consider this difference and try to understand how Mbeki's speeches and actions can be viewed so differently by different people. Raymond Dowling in *'As They See It: The Development of the African AIDS Discourse'* (2005) admits that most conclusions are based on the Western medical standards and ethics, but these are not universal. Mbeki sent a letter to many world leaders explaining his position, (See Fig 2.2).

⁴⁸ A South African politician who served as President of South Africa from 1994 to 1999.

'According to Africans, we have to deal with this uniquely African catastrophe that, contrary to the West, HIV and AIDS in Africa is heterosexually transmitted. Contrary to the West, where relatively few people have died from AIDS, itself a matter of serious concern, millions are said to have died in Africa and contrary to the West, where AIDS deaths are declining, even greater numbers of Africans are destined to die'

'...If the British are promiscuous, and the majority do not use condoms, and are not catching AIDS: and if Africans are promiscuous, and the majority do not use condoms and are catching AIDS, then, doesn't Africa deserve the right to examine why the dichotomy, in order to find a cure to the African condition'

Figure 2.2 Mbeki's position on HIV and AIDS

(Source : www.sumeria.net and Dowing, 2005)

It is therefore important to note that the different ways in which Governments intervene in the health sector do not necessarily achieve their intended objective and they may even have negative consequences. De Waal (2006) advises that there is no discernible system of political rewards for success and penalties for failure, so we should not be surprised that Governments and international institutions have not made much progress in preventing HIV infections. Nevertheless, there are rare politicians, such as Kenneth Kaunda, the former president of Zambia who has excellent AIDS fighting credentials. He was the first reigning African president to openly admit there was AIDS in his family

2.3 Area of study – HIV and AIDS in Zimbabwe

Zimbabwe is one of the countries in Sub-Saharan Africa that have been worst affected by the HIV and AIDS epidemic with a projected population size of 12 million people. The estimated HIV prevalence among adults 15 years and above was 14.3% according to the National HIV Estimates of 2010. There were an estimated 1, 187, 822 adults and children that were living with HIV and AIDS in 2009. Meanwhile, an estimated population of 389 895 adults and children were in urgent need of antiretroviral therapy by the end of 2009. The decline in HIV prevalence was projected to have started in the late 1990's according to the 2010 National HIV Estimates. In pregnant women (15-49 years), HIV prevalence declined from 17.7% in 2006 to 16.1% in 2009. In the adult population (15 years and above), HIV prevalence in Zimbabwe was estimated to be 23.7% in 2001, and 18.4% in 2005 and further declined to 14.3% in 2009. The epidemic in Zimbabwe is believed to be declining as result of prevention programmes, in particular behaviour change and Prevention of Mother to Child Transmission (PMTCT), as well as the impact of mortality⁴⁹.

Historically, the first reported case of AIDS in Zimbabwe occurred in 1985 where the main mode of transmission is heterosexual intercourse related to serodiscordant⁵⁰ couples. By the end of the 1980s, around 10% of the adult population was thought to be infected with HIV⁵¹. This figure rose dramatically in the first half of the 1990s, peaking and stabilising at 29% between 1995 and 1997. But since this point the HIV prevalence is thought to have

⁴⁹ Ministry of Health and Child Welfare, Zimbabwe National HIV Estimates 2009

⁵⁰ A couple in a relationship where one partner is HIV positive and the other is HIV negative

⁵¹ 'Evidence for HIV decline in Zimbabwe: A comprehensive review of the epidemiological data'. UNAIDS, November 2005:45.

declined. According to Government figures, the adult prevalence was 24.6% in 2003⁵², and fell to 15.3% in 2007⁵³. The Joint United Nations Programme on AIDS (UNAIDS) in its report on the Global HIV and AIDS Epidemic in 2002 stated that the estimated adult HIV and AIDS prevalence in Zimbabwe was 33.7% in 2001. Since this point the HIV prevalence is thought to have declined as earlier discussed..

The association between perception of risk of HIV infection and sexual behaviour remains poorly understood, although perception of risk is considered to be the first stage towards behavioural change from risk-taking to safer behaviour. Findings to the Millennium Development Goals Status Report of 2010 indicated that Zimbabwe appears to be on course to achieving the MDG target of reducing national prevalence of HIV to 9% by 2015 and to reduce HIV prevalence to 16% by 2015 (in the 15-24 age group) (GoZ, 2011:3). Owing to these declines, Tabitha Mutenga of *The Financial Gazette* of 15 April 2011 in an article ‘*Zim to miss 2015 MDGs deadline*’ reported that, “*The country is, however, on a stable course to achieving the MDG target of reducing the prevalence of HIV and AIDS to nine % by 2015, having reduced the prevalence rate by 14,3 %*”. Table 2.2 below shows the decline in adults and children HIV prevalence rates.

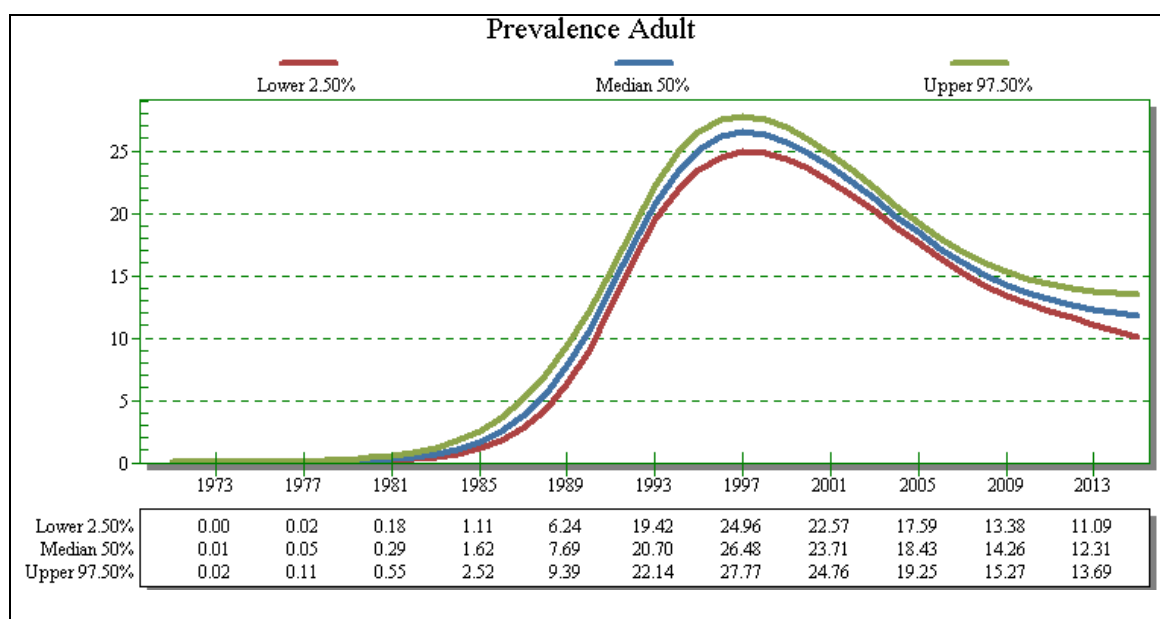
⁵² Ministry of Health and Child Welfare, Zimbabwe *'The HIV and AIDS epidemic in Zimbabwe: Where are we now? Where are we going?'* 2004:25

⁵³ The Zimbabwean Herald ‘*HIV Rate Down to 15.6 %*’, 1 November 2007

Table 2.2 : Adult and children HIV prevalence rates in Zimbabwe⁵⁴

Age Category	2007	2008	2009
Adult prevalence (15+ years)	16.1% (15.2 – 16.9)	15.1% (14.2 – 16.0)	14.3% (13.4 – 15.3)
Prevalence males (15-24)	3.3% (2.5 – 4.7)	3.3% (2.5- 4.5)	3.2% (2.5 -4.4)
Prevalence females (15-24)	7.6% (5.9 -10.3)	7.2% (5.6 – 9.5)	6.9% (5.3 – 9.0)
Prevalence children (0 -14)	3.3% (2.0 -4.4)	3.2% (1.9 -4.2)	3.1% (1.8 -4.1)

The prevalence of HIV infection peaked at 10.6% in 1995 among males aged 15 to 24 years. In women aged 15 to 24 years, prevalence also peaked in 1995 at 26% . Declining trends in HIV prevalence have been noted in both males and females aged 15 to 24 years from 1995 to 2009 as shown in Fig 2.3 below.

**Figure 2.3 : Trends in Adult HIV Prevalence, Zimbabwe 1970-2015**

(Source: MOHCW, 2007)

⁵⁴ Ministry of Health and Child Welfare, Zimbabwe *'The HIV and AIDS epidemic in Zimbabwe: Where are we now? Where are we going?'* 2004:25

The secondary data collection found that the country's HIV prevalence is thought to have declined to 24.6% in 2004 and 15.6% in 2007 (ZDHS, 2006 and MOHCW, 2007). The researcher obtained the following useful graphs from the Central Statistic Office (CSO). The first diagram is a compilation of the whole country's prevalence rates; followed by a comparative analysis of geographical prevalence rates in males and females.

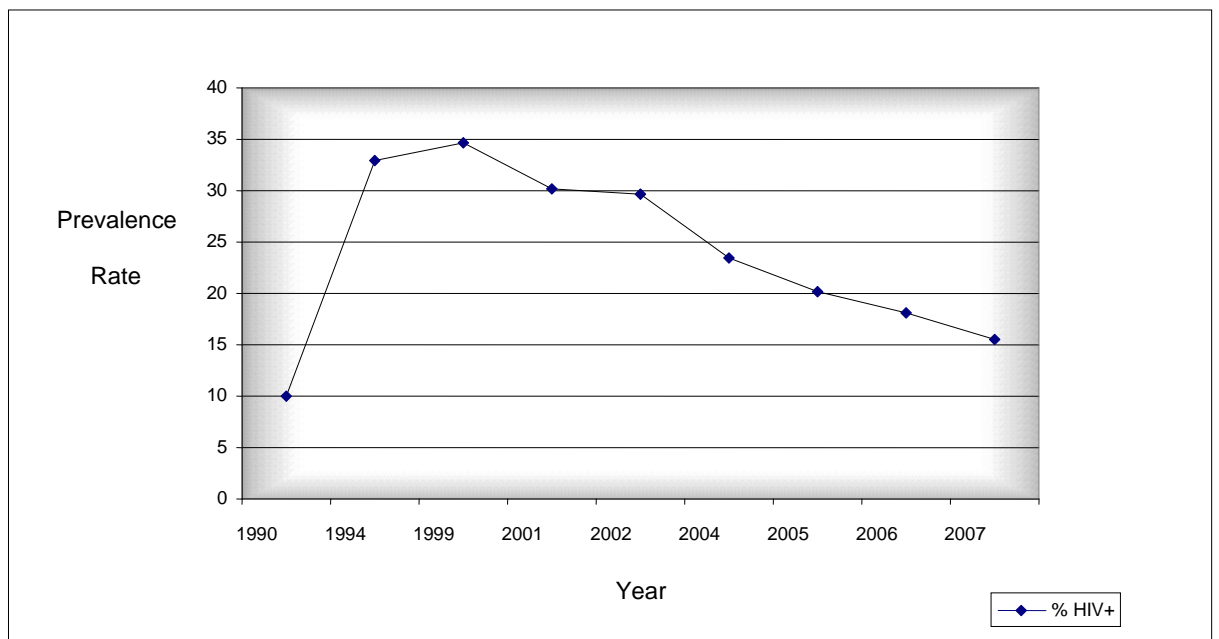


Fig 2.4 Showing the Trend in HIV Prevalence Rate in Zimbabwe, 1990 – 2007

(Source: MOHCW 2005, 2007; ZDHS 1999, 2006)

The HIV and AIDS epidemic has hit all the parts of the country and Harare being the capital city of Zimbabwe cannot be singled out. The prevalence rates for HIV by provinces indicate that between 2005 and 2006, Harare had the third highest prevalence rate of 19.3% after Matabeleland South (20.8%) and Manicaland (19.7%); however, Harare had the highest male HIV prevalence rate of 17.3%. This is shown in Fig 2.6 below. For the identification of Zimbabwe's geographical provinces, Fig 2.5 below is a Provincial map of Zimbabwe.



Fig 2.5 Provincial map of Zimbabwe

(Source: Central Statistic Office, 2006)

Zimbabwe is divided into 8 provinces and 2 cities with provincial status. The map in Fig 5.4 (opposite) shows the geographical location of Zimbabwe provinces. The numbers inserted represent the following;

- | | | |
|------------------------|---------------------|-----------------------|
| 1. Bulawayo | 5. Mashonaland East | 8. Matabeleland North |
| 2. Harare | 6. Mashonaland West | 9. Matabeleland South |
| 3. Manicaland | 7. Masvingo | 10. Midlands |
| 4. Mashonaland Central | | |

Harare had the third highest HIV prevalence rate of 19.3% after Matabeleland South (20.8%) and Manicaland (19.7%). This is shown in Fig 2.6 below. However as also shown above, Harare had the highest male HIV prevalence rate of 17.3%, followed by Manicaland with 16.6%. The statistics for Harare further confirm what is generally known about the gender differentials of HIV prevalence rates. This is shown below on Fig 2.7

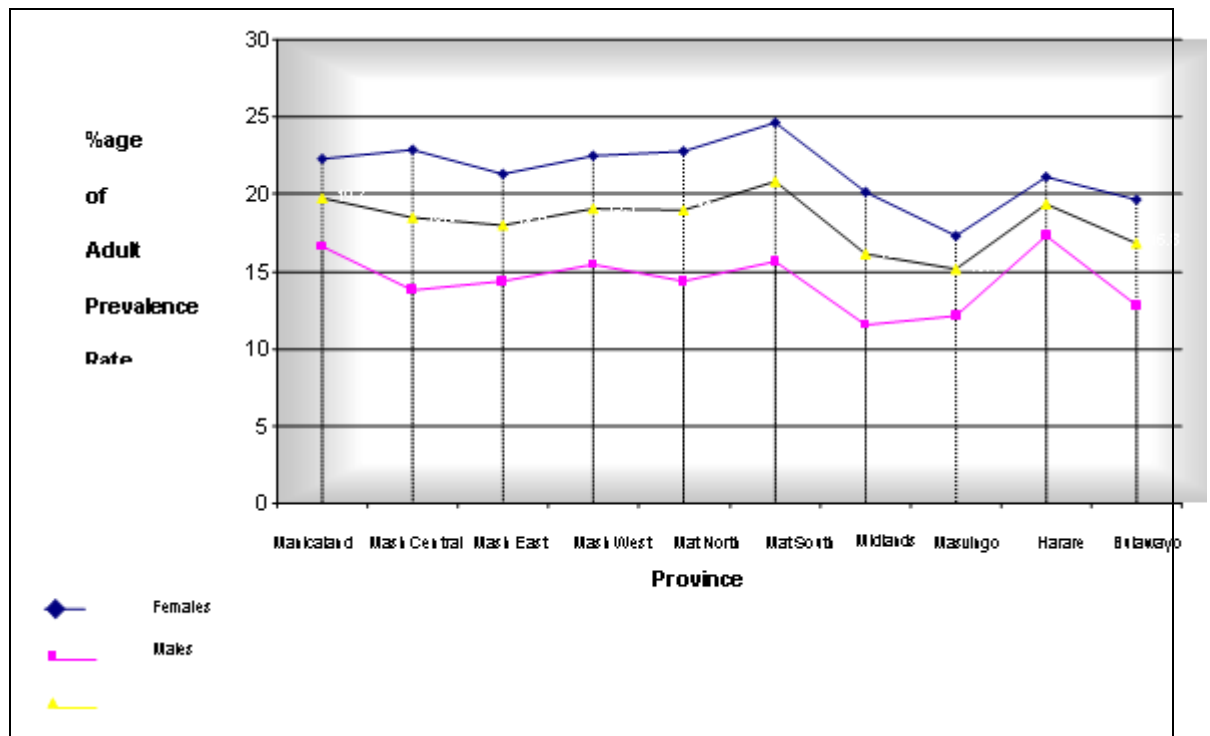


Fig 2.6 Showing HIV Prevalence Rates by sex and province
(Source: ZDHS 2005 – 06)

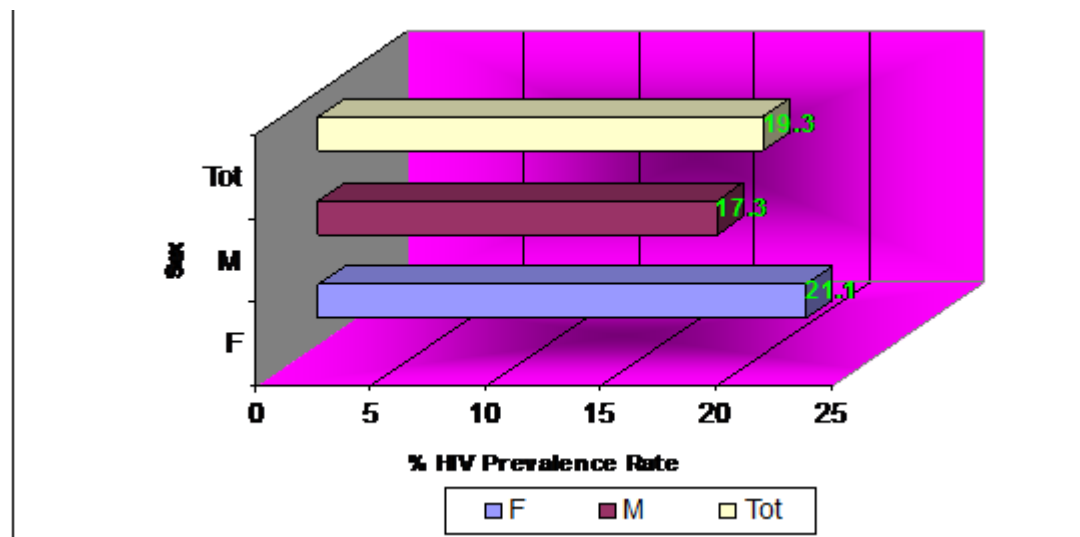


Fig 2.7 Showing HIV Prevalence Rates in Harare 2005 - 2006
(Source: ZDHS 2005-06)

2.3.1 Zimbabwe's response to the epidemic

Zimbabwe's response to HIV and AIDS has been described by President Robert Mugabe as slow, weak and selective (GoZ, 1999). The 13th International AIDS Conference held in South Africa in 1999, emphasised a critical theme, '*Break the Silence to save human life*'. The United Nations also confirms that the conspiracy of silence is one of the main reasons for this global catastrophe. As Kofi Annan, Secretary General of the United Nation declared on World AIDS Day in 2002, '*The fear of stigma leads to silence and when it comes to fighting AIDS, silence is death. It suppresses public discussion about AIDS and deters people from finding out whether they are infected*', (UNAIDS, 2002). Zimbabwe is one of the world's most severely AIDS stricken countries and yet conservative social mores in the country have discouraged open talk about the epidemic⁵⁵.

Lack of political will has been the major constraint. From the beginning of the epidemic in this country, politicians consistently refused to acknowledge publicly either the severity of the HIV epidemic or the existence of People Living with HIV and AIDS (PLWHA) in their midst. Ray *et al* (2006) notes that those who watched the unfolding of the events in East Africa and warned of a similar catastrophe in Southern Africa were accused of being alarmist and unpatriotic. As HIV infections sky rocketed in Zimbabwe in the 1990s, the Government largely swept AIDS under the carpet making it more difficult for AIDS NGOs to make headway against the conservative moves of the Zimbabwean society.

⁵⁵ This country can fall into the category of the passive adhesion model which represents double passivity, the passivity of African authorities towards international AIDS directions and the passivity of civil society toward political representatives who are concerned with remaining in power.

President Mugabe kept silent on AIDS until April 1999 when he publicly acknowledged for the first time that the virus was a national epidemic with more than 1 200 Zimbabweans dying each week from the disease. A United States Embassy official said,

“President Mugabe, although he will occasionally wear an AIDS ribbon, he has never taken the sort of leadership stance that President Museveni in Uganda has, talking openly about the problem. Zimbabwe is still a conservative society and in the background people are whispering, ‘It was the virus’ but that will not be publicly acknowledged. There is still stigma attached to HIV and AIDS which is deeply uncomfortable for the vast majority of Zimbabweans.”

(US embassy official, interview with Jake Batsell, 29 June 2000).

Zimbabwe has adopted a multi-sectoral approach that is led by the National AIDS Council (NAC). In 1995, the Government initiated the development of a National HIV and AIDS Policy, which was officially adopted in December 1999. However, since the discovery of HIV and AIDS in 1985, Zimbabwe reacted more to the AIDS than HIV⁵⁶ through a national programme of action under the leadership and guidance of the National AIDS Co-ordinating Programme (NACP), within the Ministry of Health and Child Welfare⁵⁷. At the same time, the Government introduced an AIDS levy on all taxpayers to fund the work of the NAC [Zimbabwe Human Development Report (ZHDR), 2003]. NAC’s mandate is to co-ordinate all HIV and AIDS prevention, support and care, mitigation and research

⁵⁶ There have been two ‘state of emergency’ declarations in Zimbabwe, one at the end of May 2002 to December 2002 in which HIV positive people were supposed to be availed with ARVs and drugs that treat opportunistic infections. Unfortunately, at the end of six months, nothing had materialised and another emergency declaration was made, this time spanning January 2003 to December 2008 (Zimbabwe Human Development Report, 2003).

⁵⁷ The government introduced a National HIV and AIDS Policy in December 1999 with 43 Guiding Principles to guide programmes aimed to combating HIV and AIDS.

efforts. Its Board is made up of people from all sectors of the economy and society including PLWHA. It was formed using donor funds and following the recommendations of the Global Programme for AIDS (GPA) which called for the formation of National AIDS Programmes (NAPs).

In addition to the overall coordination through NAC, other key constituencies have strengthened their coordination mechanisms. The Zimbabwe AIDS Network (ZAN) has provided leadership in coordination of non Governmental organizations working in HIV. Coordination in the private sector is still weak although there is now good progress in efforts to streamline coordination through the development of a Strategic Plan for private sector involvement in the national response.

While these measures have had a positive impact, the Government's response to HIV and AIDS has ultimately been compromised by numerous other political and social crises that have dominated political attention and overshadowed the implementation of the national AIDS policy. Chapter 5 will provide a detailed account of the HIV Prevention Programmes that were implemented by the Zimbabwean Government at the time this research was conducted.

2.4 Theories of Behavioral Change and HIV and AIDS

Social Science research has the capability to reveal the complex and important linkages between social structures and individual behaviour and to suggest how specific social changes can inspire individual changes. A number of factors have contributed to the focus on the individual as a unit of analysis in AIDS research such as prevailing public perceptions of AIDS epidemic as just punishments for the immoral and stigmatised groups 'blame the victim' mentality. From this viewpoint, AIDS patients are held personally responsible for contracting the disease. Individual emphasis is further fuelled when groups hardest hit by the epidemic are represented as problem populations and socially distanced as 'not like the rest of us', because of the representation of AIDS as punishment for sins and those affected as outside of normal society (Auerbach, 1994).

Human behaviour is determined by multiple factors in the individual and environment, ranging from the micro-level molecular biological to macro-level social and environmental. These factors often interact in mutually reciprocal relationships such that one factor both influences and is influenced by another. Theoretical models therefore play a particularly significant role predicting risk behaviour or to predict behaviour change. Such models focus on the individual's perception of susceptibility, perception of beliefs, constraints and intentions to behave in particular ways (Fishbein *et al*, 1991). Those that dominate studies of HIV risk behaviour fall into two major groups, first, those that predict risk behaviour and those that predict behaviour change. Models that predict risk behaviour attempt to identify variables that explain for instance, why some members of a given population exhibit a given behaviour at a given time while others do not (Fishbein *et al*, 1991). On the

other hand, the models that predict behaviour change focus on stages through which the individual may proceed while attempting to change behaviour. There is a third set of theoretical models raised by the maintenance of safe behaviour once such behaviour has been initiated.

Three main primary models used in attempts to understand AIDS related health attitudes and behaviours are Fisherbein and Ajzen's *Theory of Reasoned Action* (Fisherbein *et al*, 1989), Bandura's *Social Cognitive Theory of Self-efficacy* (Bandura, 1990) and Rosenstock's *Health Belief Model* (Rosenstock, 1974). These theories have in common the premise that an epidemic such as AIDS can be managed by controlling human voluntary action.

According to the *Theory of Reasoned Action*, if people evaluated the suggested behaviour as positive (attitude), and if they think their significant others wanted them to perform the behaviour (subjective norm), this results in a higher intention (motivation) and they are more likely to do so. The *Social Cognitive Learning Theory's* central concepts are those of 'modelling', 'efficacy beliefs' and self-efficacy. Modelling is the process by which people are influenced by observing others. Efficacy beliefs include outcome (or response) efficacy, which is the belief that a given behaviour will result in a given outcome, for example, wearing condoms will prevent transmission. Self-efficacy, is the individual's belief that he or she can effectively carry out a desired behaviour in a particular setting, for example, successfully negotiate the use of a condom during a sexual encounter (Bandura, 1977).

This thesis was based on the *Health Belief Model* (HBM) and will be discussed in depth in the next (Section 2.4.1). The model was specifically developed in the context of problems in the health education and public participation in screening programmes. It proposes that

readiness to take preventive health action arises from the evaluation of the level of threat associated with the disease (perceived susceptibility) to the disease and its severity. In other words, the behaviour is influenced by the individual's perception of vulnerability or risk of contracting the disease and the individual's seriousness of consequences associated with that disease.

There are two stage models of change, which have been adapted for use in HIV risk behaviour. The *AIDS Risk Reduction Model* and the *Transtheoretical Model*. The AIDS Risk Reduction Model (ARRM) by Catania *et al* (1990) incorporates elements of the Health Belief Model (HBM) and the Social Cognitive Learning Model to describe the process through which individuals change their behaviour. A goal of this model is to understand why people fail to progress over the change process. The ARRM has three stages:-

- **Stage 1:** Labelling high-risk behaviour as problematic which includes susceptibility from the HBM. This involves knowing which sexual activities are associated with HIV transmission, believing that one is susceptible and believing AIDS is undesirable.
- **Stage 2:** Making a commitment to change high-risk behaviours, weighing costs and benefits, evaluating response efficacy.
- **Stage 3:** Seeking and enacting solutions, that is, taking steps to actually perform the new behaviour.

In the Trans-theoretical Model, there are five stages of change:-

1. **Pre-contemplation stage** in which an individual does not intend to change behaviour within the next six months.
2. **Contemplation stage**, in which the individual intends to change within six months.

3. **Preparation stage**, in which the individual is seriously planning to change within the next 30 days.
4. **Action Stage**, in which the individual has modified a particular behaviour and met a specific criterion for example, condom use.
5. **Maintenance Stage** which is the period in which the individual continues behaviour change beyond six months (Prochaska *et al*, 1992)

It is important to note that the movement through the stages does not occur in a linear manner. An alternative to stage models is the *Diffusion Theory* (Rogers, 1983), which describes the process by which an innovation is communicated through certain channels over time among members of a social system. For instance, through innovative opinion leaders whose influence can accelerate the rate at which innovations are adopted through the social system. Their interpersonal networks allow them to disseminate information and to serve as social role models whose behaviour may be imitated by other members of the system. A successful diffusion intervention changes community such that the new safer behaviour becomes normative.

2.4.1 The Health Belief Model

The Health Belief Model (HBM) was originally developed in the 1950s to explain why people fail to participate in health prevention programs, specifically for tuberculosis⁵⁸. The model suggests that in order for an individual to change his/her behaviour, an individual must feel threatened, believe that a specific change in behaviour will be beneficial taking account the cost of such change, and must feel that he/she is competent to implement the

⁵⁸ Glanz, Rimer & Viswanath, 2008

recommended health related action (Rosenstock *et al.*, 1988). Since then, the HBM has evolved to be applied to many other health-related prevention situations including obesity prevention, mammography testing, breast self-examination, condom usage, smoking, alcohol reduction, vaccination practices, and AIDS prevention behaviours⁵⁹.

The Health Belief Model (HBM) focuses on two aspects of individuals' representations of health and health behaviour: threat perception and behavioural evaluation (Abraham & Sheeran, 2005). Threat perception is construed as two key beliefs (a) perceived susceptibility to illness and health problems and, (b) the anticipated severity of the consequences of illnesses. Behavioural evaluation also consists of two sets of beliefs, (a) those concerning the benefits or self efficacy⁶⁰ of a recommended health behaviour and, (b) those concerning the costs of enacting the behaviour. In addition, the model proposes that cues to actions such as individual perceptions or social influence can activate behaviours when appropriate beliefs are held (Abraham & Sheeran, 2005). There is substantial empirical evidence in support of the HBM⁶¹.

According to the HBM, *perceived susceptibility* refers to the individual's likelihood of getting a condition and *perceived severity* refers to how serious the condition is understood to be by the individual⁶². Both of these constructs together constitute the individual's level of *perceived threat*, which in turn has an effect on the individual's likelihood of acting upon a

⁵⁹ Glanz, Rimer & Viswanath, 2008; Conner & Norman, 1996

⁶⁰ The HBM has incorporated new constructs. For example, self-efficacy was incorporated into a revision of the original HBM (Rosenstock *et al.*, 1988) to expand the 1950s model so as to better explain how to change habitually unhealthy behaviours, such as smoking and overeating.

⁶¹ Janz & Becker, 1984; Broz & Karel, 2007

⁶² Academy of Health Care Management Journal, Volume 7, Number 1, 2011

recommended health-related action (Glanz, Rimer & Viswanath, 2008). The HBM also suggests that modifying factors, such as strategies to activate the individual's readiness for taking action, called *cues to action* such as education, symptoms and media information, as well as socio-demographic variables such as age, sex, ethnicity, personality, socio-economics, individual knowledge, have an impact on the individual's level of perceived threat.

In addition, *perceived benefits*, *barriers*, and *self-efficacy* also have an effect on the individual's likelihood of acting upon a recommended health-related action (Glanz, Rimer & Viswanath, 2008). *Perceived benefits* refer to the individual's opinion on the advantages of acting on the recommended health-action, and *perceived barriers* refer to the individual's opinion on the disadvantages of acting on the recommended health-action. Finally, *perceived self-efficacy* was later added to the original HBM model, which refers to the individual's confidence level in his/her ability to take the recommended health-related action.

The strengths in using the HBM are that its variables successfully predict a range of different health behaviours. However, studies have tended to conclude that one or other of the elements of the model has more predictive power than the others. In their review of the HBM, Janz and Becker (1984) observed that support for the model was evident in both the retrospective and prospective designs. They found some support for the role of each of the dimensions of the model in prediction of health behaviours. The HBM has also received some empirical support hence has been influential in this respect. The evidence of the HBM variables, have successfully predicted calcium intake (Wurtel, 1988), breast examination (Hallal, 1982), dietary compliance (Becker *et al*, 1977) as well as a host of other preventive health behaviours, including participation in screening programs and seeking

immunisation. For the purpose of this research, the Health Belief Model (HBM) was used to guide theoretically hypothesis development as opposed to testing the model.

2.4.2 Limitations of theoretical models

Theoretical models are limited in their ability to predict risk behaviour for two main reasons. First, with respect to sexual behaviour, the models are based on the assumption that sexual encounters are regulated by self-formulated plans of action and that individuals are acting in an intentional and volitional manner when engaging in sexual activity which is often impulsive. Secondly, Fishbein et al (1991) argue that the dominant theoretical models of behaviours do not easily accommodate contextual personal and socio-cultural variables such as gender, race, ethnicity, culture and class. For instance, gender roles and cultural values and norms influence the behaviour of women and men and the nature of the relationships in which sexual activity occurs. Also for teenagers, the need to be part of the group might prove more powerful i.e. peer pressure. These elements might not be taken into account by such models.

Unsafe sexual practices often are not the result of a deficit of knowledge, motivation or skill, but instead have meaning within a given personal and socio-cultural context. Klovadahl (1994) argues that the social influence does not begin and end with a partner. The scope and character of one's broader social networks, the array of individuals upon whom one relies for support, who serve as reference groups, and who establish the groups standards of conduct (social norms) and action behaviour, are central to understanding the behaviour that puts one at risk for HIV infection.

The models on the other hand, tend to focus mainly on one level of analysis, the individual, without regard to other levels. Although identifying behavioural changes is an important outcome measure for AIDS preventive interventions, these changes do not automatically translate into reductions in HIV transmission in ways that are immediately obvious. Modifying risk behaviour is key to reducing HIV transmission and behaviour change models alone may not be sufficient for evaluating prevention efforts. The relationship between the knowledge and behavioural change is complex, configured through combination of discourses, interests and actor agencies. Due to the above limitations, some of the variables outside the Health Belief Model were incorporated in this research as will be shown in the next chapter.

CHAPTER 3

METHODOLOGY

The challenge of developing explanations for why things are as they are, of establishing evidence for such explanations by means of methodologies that command the respect of professional bodies, is a serious and worthwhile endeavour. This chapter discusses some methodological matters relevant to this research by giving an account of the study area, the research strategies and theoretical perspective employed in the research as well as constraints. The final sections will discuss the data analysis techniques applied, and the validity and reliability of the data presented as well as ethical considerations.

3.1 Area of Research: The City of Harare

Harare, formerly Salisbury, is the capital city situated in the north-eastern part of Zimbabwe, a landlocked plateau country in southern Africa which takes its name from Great Zimbabwe, a fortified trading hub built in medieval times and used by the majority Shona tribe (about 70 % of today's population). In 1890, the first British settlers arrived; colony status came in 1923 under the name Southern Rhodesia. In 1965 the white minority Government unilaterally declared independence, as Rhodesia. International sanctions and guerrilla warfare against the illegal regime led to legitimately independent Zimbabwe in 1980. Although nominally a multiparty state, in practice the party of President Robert Mugabe dominates the political system⁶³.

⁶³ National Geographic Atlas of the World, 2004.

Zimbabwe has an estimated population of 13 million people with only 1, 6 million residing in Harare. Ethnic groups in Zimbabwe comprise of 98 % Black African (Shona 82%, Ndebele 14%, other 2%), mixed and Asian 1% and white less than 1%. The religions followed are mainly syncretic (part Christian, part indigenous beliefs) 50%, Christian 25%, indigenous beliefs 24%, Muslim and other 1%. English is the official language and there is also Shona, Sindebele (the language of the Ndebele, sometimes called Ndebele) as well as other numerous but minor tribal dialects⁶⁴. Fig 3.1 below shows the geographic location of Harare.



Fig 3.1 Geographical location of Harare

(Source: www.reliefweb.org)

⁶⁴ Zimbabwe Population Census, 2002.

Administratively, Harare is an independent city equivalent to a province⁶⁵. Fig 3.3 shows Harare's location in relation to other provinces in Zimbabwe.

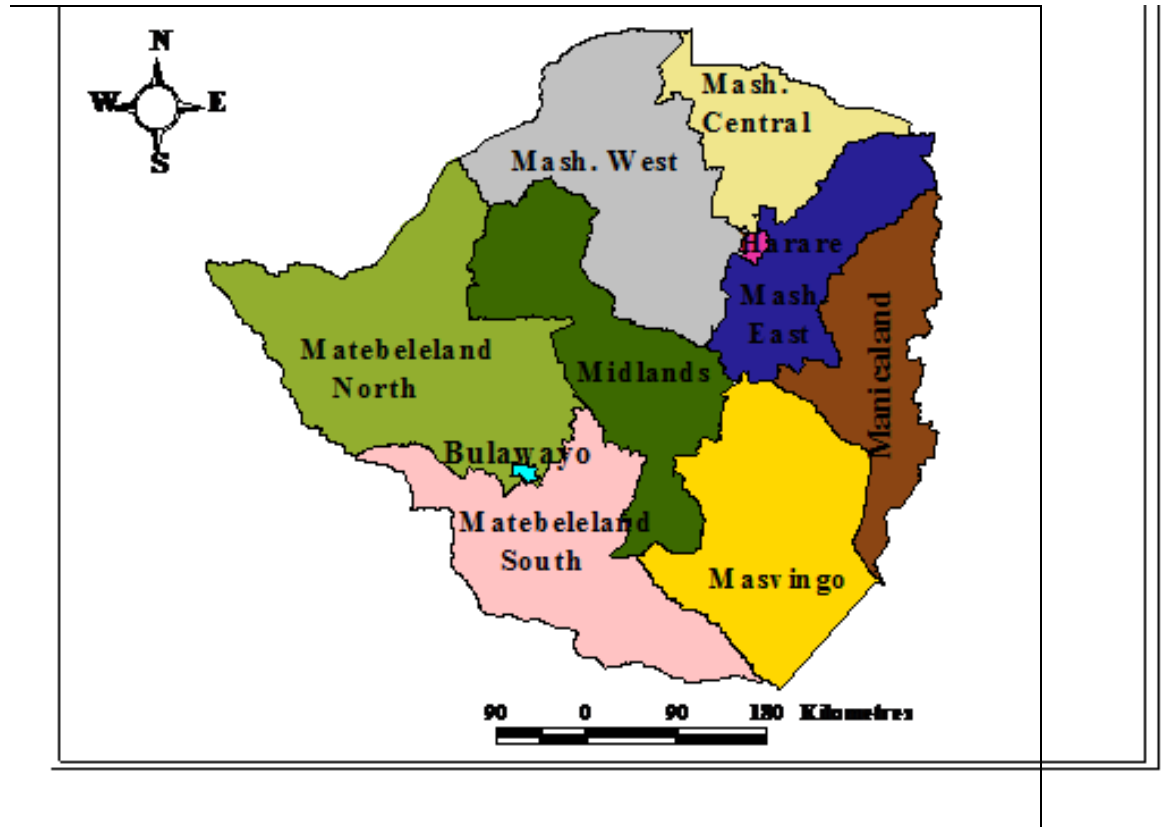


Fig 3.2 Geographical location of Harare

(Source : Surveyor General's Office in Harare)

Harare is Zimbabwe's administrative, commercial, and communications centre. The city is a trade centre for tobacco, maize, cotton, and citrus fruits. Manufactures include textiles, steel, and chemicals, and gold is mined in the area. The city is situated at an elevation of 1483 metres (4865 feet) and its climate falls into the warm temperate category, remaining

⁶⁵ Zimbabwe have two metropolitan provinces. Harare as a province comprises of Harare City, Harare Rural, Epworth Town and Chitungwiza. Bulawayo is the other metropolitan province of Zimbabwe.

cooler than most parts of Africa hence known as one of the most ideal climates in the world. It is also one of the most developed infrastructures in sub-Saharan Africa.

3.2 – Research Design

It is important to point out that the study endured challenges for research in crisis situations. This chapter argues that the use of typical quantitative and qualitative research tools such as participatory observation, household interviews as well as in-depth interviews in a crisis state raises important questions on methodological approaches of social scientists. Several factors contributed to the explicit challenge of conducting this research in Zimbabwe, like sporadic strikes, dangerous police and armed forces, high crime rate, limiting places and times for conducting research, rendering group discussions difficult; general distrust in strangers, resulting in the need for great efforts and time to gain trust. Increased vulnerability was experienced due to the politically unstable and insecure geographical areas where the research was to be conducted. It became essential to be skilled in negotiating political access, acceptance and practice in the country.

Research that involves measuring sexual behaviours, typically relies on self-reports from respondents hence the use of valid and reliable measurement tools to accurately capture these behaviours and reduce measurement errors was extremely important during the study. The researcher provides useful insights onto methodological innovation that was required to conduct the research. In a politically insecure environment such as the one in Zimbabwe at the same time of the study, there was need to triangulate various traditional methodological approaches and to be continuously adaptive and be aligned with political and economic events in Harare that shaped what the researcher could and could not do.

A combination of various research methods were applied in order to get a better understanding of the subject matter as shown in Fig 3.3below.

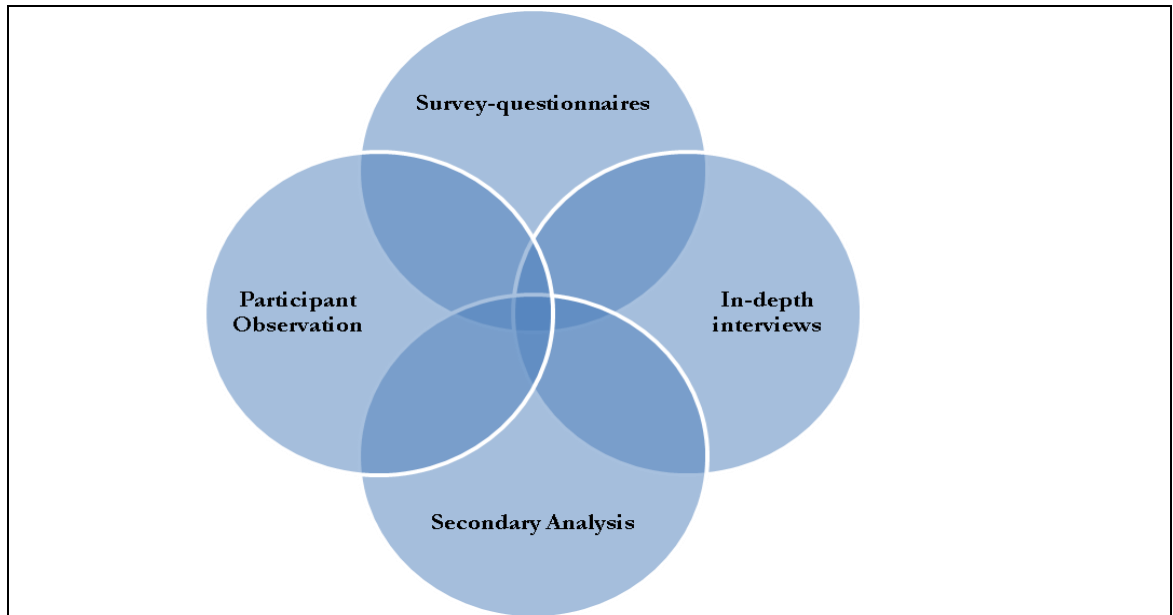


Fig 3.3 Methodological Triangulation

(Source: Survey Data)

It is now a common place among social scientists writing on research methods to state that there exist no one best method of research hence the use of triangulation (Burgess, 1984). Two types of triangulation were adopted by combining both quantitative and qualitative method to strengthen the validity of inquiry results, *Data Triangulation* where the researcher used a variety of data sources in the study and *Methodological Triangulation*⁶⁶, where the researcher applied multiple methods to study a single problem. The goal of multiple triangulations is a fully grounded interpretive research approach and that in-depth understanding not validity is the reason for mixed methods. However, the researcher had

⁶⁶ Denzin, 1989.

to bear in mind that too much variance and triangulation may create interpretational problems.

3.3 Regulatory Framework Under Which the Research Was Taken

The accomplishment of this thesis also shows that it is an over concentration on risks that can in effect prevent any research being done, which denies society the good effects which could stem from it, hence a balance needed to be achieved. A number of key methodological questions had to be resolved early in the development of the research due to the risks that were involved in travelling to Zimbabwe at the height of the country's economic and political meltdown.

Of significant importance was the Public Order and Security Act Bill (POSA), which was passed on Thursday the 10th of January in 2002, by the parliament which contains some clauses of the act which stifle freedom of expression and speech. Examples include, *Clause 15*, which makes it a criminal offence to publicise or communicate 'false' statements prejudicial to the state. Under this clause, a person may be fined or imprisoned for up to five years for publishing a false statement likely to promote, public disorder or undermining public confidence in the police or armed forces or prison officers. *Clause 16* makes it an offence to make a public statement with the intention to, or knowing there is a risk of 'undermining the authority of or insulting the president' (MISA, 2002; 18). This includes statements likely to engender feelings of hostility towards the president, cause hatred, contempt of the president or any abusive indecent, obscene or false statements about him personally or his office. *Clause 23-31* regulates the organisation and conduct of public meetings. Under this clause, a senior police officer will be the regulating authority

and has power to disperse people, ban a meeting and use reasonable force if necessary to achieve his or her goals. This meant that the researcher had to get a clearance from the police to hold any meetings or research activities involving three or more persons.

It is greatly acknowledged that speaking your mind really can lead to serious consequences in Zimbabwe as the Central Intelligence Organisation (CIO) has paid informants on every corner, whether at the universities, police roadblocks, community area or restaurants or any other public places. Basically what it meant is that the researcher could not make random comments about everything observed especially in public places. There was also the risk of running out of time before the research was complete hence the researcher took every precaution to avoid this happening. This was exacerbated by the fact the political environment in Harare was extremely tense and one could not predict the violence that could take place at any given time from general strikes and riots which posed the risk of curfews being imposed on residents.

In field investigations, a researcher can encounter illness, personal injury or road accidents hence safety precautions that the researcher had to take not only amounted to little more than good common sense, but also with the total collapse and malfunctioning of the health delivery services in Zimbabwe, the researcher would have been at a larger risk of not even receiving the treatment that would have been required. The researcher never entered the field without telling someone my whereabouts and also tried to be aware of the environment, such as knowing my location and where help could be obtained such as police stations and use of public telephones, ensured had a mobile phone at all times, despite the fact that the first phone was stolen in the second week of the whilst queuing to buy a loaf of bread.

As a result, after having consulted a number of lecturers and researchers in Zimbabwe, I can confirm that it was relatively safe and possible to carry out the research. Two general strikes occurred during my visit but they were confined to particular areas and did not last for long periods of time as the police quickly dispersed the strikers with teargas. I only had to take precautionary measures such as having a letter from the university and the police that my research was entirely for academic purposes.

3.4 The Insider- Outsider approach

HIV and AIDS research has been extremely cautious and conservative but there is need to radicalise this way of thinking and break free from such constraints and be creative. My gender, being female interviewing male respondents was also a challenge as this is not a cultural norm to be openly discussing issues of sexuality in public. As I was asking about their sexual issues and behaviour, some respondents were asking me to marry them during the interview whilst others were not very comfortable in disclosing their behaviour to a female interviewer. Fortunately, despite the more intrusive nature of my research, no one refused to answer.

3.5 Ethical Considerations

It is a general principle that the right to knowledge must be balanced by the right to personal and community integrity and privacy. This places limits on where, when and how the research could be carried out. As in all research that involves human subjects, the

researcher was attentive to the ethical manner in which the research was to be carried out; hence the question of ethics was central to my research. As the researcher did not have conditional funding for my fieldwork, thus did not have an organisation that imposed any restrictions on the way the research was to be conducted. The researcher therefore followed Floyd's basic guideline in this book '*Survey Research Methods*' (2002) that the researcher should make sure that no individual suffers any adverse consequences as a result of the survey. The researcher was more attentive to maximising positive outcomes. As it is unethical to conduct or collect information without the subjects' knowledge, their informed willingness and expressed consent, it was fundamental that the consent was voluntary and without pressure of any kind. This implies that participants were aware of the aims and purpose of the research, the anticipated consequences of the research, and the possible harms and benefits that the research could result in.

Some people are generally uncomfortable answering questions about their private conduct and regard such researches an invasion of privacy. In this study, questions of HIV and AIDS and sexual behaviour are intrusive in nature, hence to be able to ask such questions, The researcher strategically informed potential respondents at the beginning that the type of information to ask was clearly and frankly private, therefore giving them sufficient time to decide if they wanted to participate or not. Prior to consenting, individuals were given an opportunity to ask questions about their possible participation.

Sharing information about a respondent with others for purposes other than the research is unethical. The researcher therefore made sure that the information provided was kept anonymous by only identifying respondents numerically and ensured the highest degree of care over maintaining the confidentiality and anonymity of participants to my research

assistants. Being aware of bias, a practice which is unethical⁶⁷. It is also unethical to use a method or procedure known to be inappropriate such as selecting a highly biased sample as well as to report the findings in a way that changes or slants them to serve my own interest hence ensured this never occurred.

Other ethical issues that needed to be considered and that arose from conducting research such as harm to participants were of paramount importance. This can entail a number of facets, such as physical harm to participant's development, loss of self- esteem and stress. The researcher guarded against any possibilities of harmful causes, including emotional discomforts that could result from interviewing people who are both infected and affected by the HIV and AIDS epidemic.

Merely by conducting research to the public raises hopes and expectations, particularly for the less advantaged populations who may hope for some improvements in their situation or those with no particular problems may hope to see findings, a report disseminated via the media. The researcher therefore never promised anything that could not be delivered just to get co-operation. It was her responsibility to avoid methods of enquiry that are likely to infringe human values and sensibilities and considered the relevance and usefulness of the research undertaken as it is unethical to fail to justify the relevance of the research and wasting respondent's time. Since values are a form of pre-conception, the researcher attempted to suppress them and be value free.

⁶⁷ It is a deliberate attempt to either hide what I would have found in my study or highlight something disproportionately to its true existence.

It was extremely challenging at some point as I found myself developing an affection or sympathy for the participants, such as towards PLWHA and AIDS victims. I found it difficult to disentangle my stance as a social scientist from my subject's perspective. On the second day of conducting random sampling interviews, I interviewed the general public outside Harare's main Government hospital, Parirenyatwa Hospital. We interviewed respondents who spent the day sitting outside the hospital grounds between visiting hours as they did not afford to travel to their homes between the visiting hours. As I sat down with them, their encounters brought me to tears. At some point, I visited the HIV and AIDS ward in the hospital, and had a complete breakdown. I therefore needed to recognise and acknowledge that research cannot be value free but have to ensure that there is no incursion of values in the research process and to be self-reflective.

3.6 Fieldwork Logistics

Time, cost and security considerations were very relevant in this study and they influenced the different approaches applied. On my arrival, in Harare, the researcher took up residence at my parents' home in Eastlea. It is a very large and spacious 5 bed roomed house which enables me to set up an office and used this space as a training ground for the research assistants. The researcher was fortunate in that the location was very ideal and strategic as it is very close to the city centre, approximately a 15 minutes' walk, and an hour's walk to the University of Zimbabwe. With the shortage of fuel and the malfunction of public transport in Harare, this became our central meeting point as we resorted to walking most of the times.

The researcher reported to the University of Zimbabwe and registered myself as a student for the duration of my research under the full supervision of Professor Mhloyi who is a senior HIV and AIDS researcher in the Department of Population Studies. She then visited the Research Council of Zimbabwe (RCZ), which is a statutory body responsible for promoting research in all fields. *Section 26* of the Research Act provides for the coordination of research by foreigners where any person wishing to conduct research in Zimbabwe on behalf of a foreign institution, foreign organisation or other foreign person should apply for a research permit, a non-refundable fee of US\$500. Being Zimbabwean, the researcher was fortunately informed that I would not be required to have a research permit but could register myself with them and inform them of my research and its duration. The researcher also registered myself with the police at the Police General Headquarters (PGHQ) and informed them of my research. This was not a requirement, but a safety measure against the imposed POSA Act discussed earlier. This included informing them of no other intentions on researching on other issues other than for my degree.

Research assistants were also crucial to the success of the project as the planned sample size was large as well as a security measure by having safety in numbers. University of Zimbabwe students and graduates with appropriate skills and personalities were recruited. They were asked to submit *Curriculum Vitae* (C.Vs) as assistants with the ability to conduct interviews in such sensitive issues and someone who could relate easily with respondents and complete questionnaires accurately were required. Four assistants were hired, one female and three males largely for safety reasons. As a quality control measure and to avoid

research fraud⁶⁸ and ensured the team worked together at the same place every time under my direct supervision.

The researcher compiled research training packs which consisted of the general introduction of the research, guidelines on the study design, including a map of the sampling framework and the model questionnaire, interview manuals as well as the contracts they had to sign. Held a two day training sessions to review the questionnaire, practise interviewing skills, filling the questionnaires and how to motivate and establish rapport with the respondents. We also trained on how to build confidence into the interview process and how to gain the informed consent of the respondents as well as learning the nature of the study, what would be expected in the interview and what would happen to the information afterward.

Although Zimbabwe's official language is English, the training also included translating the questionnaire into the local language because most of the respondents are Shona. This procedure greatly increases the accuracy of the data collected as there is a high risk of interviewer errors when the interviewer has to translate each question during the interview without receiving any training before hand. Scott et al (1988) notes that the interviewer's error rate were two to four times higher when they translated questions during the interview than when they used questionnaires already written in the local languages. The translation had to be carefully checked using '*Back Translation*', that is, after the questionnaire is translated from the language in which it was developed into a language in

⁶⁸ This is when research assistants fill in the questionnaires alone, without a respondent present and in the absence of supervision, thereby pretending they actually conducted the interviews, when in actual fact they did not.

which it will be administered , someone then translates the versions in those languages back into the original language. The helped to solve any discrepancies in wording or meaning between the two versions.

3.7 Sampling Framework

3.7.1 – Sample study area

Sampling is the selection of a part to represent the whole. It takes place in selection of research topic, research site, the people to be studied, concepts and variables which are used, the data collected, methods employed and the relationships in which the analysis is followed⁶⁹. The decision to conduct the research in Harare alone was largely determined on the degree of researchers safety and financial constraints as most politically related violence was occurring in remote areas outside the city.

Harare was also selected for various other reasons. It is a dynamic city and currently presents significant disparities between the rich and the poor due to the economic crisis making it an ideal sample. I had full supervision from the University of Zimbabwe, where I was allocated office space and had to report to the office constantly hence kept the travelling to an absolute minimal due to financial constraints and fuel shortages.

Fig 3.4 shows the areas in which the research was conducted. This map was tailor made only for the purpose of this research at the Surveyor General Office in Harare.

⁶⁹ Peil et al, 1982

service settlements like Kuwadzana and Budiro. The high-density suburbs have small plots, crammed together, with little space for gardens and trees. Houses are typically simple four-room buildings, but there is variation of size and type. Lodgers may rent a single room, or a rough wooden shack outside the main house, or perhaps even half a room. In the more densely populated areas there are around thirty persons living on each plot, with only one official dwelling unit and normally only one toilet.

The research used the above map for the study area by identifying:-

- Boundaries of residential areas
- Upper and Lower income residential areas
- Major target groups in the area.
- Commercial activities, particularly those related to HIV transmission, including major sources of employment, nightclubs, bars and other liquor outlets
- Nightlife (bars/hotel/nightclub) areas
- Health, education, religion, social and NGO services in an area
- Security and crime in an area
- Major highways and public transportation arteries as sexual risk behaviour is often more common along such routes

As the random sampling method was adopted to administer questionnaires, all the above criteria helped in the selection of the sample. Boundaries of residential areas helped in identifying the high and low income earners and their perception on HIV prevention. Commercial, health, education, religion and major highways enabled the identification of different categories of the work force including commercial sex workers who are most at

risk populations in the contraction of the virus. The research was conducted in the following areas:-

- High Density Areas (Mabvuku, Kuwadzana and Epworth⁷⁰)
- Low Density (Mount Pleasant, Avondale, Borrowdale)
- Central Business District CBD including bus stations, departmental stores and shoppers.
- Parirenyatwa Hospital
- The University of Zimbabwe

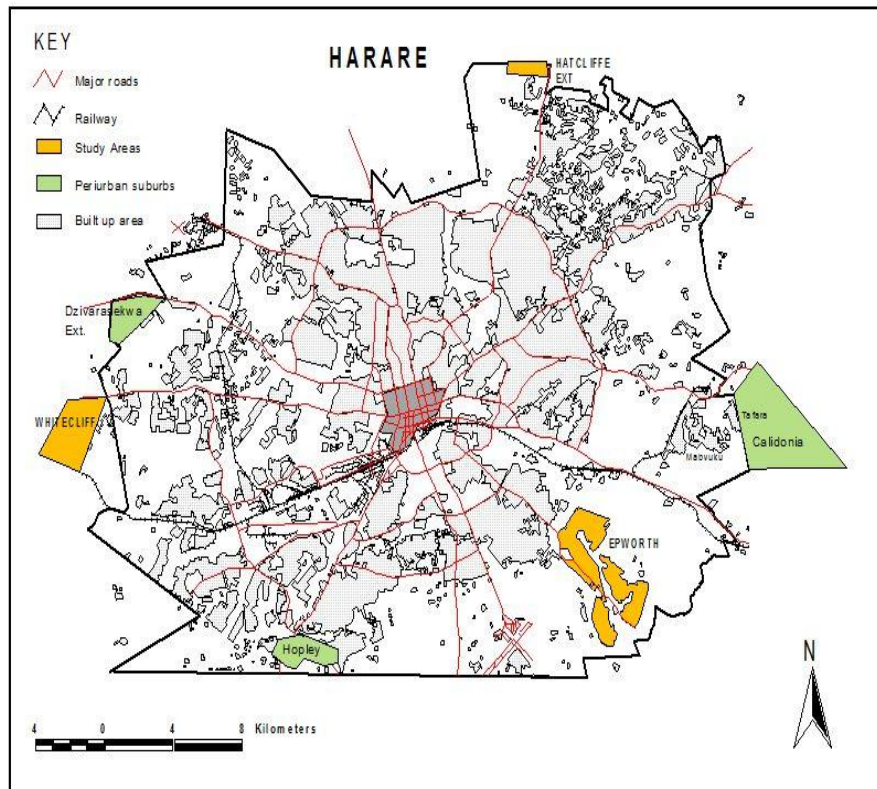


Fig 3.5 Peri–urban Areas of Harare

⁷⁰ Fig 3.5 Above shows the location of peri –urban areas such as Epworth which is one of the areas the research was conducted.

3.7.2 – Sample Population

The challenge in sampling is the difficulty in making it representative in sexual behavioural change studies, as the determinants of the epidemiology of HIV vary across time and space in Zimbabwe, and as the exact factors relating to each audience of transmission are unique. Mapping of risk behaviour by population groups is essential for the effective targeting of prevention efforts hence population sampling was aimed at obtaining unbiased and representative samples. However, the problem with sampling is the difficulty of making it representative hence I took the following approach:-

- I visited the Central Statistic Office⁷¹ in Harare for information on the Enumeration Zones in the city, the population, demographic status and the gender ratios between men and women by using the 2002 Census Report, which was the latest at the time the research was conducted as the census only takes place every 10 years.
- The City Council of Harare was also approached for information regarding the traditional land use patterns. This was fundamental in mapping out the residential areas considered as affluent and those considered poor.

In general principle, it is best to have as large a sample as possible to increase the possibilities of analysis, increase representation of the population and decrease the sampling error. As a precaution however, I did not collect more than I could handle, hence used a realistic figure of 364 questionnaires derived from using the following equations,

⁷¹ Now named Zimbabwe Statistical Agency (ZIMSTAT)

Determination of the number of Questionnaires administered

A formula of sample size determination was used to determine the number of questionnaires to establish using an attribute of **P** as the target population of 15 -49 year olds as a percentage of the Harare Population;

$$N = \frac{z^2 pq}{d^2}$$

Where : -

N = sample size desired

Z = standard normal deviation⁷² set @ 1.96.

(corresponds to 95% confidence interval)

P = proportion target population with desired characteristics/ attribute

(15 – 49 age groups)

Q = 1-p (a compliment of p, that is p + q = 1)

D = degree of accuracy required,

(set at 0.05)

Therefore, our **P** = sexually active age group of 15 -49 years olds

According to the 2002 Central Statistics Office (CSO) data in Harare, the total sum of this age group is 880 378. Therefore, the proportion of the population of this age groups from the total population of 1 435 784 in Harare is:-

$$= \frac{1\,435\,784}{880\,378}$$

⁷² The standard deviation measures the spread of the data about the mean value. That is, it measures the variability of the data or how spread my data is.

$$= 61.31688$$

$$= 61.3\%$$

$$= \frac{61.3}{100} \quad \text{for use as a proportion of the population}$$

$$= \mathbf{P} = 0.613\%$$

Where : -

$$\mathbf{z} = 1.96$$

$$\mathbf{p} = 0.613$$

$$\mathbf{q} = (1.0 - 0.613) = 0.387$$

$$\mathbf{d} = 0.05$$

$$\mathbf{N} = \frac{\mathbf{z}^2 \mathbf{pq}}{\mathbf{d}^2}$$

$$= \frac{(1.96^2) \times (0.613 \times 0.387)}{0.05^2}$$

$$= \frac{3.8416 \times 0.237231}{0.0025}$$

$$= \frac{0.9113466096}{0.0025}$$

$$= 364.53864384$$

$$= \mathbf{364 \text{ Questionnaires}} \text{ administered}$$

Determination of the number of Male and Female correspondents – Sex Ratio

The total number of 15-49 year old in Harare at the time of the study was 880 378

With: - 442 987 Males

437 391 Females

The %age of males of the total population -

$$\frac{442\ 987}{880\ 378} = 0.503178 \times 100 = 50.3\%$$

The %age of females of the total population -

$$\frac{437\ 391}{880\ 378} = 0.496822 \times 100 = 49.7\%$$

Stratification of the sample

The number of questionnaires administered as per sex ratio –

$$364 \times 0.503178 = 183.398 \text{ male respondents}$$

$$364 \times 0.496822 = 181.0816 \text{ female respondents}$$

Therefore 183 (male) + 181 (female) = **364 questionnaires**

The respondents were selected through purposive⁷³ random sampling⁷⁴ which is the selection of characteristics rather than individuals mainly for security reasons as the research was much safer to conduct in open public spaces as opposed to the systematic or stratified sampling in households. Another reason of using random sampling is that at the time the survey was conducted, Harare was experiencing severe food shortages where numerous long queues in for different commodities including food and fuel could be observed. This enabled us to effectively select participants who were very much interested in the research as this took off the frustration of queuing for several hours. The

⁷³ Respondents were selected through simple purposive sampling for reasons of security and convenience.

⁷⁴ A simple random sample is selected so that all samples have an equal chance of being selected from the entire population.

advantage of this method is that each individual in a given population has an equal chance of being selected.

3.7.3 Background characteristics of the respondents.

Table 3.1, Tables 3.2, Fig 3.6 and Fig 3.7 show the socio-demographic characteristics of the sample population interviewed using questionnaires in Harare. Please note, there was one incomplete questionnaire after the research, hence the total number of questionnaires analysed is **363**.

Table 3.1 Gender

Variable	Frequency	Percentage
Male	183	50.4
Female	180	49.6
Total	363	100.0

(Source: Survey Data)

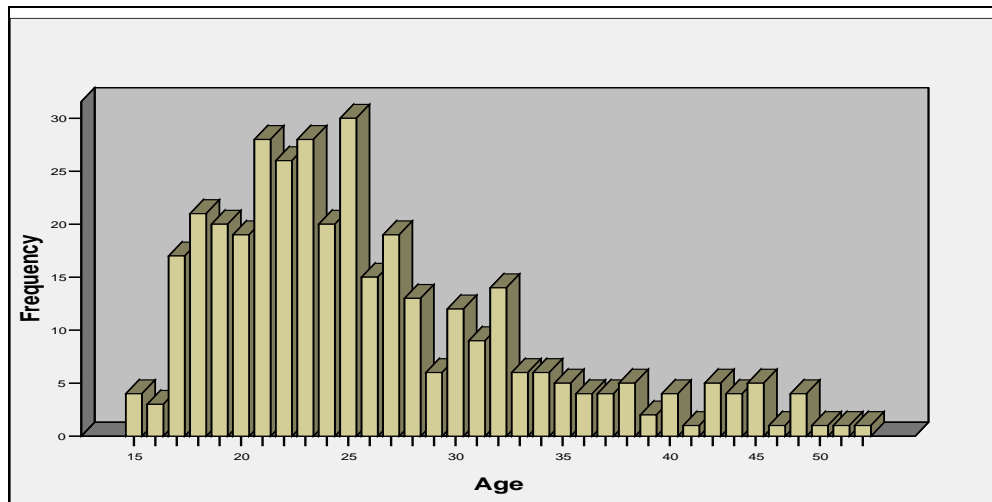


Fig 3.6 Age distribution of the total sample population

(Source: Survey Data)

As Zimbabwe shows a classic age distribution of AIDS cases in which most cases are found among sexually active people, the study used the random sampling of 15 to 49 year

old age group which is the sexually active group with higher HIV prevalence rates. More than 70% of AIDS cases are among adults between the ages of 20 and 49. They are the economically productive part of the population hence deaths constitute an important economic burden. The smallest number of AIDS cases is in the 5 to 14 year old age groups emphasising the fact that the main mode of transmission is through sexual contact or perinatal transmission.

Table 3.2 Marital Status of the sample population

Variable	Frequency	%age
Married	141	38.8
Never Married	194	53.4
Divorced	9	2.5
Separated	12	3.3
Widowed	7	1.9
Total	363	100

(Source: Survey Data)

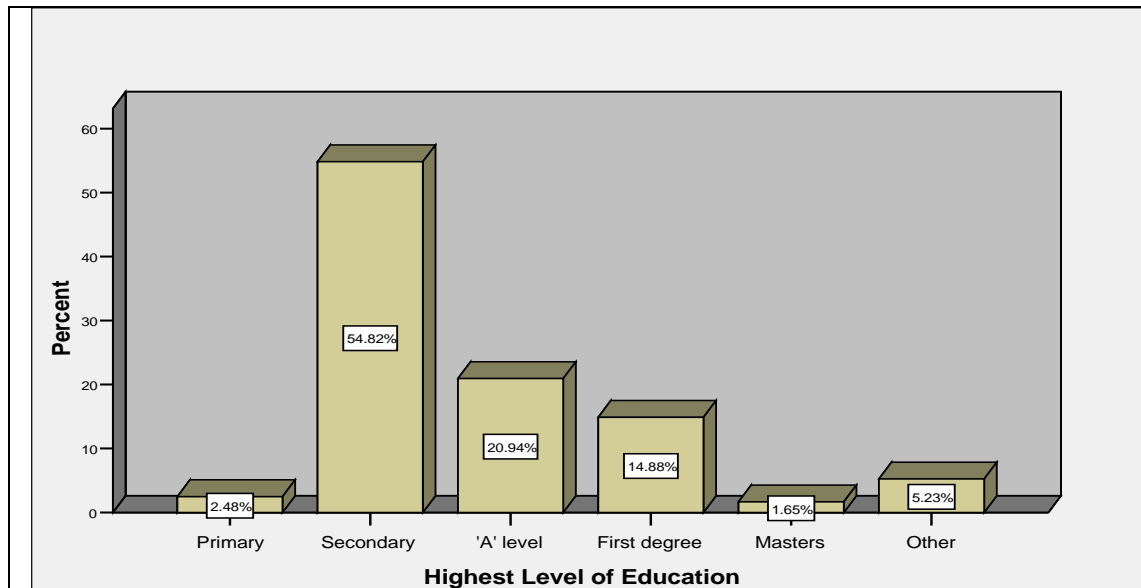


Fig 3.7 Highest level of Education

(Source: Survey Data)

Education is an important factor in influencing an individual's attitude and outlook on various aspects of life, hence the educational level of respondents was among the most important variable in this research because it is associated with many factors that have a significant impact on health seeking behaviour, reproductive behaviour, use of contraception, and the health of children. Overall, the majority of Zimbabweans have attained some education, and there is very little difference by sex in educational attainment. Literacy is widely acknowledged as benefiting both individuals and society. It is also associated with a number of positive health outcomes.

3.8 Research Methods Applied

The study applied research triangulation by using both qualitative and quantitative methods. This multi-method approach to real life questions is important as one approach is rarely adequate, and if results of different methods converge, then we can have greater confidence in the findings. Research was largely conducted by using non randomised interventions to complete questionnaires and planned interview schedules as research tools for collecting data. One important determinant of the quality of data is the way the purpose of the study is explained to potential respondents, hence had to make sure they clearly understood the purpose and relevance of the study. This was because some respondents, did not feel either at ease with a particular method of data collection such as being interviewed and felt comfortable to express opinions in a questionnaire.

3.8.1 – Quantitative Methods Applied

Quantitative techniques according to Scheyvens et al (2003) can be a powerful aid to development studies research for they give precise and accurate results that can allow us to gain a picture of broad patterns and phenomena, and they can provide us with evidence to inform policy formulation. They have particular utility when firm answers are required. Quantitative assessment methods require subjects to use a clearly defined scale. Experimental psychological research on risk has found that subjects experience relatively little difficulty in using clearly defined quantitative scales (Pryor et al, 1993). The particular strength in this approach is that it can be verified and replicated.

The application of quantitative research tools as measurement procedures is especially helpful in HIV and AIDS researches, where individuals perceive their personal risk as very small. However, they are not without their shortcomings. They are subject to context biases. Caution therefore had to be taken as the measurement process possesses an artificial and spurious sense of precision and accuracy and the reliance on instruments and procedures hinders the connection between the research and everyday life. This creates a static view of social life that is independent of people's lives as it omits the process of interpretation or definition that goes on in human groups.

Appendix 1 shows the questionnaire that was developed for quantitative data collection comprising of pre-determined set of questions, with the same wording and order of questions for each respondent. This is the most common means of collecting quantitative data and it enables collection of uniform information, which assures the comparability of data as well as minimising differences between interviews. The questions are very specific,

offering a fixed range of answers, which are also known as closed, closed ended, pre-coded or fixed.

With the realisation that a good questionnaire formatting can make a tremendous difference in the quality of the data, a significant amount of time was invested in its construction to minimize potential interviewer and data entry errors. This improves the accuracy of the data and reduces the time needed to check the data before making them available to data analysis.

The starting point was a compilation of research questions hence the overall objective of the questionnaire was to collect the data needed to answer these questions. The questionnaire was composed of sections that collect information on a specific topic. All the potential responses to almost all the questions in the questionnaire were pre-coded and given code numbers so that interviewers recorded only code numbers as opposed to words or phrases.

One weakness of such a research method is that it seeks to get answers just by asking questions. The researcher determines the questions that are asked, and the range of answers that are given. This as Gillham (2000) argues, makes it very tidy and easy for a researcher to analyse, and if all the questions and all possible answers are determined in advance, the element of discovery is much reduced. We do not know what lies behind the responses selected, or more importantly, answers the respondents might have given had they been free to respond as they wish. However, this method is easy to get information from a lot of people in a short space of time.

A nine paged questionnaire was then developed mainly using the 6 components of the Health Belief Model namely:-

1. Perceived severity (Beliefs concerning the consequences of an illness).
2. Perceptions of vulnerability to HIV and AIDS or their beliefs concerning the likelihood that one will contract the illness.
3. Perceived effectiveness of the proposed preventive behaviour.
4. Anticipated costs of the barriers to performing the behaviour.
5. Environmental cues, such as exposure to media campaigns.
6. Measure of health motivation. Factors that can motivate them to behavioural change.

However, additional measures as age at marriage, age at first sexual experience, knowledge of prevention methods, career opportunities, occupations, income levels as well as poverty levels were also explored. This is because a common criticism of the Health Belief Model is that additional variables should be considered as the model tends to focus only on one level of analysis, the individual, without regard for other levels such as culture and community to which an individual belongs. Other variables that were adopted include personal experiences to HIV and AIDS and access to health services resulting in 11 sections namely;

Section 1, examined the socio-economic and demographic characteristics, specifically looking at background characteristics where the questionnaire started with standard and relatively innocuous questions about background of respondents. One purpose of this order was to establish rapport before more sensitive issues were introduced. Details about the respondent included such characteristics as sex of the respondent, education, marital

status and age groups. Other variables were measured because of their possible influence on the association with behaviour, these included variables such as religion and incomes. Generally, education and professions are both determinants and key indicators of living standards, however, findings in succeeding chapters will highlight a different case in Harare. Due to the dynamic changes in the value of the Zimbabwean currency as a result of uncontrollable levels of inflation, the questionnaire had to be administered in a short space of time to get the same income bands for the purpose of validity of the data. If the same respondent was to be interviewed again after a few weeks, the income levels would significantly differ.

Section 2, was on the sexual matters and history highlighting the need to define behavioural criterion, that is, specifying the action component of the behaviour as well as the time-frame. For example, condom use (action), on the person's previous or next sexual encounter (time). I also had to define and specify the behaviour further by specifying the type of partner (Regular, casual, new partner). Section 3 measures the knowledge of HIV and AIDS and Prevention Strategies where questions dealt with respondents' knowledge of various aspects of HIV infection and AIDS. The questions were designed to identify specific areas of misinformation that needed to be considered in policy formulation of health promotion campaigns. Sections 4 to Section 8 measure the components of the Health Belief Models in attempting analyse the extent to which respondents regarded AIDS as an issue which directly affects themselves and others. This was followed by Section 9 measuring environmental cues and access to preventive information where I examined the respondents' exposure to mass media because of its potential role in determining knowledge, attitudes and beliefs. In Zimbabwe, mass media initiatives are one

of the key components of HIV and AIDS control and prevention. Specific items of information were included such as frequency of newspaper readership, radio listening and television viewing. Section 10 measured health motivations and lastly, Section 11 which assessed personal experiences and opinions about HIV and AIDS.

From the realisation that the pilot project is one of the most critical steps of the survey design process, a pilot research was conducted in five days to ensure that the questionnaires are capable of collecting the information that they are intended to collect. The field test or pilot study is particularly important because it is the last check on the design on the questionnaires before the survey is implemented. Fortunately, the pilot study pointed to a greater than anticipated willingness on the part of the respondents to discuss and provide information on their personal behaviour. It also enabled the identification of main logistical, equipment and financial needs of the research.

3.8.1.1. The Pilot Study

The pilot study addressed the adequacy of the draft questionnaire at three levels.

1. The questionnaire as a whole, that is, the full range of required information collected. The consistence of the information collected in different sections and the ability to code variables.
2. Individual Sections where each section was tested to ascertain if it collected the intended information, if all major themes have been accounted for and the relevance of questions.
3. Individual Questions where I examined if the wording on each question was clear or if there were any questions allowing for an ambiguous responses.

It also tested for multiple interpretations and if all responses anticipated were coded.

3.8.2 – Qualitative Methods Applied

Quantitative surveys could not possibly go into the type of detail required on all aspects and that complimentary qualitative methods would be necessary to explain and provide in-depth insights into the differences in individual behaviours and help explain any group differences that might emerge. Qualitative methods served the needs of this study favourably as they are neither ‘unified nor well defined’ (Mays and Pope, 1999), involving an interpretive, and interdisciplinary approach to the subject matter. How one investigates a concept like behavioural issues and how we investigate the meanings with which behavioural issues are invested were fundamental questions in this study. The best way to investigate these meanings was to understand the way they are spoken about, hence the concept of discourse became important⁷⁵. A discourse consists not of one but several statements working together to form a discursive formation. Data collection in qualitative research involves a variety of techniques, in-depth interviewing, document analysis and unstructured observations which are all often referred to by a single term, participant observations. Collecting such discourses was done through participant observation and in-depth semi- structured interviews.

Observation is one of the most crucial tools for a researcher, whether they result in the generation of hard data or merely impressions and surprises which help the way we shape and interpret our research (Scheyvens et al, 2003). Observations might also involve measurements and analysis of human behaviour and this may require more subjective

⁷⁵ Hall (1992:2) elaborates that a discourse is a group of statements that provides a way of talking about, or representing, a particular kind of knowledge about a topic.

assessments of what is actually happening and being measured, hence the need for qualitative methods such as participatory observation. This research also involved participatory observation to some extent, but was limited by limited funding and security issues as the researcher at times went to places well known to be entertainment areas where one could find the most at risk populations such as commercial sex workers. the researcher also drove at night in some part of Harare and witnessed commercial sex workers standing by the road sides in search of male clients. This enabled me to supplement information from responses with those gained from observation of non-verbal reactions, which is a purposeful systematic and selective way of watching and listening to an interaction or phenomenon as it takes place. Observation provides information on effects of situations; it is flexible, rich data on a range of hard-to-measure topics and generates insight and new hypothesis. However, there are constraints on access such as timing, secrecy, sample problems and can be costly.

Face to face interviews are the most appropriate approach for studying complex and sensitive issues, the opportunity to prepare a respondent before asking sensitive questions. Before interviews, the researcher engaged in networking with potential respondents and their organisations where applicable in order to win their confidence. This interaction enabled me to obtain a further list of potential interviewees from recommendations. Those who gave their consent were interviewed at their workplaces. Access to HIV and AIDS organizations in the city was not a problem as contacts and appointments were made before hand. The interviews were tape recorded with the respondent's permission as attempting to make notes during the interview can be very distracting. The interview length was kept down to 30 minutes.

However, problems encountered during the interview process was that access to Government documents was refused by some key informants who gave a reason that it was for political reasons and for national security that they had to hold the information from the public. Other key contacts within an organisation had also left the country unannounced due to high rates of skilled workers emigrating out of Zimbabwe for better jobs as economic refugees. Their posts remained unfilled which resulted in a severe brain drain in most institutions in the country and had an effect on the response rates of this study.

In this research proposal, the researcher had proposed to use Focus Group Discussions (FGDs) and apply some participatory research methods. This is especially important in sexual behavioural research where sensitive issues such as condom use can often be better explored in a more congenial environment of a focus group than by answering a questionnaire. These sessions provide more qualitative information on behavioural issues and the relevance of the messages to a particular group. The groups aimed for were pre-existing groups of people, with a range of demographic characteristics. To access some of the target populations, the researcher approached civil society organizations and non-Governmental organisations such as the Zimbabwe AIDS Network (ZAN) and the Zimbabwe National Network of People Living with HIV and AIDS (ZNNP+). The researcher had to win the confidence of the people for them to confide in me, and could do this by direct involvement in the programs being carried out. The researcher also visited senior high schools and hospitals, churches and other Government institutions where various groups including school teachers, nurses, and the police, youth clubs and church groups were identified.

In attempting to get clearance to conduct the FGDs at a local police station in Harare, the researcher was strongly advised against adopting this research approach in such a politically sensitive environment where the rule of law, democracy and freedom of expression were not recognised by the Government. Reference was particularly made to the previously Public Order and Security Act Bill (POSA) where *Clause 23-31* regulates the organisation and conduct of public meeting gatherings. Under this law, a senior police officer has to be the regulating authority and has power to disperse people, ban a meeting and use reasonable force if necessary to achieve his or her goals. This meant that the researcher had to get a clearance from the police for my research to hold any meeting or research activities involving three or more persons and there was no guarantee that the discussions would be approved or allowed to be carried out to completion hence decided not to conduct the discussions.

There were times when the researcher needed to be flexible hence used unstructured interviews whereby the interviewer typically has a list of topics or issues often called an interview guide or *memoir*. The questioning was informal and phrasing and sequencing of questions varied from interview to interview. Shortfalls of qualitative research methods included the challenges in judging the absolute accuracy of responses in attempting to measure risk perceptions. This resulted in the answers to be ambiguous, requiring an act of interpretation by respondents.

3.8.3 – Secondary Data Collection

The study also involved the collection of secondary data and official statistics which is the use of documents, reports, files with unobtrusive measurements. As a student, I did not

have the financial resources to conduct very extensive research hence utilised existing data compiled by various NGOs and Government departments. Analysing the existing data was an advantage as it offered the prospect of having access to good quality data for a tiny fraction of the resources involved in carrying out a data collection exercise itself. Most information was of high quality and the sampling procedure would have been rigorous resulting in samples that are as close to being representative as one is likely to achieve as they are often done by highly experienced and skilled research specialists, mainly those working in the Monitoring and Evaluation teams.

Secondary data collection was mainly carried from the same organisations where in-depth interviews were conducted and were as follows:-

- The National AIDS Council where I interviewed the Chief Medical Officer and the Head of the National AIDS Council.
- The Ministry of Health and Child Welfare
- Parirenyatwa Hospitals which is the largest medical centre in Zimbabwe, where I interviewed health personnel including doctors, nurses and nurse aids.
- Religious organisations where I interviewed HIV and AIDS Projects Coordinators and Bishops of the Methodist Church in Zimbabwe.
- Civil Society Organisations such as the Zimbabwe AIDS Network and the Zimbabwe National Network of People Living with HIV and AIDS
- International and Regional NGOs including Population Service International (PSI), Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS) and United Nations Development Program Zimbabwe.

- The Media Monitoring Project in Zimbabwe (MMPZ) which is an independent Trust working to promote responsible journalism in Zimbabwe⁷⁶.
- The Associated newspapers of Zimbabwe Private Limited, where I collected archive newspapers.
- Key informants in Harare were also interviewed including experts and consultants working in the field of HIV and AIDS in Zimbabwe⁷⁷.

There were limitations regarding the use of secondary analysis as the period of familiarising the data was substantial with large complex data sets. At times, the sheer volume of data can present problems with the management of the information at hand hence more caution was necessary, as it was not collected on an aspect of a topic that would not necessarily be specifically linked to my research questions.

3.9 - Data Analysis

In quantitative analysis, the thought processes are certainly more formalized and codified than in qualitative analysis. Quantitative responses were analysed using Statistical Package for Social Sciences (SPSS) to analyse the frequencies distribution tables which summarise the variables in the study and cross tabulations to analyse relationships between variables .

⁷⁶ The project monitors the information output of the country's radio, television and print media. It produces weekly reports of its findings and occasional reports on current issues.

⁷⁷ Their names will not be disclosed in this thesis for security and ethical reasons.

Analysis of qualitative data from secondary sources involved data reduction by structuring, organising, and streamlining the material, identifying groupings and relationships and drawing conclusions and verifications.

A context analysis of the in-depth interviews was performed, in which similar responses were grouped together and labelled to capture the essence of the common theme. Most of the respondents answered the questions in the English language although a number of the open ended questions were answered in the local language, *Shona*, which were translated into English and categorised into thematic areas. The themes were then given tentative titles as variables. Analysis of in-depth interviews proved effective when carried soon afterwards while memory and impressions were still fresh to carry out content analysis. Some demonstrative quotes from respondents are included in the report findings.

3.10 - Reliability and Validity of the methods applied.

One of the difficulties is knowing '*how we know what we know*' because the topics of human sexuality and perception are considered to be highly private and open to methodological problems. The question of reliability and validity was introduced early in the study. There is no simple satisfactory way of validating survey data on sexual behaviour. In addition to the usual problems of definitions and recall that may beset most large household surveys, Cleland et al (1995) argue that the collection of information on sexual behaviour is further complicated by the sensitivity of the topic. It was also difficult to define basic concepts and their operationalisation given the lack of literature on how best to reliably and validly assess intimate behaviour. As Cleland and Ferry (1995) noted, the apparent lack of interest by researchers in the study of sexual behaviour reflected the many methodological and cultural

constraints involved. Validity and believability of secondary analysis may be low and interpretation difficult when data are not used for original purpose of this study.

There is much evidence to show that different interviewers get different answers through differences in perceived race, sex, social class, age and educational level hence affecting answers given. On the validity of self-reported sexual behaviour, conscious distortions can be motivated by embarrassment or fear of reprisal. People may also make honest errors, not necessarily motivated by psychological factors, in recalling the frequency with which they engage in specific behaviours (Pryor et al, 1993). Therefore, the challenge of knowing to what extent individuals are willing to report details of their past sexual behaviour was dealt with by checking the following questions:-

- Are the reports of males and females mutually consistent?
- Are responses of an individual internally consistent?
- Do the overall patterns of results and interrelationships appear plausible?

During the pilot study, I learnt that young female respondents were not giving accurate information from analysing the responses where inconsistencies were identified. I therefore had to assign each research assistant the respondent to interview who would be comfortable in answering private questions.

As I had to rely on people's willingness to participate in the survey and analyse at their sexual behavioural patterns, I was always conscious of the problems concerning the reliability of the estimates in the number of sexual partners respondents would give. The retrospective recall of information tends to be selective, ordinarily distorted and unreliable. Time lapse is also an important factor to take into account in assessing the reliability of the data. The further back in the time an event occurred, the less reliable people's reports

become. People seem generally incapable of recalling accurately what happened a fortnight ago, let alone before this. As Tory Coxon (1988) in *'The Number Game – Gay Lifestyles'*, noted:-

'...nowhere are the consequences of low quality data-collection more important than in assessing the reliability and hence the validity of the responses given to apparently innocuous questions about the number of sexual partners an individual may have had'.

People remember best what has happened in the immediate past. But the accuracy of their recall, or memory also depends on how varied a person's sex life is and how large or significant a fraction of it is comprised of one – off contacts. The use of a short-time frame to minimise the problems of recalling and distortion of memory on sexual partners maximised the validity of the data. For example, I asked how many people they had sex with in the past 12 months instead on in their life time. The question regarding the number of sexual partners in less than 12 months was omitted after the pilot study when the analysis revealed that it was not uncommon for couples not to have sexual contacts in a prolonged period of time. Some of the reasons included issues of rural-urban migration where husbands are employed in urban area whilst the rest of the family resides in the rural areas. Regional and international migration was also a factor as a number of married couples are now living apart following a massive exodus of Zimbabweans to other countries. Analysing a 12 month period helped to capture couples in this category that do not necessarily have frequent encounters but are sexually active.

One arguable shortfall in my questionnaire is that I did not ask the respondent how they arrived at their estimated number of sexual partners. I could have provided them with

coded responses such as, roughly, guessing, grossing up, exact and nearly precise. Another major problem avoided in the study was conducting a lengthy questionnaire which would have resulted in some respondents not giving enough thought in the answers just to get it over and done with. The questionnaire used in this study was of tolerable length as we noted from the overwhelmingly favourable responses to such an extent that we almost were arrested under the POSA law, for causing havoc at *Fourth Street* in Harare, when public transport drivers and conductors started whistling, cheering and shouting with excitement of wanting to be interviewed. One of the respondents told us someone had spread the word we were distributing free HIV and AIDS T-Shirts! This was a false statement as we strictly observed the research ethics on non payments. There was also the risk of observer bias or reliability as this may affect behaviour of those observed resulting in problems of interpretation of what was observed, in particular reference is the commercial sex workers I encountered with during my observation routines.

The duration of collection of data obviously influences results. The longer the time period, the greater the likelihood of significant increase in knowledge. However, this was not the case in the questionnaire survey where there was an urgent need to administer them in the shortest possible time due to frequent changes in income levels as a result of inflation in Zimbabwe. For example, a teacher could be earning ZW\$3 Million (ZW\$ 3 000 000.00) at the time of being interviewed and if the same teacher was to be interviewed a few weeks later on, their salary would have shot up to ZW\$100 million (ZW\$100 000 000.00), resulting in the difficulty of data analysis and establishing valid income groups as will be shown in the next chapter.

CHAPTER 4

AN OVERVIEW OF THE CRISIS IN HARARE

The next chapters are based on the findings from the fieldwork. It is critical to know that whilst this thesis was later written and submitted in 2012, the findings are based on the survey that was done in Zimbabwe back in 2007. The researcher will not change and update any of the recorded accounts that transpired as an attempt to do so would distort the findings. However, where feasible, comparison will be made highlighting what has changed since then. This thesis is still very relevant to this day as the findings do provide a representation and inform policy makers on the effective implementation of behavioural change health programmes when a country fall into a crisis.

The starting point for discussing any health policies is to provide a good understanding of the socio-economic conditions experienced by the target population hence this chapter specifically gives an account of the socio-economic environment that prevailed in Harare. Social representations are systems of values, ideas and practices adopted by members of a particular society, they are the perspectives in terms of which social events are conceptualised and explained⁷⁸. Social arrangements can affect behaviours related to the transmission of HIV ranging from couples, to social networks in the community to society as a whole. At the broadest level, social conditions such as the lack of access to health care, unemployment and lack of public funds to promote AIDS prevention, contributes to a social context in which HIV transmission is prone to occur. As previously discussed in the

⁷⁸ Edgar et al, 1992.

first chapter, Zimbabwe's political and economic crisis was magnified by a world record inflation rate, growing unemployment, crumbling infrastructure and rising poverty levels, all arguably known to be a fertile ground for the spread of HIV and AIDS. From the participatory observations carried out in this study, it was easily noticeable that Harare had become a humanitarian crisis. Authorities demonstrated no capacity to address the crisis and protect Zimbabweans from its consequences. In a review of the country's economic performance during 2004–2005, McGarry (2005) argued that Zimbabwe at that point had the world's fastest-shrinking economy and arguably the highest inflation rate to a degree that even the Ministry of Finance no longer used statistics from the Central Statistics Office in Harare as they became irrelevant. Fig 4.1 below is an example of the secondary data that I collected from the Central Statistics Office that was not published by the Government.

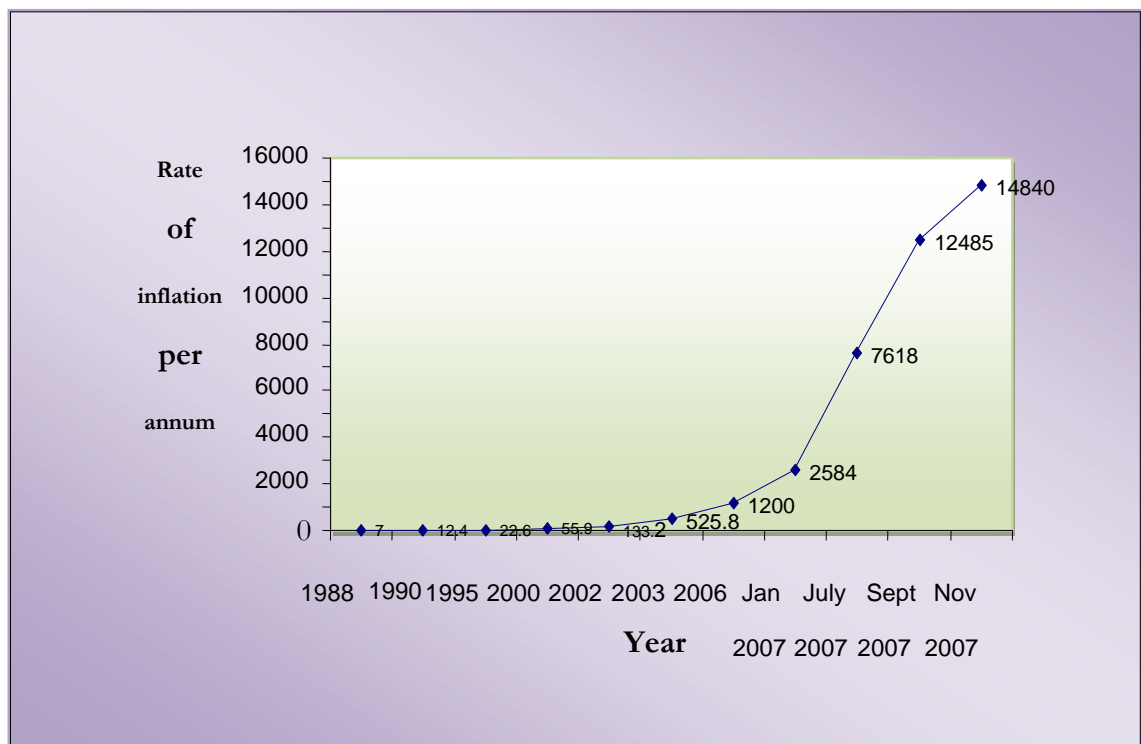


Fig 4.1 Inflation rate 1988 – 2007

(Source: Central Statistics Office of Zimbabwe, 2007)

The *Financial Gazette* reported officially estimated inflation at 231 million % in July 2008 and a consolidated budget deficit in excess of 80 % of GDP. As at the end of September 2008, independent inflation figures of over a trillion % (1.1 trillion %) on food inflation. Urban living standards have therefore been significantly reduced, resulting in the violation of basic human rights of Zimbabweans to food, health and clean water. The following sections provide a concise descriptive analysis of the critical socio-economic conditions prevalent in Harare at the time.

4.1. Critical food shortages

At the time this research was conducted, the agricultural sector was in a state of near collapse whereby export crop volumes had plummeted over the previous decade resulting in unprecedented food insecurity. Malnutrition was much evidenced during the fieldwork visits including amongst survey respondents. As food security not only involves the availability of food on the market, but also its affordability, this posed a serious challenge to low income earners with competing needs which had to be met, such as housing, health and education.

Through participation observations and in-depth interviews, a significant number of respondents reported that their living standards in Harare were either worse than rural living standards, or no better. Many could no longer afford to travel to work and it was uncommon for the daily commute to cost more than 75% of a day's wages resulting in an increase in the number of workers getting up at 04:00am to walk to work for an 08:00hrs start. There was an increased number of formally employed workforce that opted to quit their jobs due to the deficit they accrued at the end of every month. Prices of basic

commodities kept going up. Every new stock of goods had a new increased price, sometimes double the previous. For example, whilst the researcher was in Harare for the fieldwork, the price of a loaf of bread went from ZW\$300 to ZW\$1 200 in a single week.

The semi-dollarisation⁷⁹ of the economy worsened the situation for the employees who still received their income in the local Zimbabwean currency. Most retail outlets began to charge the United States Dollars or the South African Rand. What exacerbated this crisis is the fact that those who still received their incomes in local currency found it difficult to access foreign currency as the demand exceeded the available notes on circulation. UNICEF (2007) produced a report stating that more than half the population now lived on less than US\$1 a day. The situation potentially became unstable as workers were frustrated by the Government's failure to find solutions. Reports of violence emerged on several occasions and the research team witnessed such an act at one of the long queues outside a bank. The protest was dispersed by brutal riot police beating up desperate people with baton sticks. Leading to a desperate situation were PLWHA who faced the risk of being overlooked as more immediate survival needs became a priority. What worsened their plight was the repeated political interference in the programme implementation of NGOs and humanitarian agencies. The Government were in an attempt to conceal the extent of the disaster.

4.2 Service delivery systems during a crisis in Harare

Observation techniques applied in this study noted that service provision in Harare was significantly sporadic, with the Harare City Council's water and electricity charges

⁷⁹ The use of hard currency, in this case, the United States Dollars (US\$)

increasingly unaffordable resulting in a collapse of basic service provision due to non payments. Zimbabwe National Water Authority (ZINWA)'s water supply and sewer reticulation management was at a standstill due to continued strikes by its workers. Residential areas namely Glenview, Budiro, Glen Norah, and Msasa Park, Mandara, Glen Lorne, Marlborough and parts of Hatfield experienced water cuts for several months⁸⁰. During the questionnaire administrations in poverty stricken areas Epworth and Mabvuku residential areas, the majority of respondents reported not to have had access to water supplies in more than 15 months. International organisations such as UNICEF were visibly making efforts to provide water to residents who had resorted contaminated rivers and shallow wells. Where provision of water by the council was in existence, the residents criticised about the hours the water was made available, only during unsocial hours, between 10pm and 5am . Pools of raw sewerage were common in many residential area as ZINWA failed to attend to burst sewer pipes. The distribution of electricity supplies has been similar to that of water, and most areas in Harare received power supplies for only four hours on a daily basis. Petrol shortages continued to worsen and the paraffin used for heating and lighting by most Zimbabweans was almost unobtainable. The collapse in the above service delivery areas suggest a major obstacle to economic recovery. The power deficit has resulted in load shedding that constrained the industrial and agricultural sectors.

With regards to the educational system, there was a serious shortage of primary, secondary and tertiary school teachers as a result of the majority emigrated to countries such as South Africa, Botswana and United Kingdom. Students interviewed during the research reported that they were no longer motivated to advance in education as income levels signified the

⁸⁰ See Fig 3.3 for the Map of Harare.

worthlessness of educational qualifications in a crisis state. Those that were not educated to university level were potentially earning significantly more incomes than their university counterparts. A number of cross-border traders to neighbouring countries like South Africa, Mozambique and Zambia were found to have much higher income levels compared to the educated and formally employed. One of the informal workers interviewed whose job was to carry heavy bags for cross border traders with his trolley boasted,

'...sister, there is no point of been educated nowadays. It is all irrelevant in Zimbabwe. It is now a matter of survival of the fittest. I have a booming business pushing goods for my customers. At least I am guaranteed to go home everyday with some money, in cash which is tax -free, unlike all the civil servants who are going for months with no salaries. My neighbour, who is a nurse, always comes to my house borrowing some money from me. I am now much better off than her and I no longer regret not going to school anymore!'

4.3 Unemployment levels in a crisis state

Poverty seemed a growing phenomenon among the majority of households in Harare due to limited opportunities for formal employment and low foreign investment in productive jobs at the time this research was conducted. The Government's campaign rhetoric about nationalising the country's major privately owned companies resulted in the majority of companies in Harare pulling out altogether. This has resulted in an un-quantifiable effect on ordinary citizens. Fig 4.2 shows the trend in unemployment rates which reached around 80% in 200.

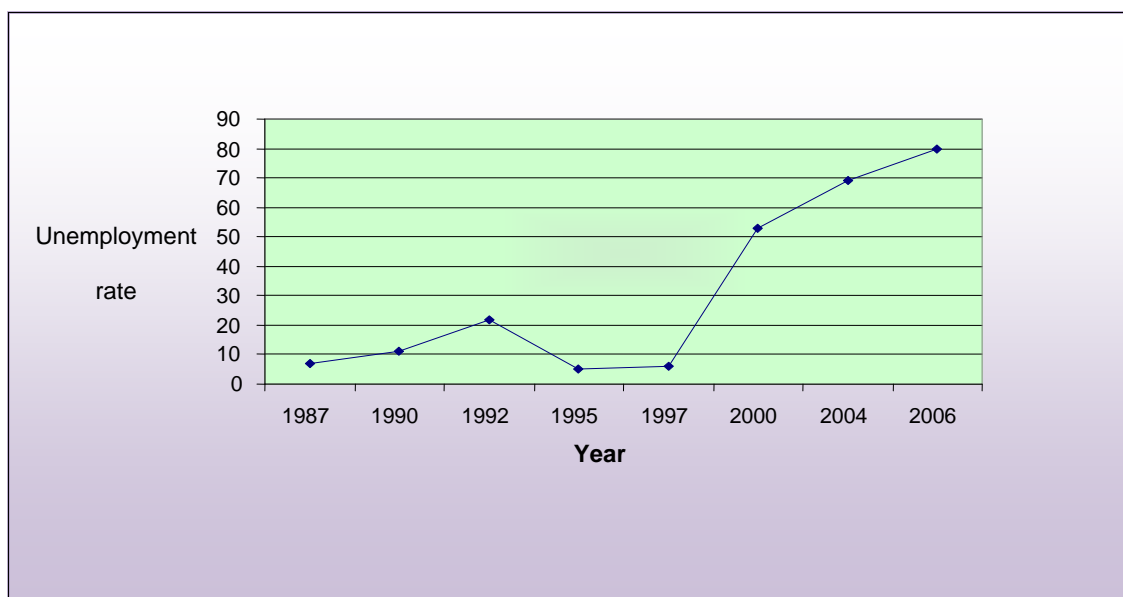


Fig 4.2 Unemployment rates in Zimbabwe from 1987-2006

(Source: University of Zimbabwe Statistics Department)

An analysis of monthly incomes suggests that the gap between formal incomes and necessary expenditure in an urban context had become highly problematic. For example, the research findings reveal the price of a 20 kilogram bucket of maize meal was US\$20 whilst teachers were earning an average of average of US\$4 per month.

4.4 Inadequate housing

The current urban crisis in Harare is a result of the development of increasingly informalised urban employment and ‘illegal’ low- income housing solutions across the urban hierarchy. These two developments became the prime targets of the *Operation Murambatsvina*⁸¹. The Government’s drastic campaign swept through the urban areas of the country from May to July 2005 when it embarked on a far-reaching and unprecedented

⁸¹ Murambatsvina means drive out the rubbish or restore order.

campaign within its towns. This policy was designed to eradicate ‘illegal’ housing and informal jobs, which directly affected hundreds of thousands of poor urban residents. It also affected rural residents. For example, roadside kiosks selling curios to tourists were also destroyed in this operation. According to the Government, this drastic policy was necessary to eradicate illegal housing and activities from the cities although such justification obscures far deeper economic and political causes. On 19 May 2005, the Chair of the Government, appointed Harare Commissioner that was running the city, announced at the Harare’s Town House that the City of Harare intended to embark on *Operation Murambatsvina*, a programme to:

...enforce by-laws to stop all forms of illegal activities. These violations of by-laws in areas of vending, traffic control, illegal structures, touting/abuse of commuters by rank marshals, street-life, prostitution, vandalism of property infrastructure, stock theft, illegal cultivation, among others have led to deterioration of standards thus negatively affecting the image of the city....Harare has lost its glow. We are determined to bring it back... It is not a once-off exercise, but a sustained one that will see to the clean up of Harare...Murambatsina is going to be a massive exercise in the Harare and the suburbs which will see to demolition of all illegal structures and removal of all activities at undesignated areas... (The Herald, 2005).

The campaign was truly massive and nothing on this scale in such a short duration has ever been witnessed in urban Africa hence the operation was nicknamed ‘Operation Tsunami’ by the victims due to its speed and cruelty. The most authoritative report, produced by the special envoy from the UN Habitat, Anna Tibaijuka, estimated in July 2005, that around 650 000 to 700 000 people had lost either the basic of their livelihoods or their homes, or both (Tibaijuka, 2005). These calculations were based on the Government’s own estimates

and average household size, plus information gathered from a variety of different organisations and individuals within the country.

A Harare based survey, by Action Aid and the Combined Harare Residents' Association (CHRA), covering a large sample of 14 137 respondents from 26 affected high density (low income) wards, was conducted towards the end of the campaign. The survey found that nearly every household interviewed (97%) has been negatively affected, in the vast majority of cases, at least one source of household income had declined or been lost as a result of the operation and 76% of the respondents had lost their shelter. Food security was also affected in two ways. First, the loss of income would have made food less affordable and the disruption of informal markets affected the food supplies of the population (Action Aid, 2006). Table 4.1 shows a summary of the impact of the operation.

The Zimbabwe Human Rights NGO Forum (ZHNGO, 2005) estimated that 114 000 (20%) of those displaced from the city went to the communal areas. However, most men affected by the operation remained in the city and continued with income earning activities. This prolonged absents from their spouses is one of the key drivers of the HIV virus spreading through as casual sexual partners could be sought.

Table 4.1 Impact of Operation Murambatsvina in Harare's High Density Areas

Category of impact	Percentage of responses
Affected by Operation Murambatsvina	97
Income source lost ⁸²	79
Shelter/house lost ⁸³	76
Food security affected ⁸⁴	60
Ability to safeguard physical assets affected	49
Other property lost ⁸⁵	45
Disruption of family unit ⁸⁶	40
Loss of women's status and dignity	39
Increased vulnerability of children, orphans and women	37
Children's education affected/ dropped out	22
Deterioration in health due to Operation Murambatsvina	20
Coping mechanisms/current sustenance	
Own resources	37
Relatives' help	22
Govt, CBOs, NGOs	6
Not managing/ in desperate need	35

(Source: Action Aid/CHRA, 2005)

⁸² The questionnaire indicates this could be one source of household income – it therefore may not be all sources or the primary source.

⁸³Includes tenants being evicted and landlords and landladies losing rental units as a result of demolitions.

⁸⁴ Many urban families were already food insecure before Operation Murambatsvina (mainly because of affordability issues) so this must indicate an increase in this form of insecurity in many cases.

⁸⁵ Including possessions destroyed in house demolitions, property seized by police, artisans and vendors selling tools and products at knockdown prices to minimise losses.

⁸⁶ This mainly involved children and/or wives going to rural areas.

4.5 Restricted Humanitarian Aid

In late 2004, the Zimbabwean parliament approved an NGO Act that prohibits organizations working on human rights, and gives the Government the power to interfere with how NGOs are run. Although this Act had not yet been signed or implemented by the president, some foreign NGOs pulled out of Zimbabwe, having found it too difficult to operate in the country. Relations between humanitarian agencies and ZANU-PF have been poor for several years as the Government has repeatedly accused NGOs and humanitarian organizations, of supporting the MDC and working with western donors to overthrow the Government (regime change agenda). Growing international isolation resulting from controversial Government policies has also led to greatly reduced donor funds for the country which has adversely affected most people who are living below the poverty datum line and who are in dire need of food, medical and financial aid.

On June 4 2008, the Minister of Public Service, Labour and Social Welfare wrote to all NGOs and private voluntary organizations and announced a full suspension of all their field operations. Earlier, the Minister of Local Government had accused local and international humanitarian agencies of breaching their registration terms and conditions and accused some NGOs of using food distribution programmes to support the MDC despite the fact that the Zimbabwe authorities have failed to provide any evidence to support their allegations. This raises theories that the suspension was an attempt to prevent NGOs from witnessing and reporting on the state-sponsored violence that was taking place in the rural parts of the country at the time.

The terms of a new Memorandum of Understanding that were later signed between local and international humanitarian agencies and the Government authorities state that if the agencies wish to operate in a specific area, they must first get permission and sign a written agreement with local Government structures setting the terms for the distribution. While such a request by the Government may seem reasonable, local Government and party structures in Zimbabwe have attempted to use this requirement to control and impede the efforts of humanitarian agencies to assess needs and provide much needed food and other assistance to Zimbabweans. The requirements have also left the delivery of humanitarian assistance open to manipulation by Government agents and ZANU-PF officials. The Government has also hampered the work of international humanitarian organizations by unnecessarily denying foreign staff employment permits and extensions of permits. The next chapter provides the finding on the extent to which the crisis affected the health delivery system in Harare and subsequently the HIV prevalence rates.

CHAPTER 5

HIV PREVENTION PROGRAMMES IN A COLLAPSING HEALTH DELIVERY SYSTEM

This chapter gives an account of the HIV Prevention strategies that were implemented during the crisis. The researcher will provide a narration of the conditions of the health delivery system that prevailed prior to discussing HIV prevention programmes. The starting point for discussing any health behavioural dynamics in a crisis state and the effectiveness on implementation of programmes and is a good analysis of the health situation that prevailed during the time the research was conducted. The onbe Zimbabwe was named World Health Organization (WHO)'s best health service provider in 1985 because of its efficient health delivery system. During that period it managed to eradicate polio⁸⁷. Health care was fully subsidized at that time and Mhloyi (1994) reported that 85% of the population lived within 8km of a health care centre and the Government upgraded 550 health centres and built 321 new ones all over the country.

The findings of the research shows that, the health sector in Zimbabwe includes organized public and private health services (health promotion, disease prevention, diagnosis, treatment and care). Zimbabwe has a diverse health sector that is composed of the following health institutions;

⁸⁷ Polio is a highly infectious disease caused by a virus. It invades the nervous system, and can cause total paralysis in a matter of hours

- State funded public health institutions
- Private-not-for-profit including mission health institutions run by Faith based organizations
- Private-for-profit health facilities
- Allopathic practitioners (Traditional and Alternative medicine).

Records from the Ministry of Health indicated in 2007, approximately 2 800 registered health institutions in the public sector clinics and hospitals , private general and specialist practices, industrial, mining and agricultural clinics, hospitals and pharmacies, mission clinics and hospitals, emergency rooms and trauma centres, ambulance services, x-ray service facilities and laboratories among others were registered..

However, many of these institutions in particular the district hospitals and municipal clinics were forced to shut down or operated at minimum capacity. Other aggravating factors include dilapidated infrastructure, equipment failures, and a “brain drain⁸⁸” of medical professionals. This crisis turned Zimbabwe's once impressive health care gains of the early years of independence in the 1980s into a major disaster resulting in the removal of subsidies to all social sectors including health.

Health personnel within the School of Medicine at the University of Zimbabwe that 92% of the medical students who graduated in 2006 from the University of Zimbabwe have since left the country citing poor remuneration as the factor that forced them to look for greener pastures. The health personnel in Zimbabwe were poorly remunerated and they had no incentives to keep them working in the country. Zimbabwe has more than 2,000

⁸⁸ Large-scale emigration of a large group of individuals with technical skills or knowledge.

registered doctors, but many are leaving after being attracted to better working conditions and remuneration in neighbouring countries, mainly Botswana, Namibia and South Africa. As a result, patients sometimes hardly see doctors. They are now only attended to by nurses and in some worst case scenarios, by nurse aids. The researcher observed nurses no longer provided bathing and feeding services to patients and this role was taken over by relatives due to high attrition. More than 80% of the medical professional interviewed admitted of considering using hospitals facilities for their private gain by booking private appointments with desperate patients.

The consultation fees and medication were out of reach for many Harare residents. At the time this study was conducted, the admission fee for a private hospital stood at ZW\$40million in November 2007 whilst the monthly average incomes where at ZW\$20 million. At the time of the research, an official exchange rate was ZW\$30,000 to US\$1, although the black market exchange rate was estimated to be ZW\$600,000 to US\$1⁸⁹. Medical aid societies did very little to help their beneficiaries resulting in residents cancelling their medical aid contributions, as in most cases, patients were asked to top up the fees by as much as 90% of the bills. Shortages of medication was also visible at the hospitals resulting in patients being handed over a prescription after consultation, where they were asked to find the medicine themselves.

⁸⁹Raath, Jan. [Devaluation is 'too little, too late' to save Zimbabwe](#). *Times Online*. 7 September 2007.

5.1 Care and Treatment of PLWHA

The Government of Zimbabwe introduced Antiretroviral Therapy (ART) in April 2004 and the 'Plan for the Nationwide Provision of ART' was finalized in December 2004 covering the period (2005-2007)⁹⁰. As part of its strategy to scale-up ART services towards universal access in 2010, the MOHCW commissioned a review of the ART programme and there were over 60 000 people in both the private and public sector that were receiving treatment out of an estimated 300 000 people that were in need of the drugs. There are presently 1.6 million people, 12% of the population living with HIV and AIDS in the country (GOZ, 2006). Antiretroviral therapy (ART) is said to decrease the morbidity and mortality for people that are living with AIDS. The Ministry of Health and Child Welfare, National AIDS Council (NAC) and its partners⁹¹ committed to providing universal access to treatment. Providing antiretroviral treatment to people living with HIV and AIDS may seem to be the most effective means of managing AIDS. It is an easily measured service delivery operation. It is a humanitarian activity that prolongs people's lives and reduces the social and economic impacts of the disease.

The demand for ARVs had reached unprecedented levels whilst supply still remained insufficient. The main obstacle to universal access of ARV treatment now relates to the

⁹⁰ Plan for the Nationwide Provision of ART 2005-2007, MOHCW, 2004

⁹¹ Other local and international partners that are working in the area of ART in Zimbabwe include DFID, WHO, UNICEF, Italian Cooperation, United States Government, Centre for Disease Control, European Union.

weak health systems and budget management, the migration of health workers as the remaining unqualified nurse aids are prohibited from administering ARVs to patients under the National Guidelines.

Many HIV positive patients reported that they had resorted to acquiring the drugs from illegal markets through importation from neighbouring countries such as South Africa where they are readily available but at exorbitant prices. Considering that more than half the population is living below the poverty datum line (US\$1 per day), this means the majority of the infected people cannot afford the ARVs and tend to prioritise on other needs such as housing and food resulting in deterioration of their health.

The Government has taken various measures in the past to expand the provision of antiretroviral drugs. In 2002 it declared that the treatment shortage was a national emergency, allowing Zimbabwe to produce and purchase generic AIDS drugs locally under international law, thereby reducing their cost. NAC set aside US\$700,000 for the procurement of ARVs, pledging a further US\$2.9 million in 2004. The number of centres providing treatment was also scaled up, increasing from just 5 in June 2004 to 48 by September 2005 (Avert, 2008). Figure 5.1 below shows the location of ART sites during the time the research was undertaken.

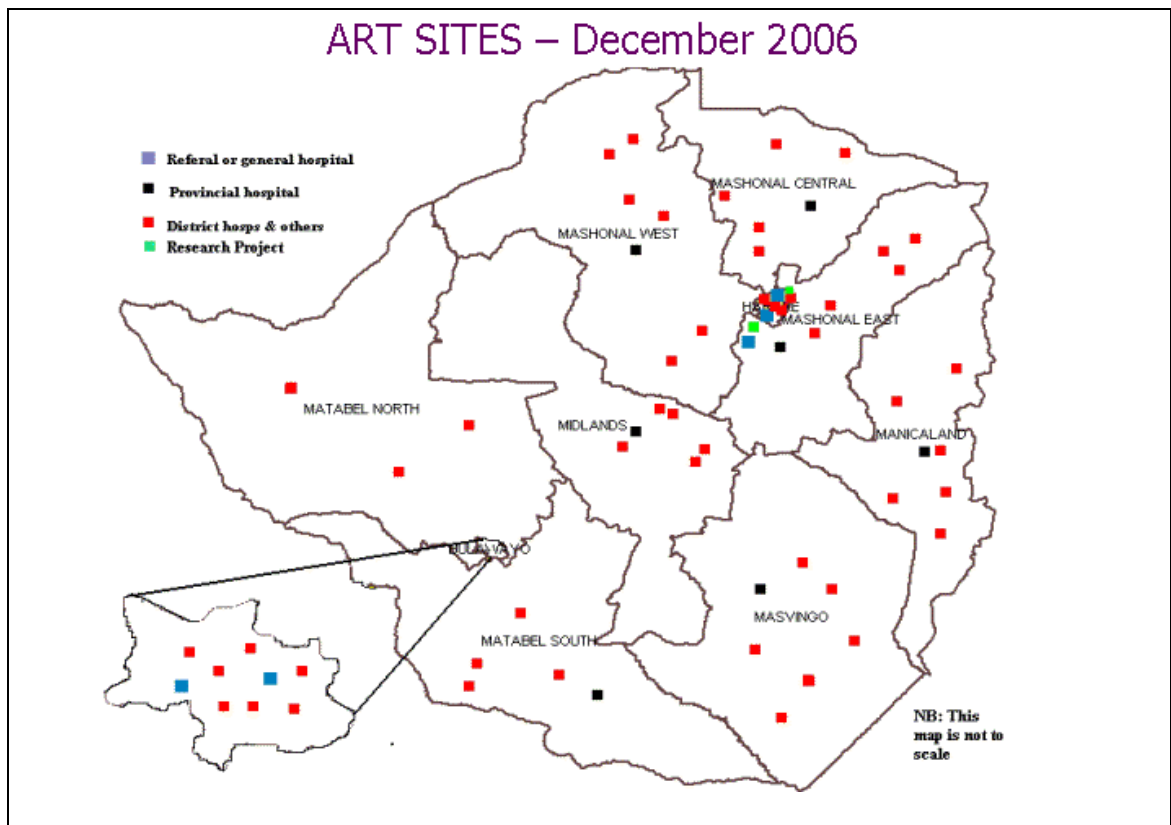


Figure 5.1 Antiretroviral Therapy Sites, 2006

(Source: MOHCW, 2007)

Unfortunately, the reality for most people living with HIV in Zimbabwe is that drugs are still not readily available. Even at sites where treatment has been made accessible, a severe national shortage of healthcare workers has led to long waiting lists and administration problems. Despite the chronic shortage, there have recently been reports that Government officials who are HIV-positive are being given priority access to ARVs, and intercepting drugs meant for public hospitals for their own use. Research findings were that ARVs were procured for public hospitals were diverted to private chemists and sold at inflated prices.

It is important to note that, if the patients do not take the treatment exactly according to guidelines, there is a risk that the virus might develop resistance to the medication, making

the treatment useless. Some of the HIV positive residents in Harare, were reported to be drug resistant, that is when the virus adapts itself and becomes able to survive the effect of antiretroviral drugs. This normally happens when insufficient doses of ARVs are taken or treatment is interrupted due to irregular supply of drugs to the patient or by poor adherence to treatment. The threat of this prospect puts the strain on both the health delivery system and the patients themselves who cannot afford the costs of travelling to hospitals.

Other critical elements in the health delivery systems observed included the erratic supplies of water and electricity resulting in hospitals resorting to the use of diesel generators, which were further constrained by fuel shortages in the country. Due to the low funding levels, hospitals have not been able to procure ambulances and the majority of existing ones were now out of service. Those that were still functioning were grounded because of fuel shortages. Due to security reasons, no photographs were taken during the research, but it is fundamental to share the picture in Fig 5.2 below that the researcher came across. The picture depicts what became a normality in transporting patients to health institutions.



Fig 5.2 Patient being transported to a Harare Clinic

(Source: *The Guardian*, November 2008)

Transportation has not just affected the patients, but also the health care providers as they reported not having sufficient resources to commute to their duty stations as expected, due to high transport costs.

Regarding care and treatment of the sick, the burden of care for HIV and AIDS usually falls on the old and the children in Zimbabwe who are not financially sound. Families are usually depressed when the breadwinner falls ill. Such infected persons suffer from emotional and psychological stress, as they feel unable to provide for their families. They feel that they are burdening their families with their illness making their health worse and hampering the recovery process. The research shows that the epidemic has mainly affected the economically active population (15-49 years). The majority of the dependents that care for sick patients cannot afford antiretroviral therapy for their loved ones and they do not have an option but to watch them die slowly.

Despite the numerous strikes by health workers to increase salaries, housing and transport allowances, improve their working conditions and for better provision of health services, the authorities have treated them harshly. Those interviewed at Parirenyatwa Hospital reported that heavily armed riot police often prevented them from submitting their petitions to the Ministry of Health and Child Welfare. On one occasion, the police initially forced the health workers to protest within the grounds of Parirenyatwa Hospital, but after four hours the police entered the hospital grounds and forcibly dispersed the workers, assaulting several.

5.2. HIV Prevention Programmes

Prevention of new HIV infections remains the cornerstone of the national response to the epidemic in Zimbabwe. In the absence of a national prevention strategy, the 2006 -2010 National Behavioural Change Strategy was developed by the National AIDS Council to consolidate HIV prevention and accelerate the country's goal to reduce the HIV prevalence to less than 10% by 2010, in line with the MDGs. This strategic plan was designed to guide systematic and strategic programming in the area of promoting behavioural change in terms of preventing HIV transmission and has the following four key outcome areas:

1. Enabling environment for behavioural change through increased leadership and gender equality as well as reduced stigma associated with PLWHA.
2. Increased adoption of safer sexual behaviour and risk reduction
3. Increased utilization of HIV prevention services and
4. Improved national and sub-national institutional frameworks to address behaviour change.

In 2007 at the time this research was being conducted, Zimbabwe launched a behaviour change promotion strategy with funding for the Expanded Support Programme⁹². This created an enabling environment mainly through community leaders' involvement, gender equality and Meaningful Involvement of People openly living with HIV and AIDS (MIPA) aimed at reducing stigma and discrimination. This national strategy also aimed to adopt safer sexual behaviours, risk reduction and increased utilization of HIV prevention services such as Testing and Counselling including post test support.

The finding also identified the Prevention of mother to child transmission of HIV (PMTCT) program which was argued to be one of the strongest pillars of the HIV and AIDS responses in Zimbabwe. The primary aim of the PMTCT programme was to decrease the number of HIV infected babies born to HIV positive mothers. It is integrated within the broader framework of reproductive health service provision⁹³ where a multi-sectoral national PMTCT Partnership Forum (PPF) was established to improve coordination of the programme.

Tuberculosis (TB)⁹⁴ and HIV collaborative activities were found to be one of the prevention approaches in Zimbabwe. It is estimated that 70% of all TB patients are co-

⁹² The programme was designed to scale up the national HIV and AIDS response and is financed by a Common Fund supported by five bilateral donors namely, CIDA, DFID, Irish Aid, Norway and Sida.

⁹³ PMTCT and Paediatric HIV Prevention, Treatment and Care National Plan, 2006 – 2010, MOHCW, 2006.

⁹⁴ A contagious bacterial infection that involves the lungs.

infected with HIV, but there was no routine surveillance among TB patients. The National TB Control Strategy⁹⁵ has the following strategic implementation approaches;

- Dots expansion and enhancement.
- Addressing TB/HIV
- Contributing to health systems strengthening
- Greater involvement of all health care providers
- Engagement of people with TB.
- Enabling and promoting operational research

At the Parirenyatwa Hospital, officials reported an increase in the number of TB patients being offered HIV testing and counselling. A strategic framework was being developed to increase access of TB patients to ART (and vice versa) by strengthening TB/HIV collaborative activities⁹⁶. Furthermore, these activities include establishing collaborative TB/HIV committees at different levels (district, provincial and national) of health delivery system and conducting joint training for HIV and TB at all levels.

The Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) developed for 2006 - 2010 by the National AIDS Council identified HIV Testing and Counselling (HTC) as an important component of the behavioural change strategy. Broad objectives of the strategic plan emphasized the need to increase the percentage of the Zimbabwean population who know their HIV status, from 20% in 2006 to 85% by 2010⁹⁷; and to expand HTC services.

⁹⁵ TB-HIV Guidelines, AIDS and TB Unit, MOHCW, 2009

⁹⁶ Plan for the Nationwide Provision of Antiretroviral Therapy, 2008 – 2012, MOHCW, 2008

⁹⁷ As this report is on the findings beyond 2010, it is interesting to note that knowledge has since increased to above 30%, mainly due to the Prevention of mother to child transmission programme (PMTCT).

The Zimbabwe Demographic Health Survey of 2005- 06 reported that 5.9% women and men (15-49years) had been tested and received their HIV results in the 12 months prior to the survey. HCT services were also provided through mobile outreach programmes, workplace programs, and family planning clinics.

The research also found that the Ministry of Education, Sport, Arts and Culture partnered with the Ministry of Health and Child Welfare to develop a life skills based HIV and AIDS education in schools policy. The policy required all schools should provide life skills based HIV and AIDS education to pupils in schools. Consequently a pre-service training on life skills based HIV and AIDS education was introduced for all student teachers from 1994.

A total of 2,471,605 school pupils were exposed to life skills HIV and AIDS education by 2006 through school based programs. A total of 22,790 school based peer educators were trained by 2006⁹⁸. However, the remaining challenge was the weak coordination of youth programs and absence of focal persons to focus on implementation of HIV prevention activities in tertiary institutions.

Male circumcision was identified in the ZNASP as one potential service-based HIV prevention intervention strategy. Research was proposed to assess feasibility and acceptability of large scale male circumcision and pilot the initiative in some selected geographical areas⁹⁹. Zimbabwe is mostly a non-circumcising country but has traditionally circumcising ethnic and religious communities such as the Xhosa, VaRemba, Chewa, Tshangani, Tonga and Moslems. The ZDHS (2006) noted self reported MC prevalence at

⁹⁸ Data provided by the Ministry of Health and Child Welfare in data gathering process for this report

⁹⁹ ZNASP 2006-2010 Mid-Term Report, July 2009

10%. Male Circumcision surgery is conducted by medical doctors, using sterilized pre-packed kits and guided by the minimum standards operating procedures (SOPs) for safe male circumcision developed for Zimbabwe. The next chapter provides research findings on components of the Health Belief Model against sexual behavioural change as an HIV prevention strategy in the midst of a crisis. This chapter has provided an overview of the state of health delivery services that existed during a crisis state and the HIV prevention programmes that were implemented at the time. The next chapter gives an account of the findings on the Health Belief Model components and how they influence behavioural change.

CHAPTER 6

COMPONENTS OF THE HEALTH BELIEF MODEL AND HIV PREVENTION PROGRAMMES DURING A CRISIS.

Effective HIV prevention programming depends on a number of variables such as levels of HIV and AIDS-related knowledge among the general population, social stigmatisation, risk behaviour modification, access to high-quality services for sexually transmitted infections, provision and uptake of HIV counselling and testing, and access to care and antiretroviral therapy, including prevention and treatment of opportunistic infections. The principal objectives are to determine if awareness and knowledge on HIV and AIDS in Harare is linked to changes in sexual behaviours and HIV infection rates, to examine if perceptions of HIV vulnerability motivates risk reduction through behavioural change and to establish the effectiveness of HIV Prevention Programmes highlighted in the previous chapter using various components of the HBM, when a country is in a crisis. There is a need to look at the discrepancy between levels of HIV and AIDS knowledge and levels of behavioural change or risk reduction approaches. The researcher however made no attempt to be exhaustive in this research but tried to be representative, neither did the researcher review the HBM extensively, but explored how variables of the socio-economic status of Harare residents during a crisis can be analysed in the theoretical perspective.

As discussed in the previous chapters, the underlying concept of the HBM is that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence. This is because socio-economic and political arrangements can affect behaviours related to the transmission of HIV, ranging from couples, social networks, community to society as a whole. At the broadest level, socio-economic conditions such as the lack of access to health care, unemployment and lack of public funds to promote AIDS prevention, contributes to a social context in which HIV transmission is prone to occur.

The researcher conducted an in-depth interview with the Chief Medical Officer at the National AIDS Council and learnt that in 2005, the NAC led a consultative Behavioural Change Review process. The purpose of the review was to provide an evidence base for the development of a Behavioural Change Strategy, which has assisted in providing insights and greater detail regarding behavioural change in Zimbabwe. The Health Belief Model states that a person's motivation to undertake health behaviour can be divided into three main categories: individual perceptions, modifying behaviours, and likelihood of action. Individual perceptions are factors that affect the perception of illness or disease; they deal with the importance of health to the individual, perceived susceptibility, and perceived severity. Modifying factors include demographic variables, perceived threat, and cues to action. The likelihood of action are factors in probability of appropriate health behaviour; it is the likelihood of taking the recommended preventive health action¹⁰⁰.

¹⁰⁰ Abraham & Sheeran, 2005

Various scholars such as Magesa (1992) suggest the central concern in the campaign to contain the epidemic is behaviour modification, which can be approached in two ways. The first one is structural changes such as economic development, political stability, control of commercial sex industry and improved health systems. The second one is a moral or ethical approach, which must be rooted in traditional African cosmology, to seriously take cultural elements still existing in the African social psyche because completely alien borrowed solutions will hardly work.

Kalipeni *et al* (2004) in *HIV in Africa: Beyond Epidemiology* recognises that when 'biomedical models remain dominant in generating understandings of AIDS in Africa', there is a tendency in these studies to focus on sexual practices devoid of socio-economic contexts consequently ignoring the social embeddedness of vulnerability'. For this reason, demographic, social, structural and personality factors are included in the health belief model because they are believed to indirectly influence behaviour. However, bearing in mind that a number of factors have contributed to the focus on the individual as a unit of analysis in AIDS research.

Zimbabweans are part of a socio-psychological environment or social reality in which they live. In case of AIDS, they encompass not only rational constructs but also societal beliefs and attitudes, deep-seated socially shared anxieties, cultural values and moral norms. The HBM components enabled this study to identify factors that influence the adoption of preventive, risk reducing behavioural practices. These will be discussed in length in this chapter in the following order :-

1. Perceived severity.

2. Perceptions of vulnerability
3. Environmental cues and access to preventive information
4. Perceived effectiveness of preventive behavioural strategy.
5. Anticipated costs of the barriers to performing preventive behaviour.
6. Measure of health motivation.

It is important to note that the research findings suggest that issues of sex and sexuality in Zimbabwe have proved difficult to segment by minor places of residences, except the broad categories of urban and rural areas. Secondary data and literature that shows the sexual behavioural attitudes for Harare residents was scarce, making it a research gap existing in this field.

6.1 Perceived severity

Perceived severity is an individual's assessment of the seriousness of the condition, and its potential consequences. The construct of perceived severity speaks to an individual about the seriousness and belief or severity of the disease. While the perception of severity is based on medical information or knowledge, it may also come from the beliefs a person has about the difficulties the disease would create or the effects it would have in the individual's life in general.

The research questionnaire (Appendix 1) assessed Harare residents' opinions on how serious the problem of HIV and AIDS and its consequences really are. There was need to assess the beliefs individual respondents hold concerning the effects HIV and AIDS would have on their state of affairs. These effects can be considered from the point of view of the

difficulties that the disease would create. For instance, pain and discomfort, absenteeism from work and eventually loss of work, financial burdens, strains within the family, stigma and discrimination, and stress. All these factors and more are fundamental when considering the severity of HIV and AIDS.

Research findings suggest 47.4% of the respondents agreed that all the people who get HIV eventually develop AIDS, with 37.5% disagreeing with this fact and 15.2% reporting that they did not know. In this recognition that once an individual is infected by the HIV virus, they eventually develop AIDS and die as time progresses, 63.6% confessed to the fact that getting the HIV virus is the worst thing that they could imagine. However, despite the remaining 36.4% acknowledging the severity of the epidemic, they surprisingly reported that getting the virus would not be the worst thing they can imagine. Opened ended questions in the questionnaire and participatory observations reveal that there are various logical reasons to these claims, which include an individual's background, socio-economic status, and their cultural and religious beliefs. The researcher conducted participatory observations by attending different church services on Sundays and having informal discussions after the service. Findings suggest it was a common act by many worshippers in Harare to accept the suffering they experience in the belief that it is God or the spiritual ancestors who would have allowed such to happen. Some interpreted any suffering as a punishment for their sins or sins committed by their fore-fathers. With the country experiencing a crisis in every aspect, one would expect Zimbabweans to be vocal about their grievance and organise constant demonstrations against the Government. This was not the case, as there was a significant degree of resilience and a silent acceptance of misfortunes experienced which also is a reflection of perceptions of getting the virus. Some reported to have experienced so many tragic conditions, such as a sharp increase in

the number of deaths in their families, getting their homes demolished by Government policies, loss of employment and income and severe poverty, to a point that getting the HIV virus would not be the worst catastrophe in their lives. A 31 year old female respondent commented:

I do not remember the last time I was ever happy in my life. It is hard for me to imagine if ever I will. I am only 31, I was married at 22, but my husband died when I was 26 leaving me with a two year old baby boy who then died a year later. I lost all my property that my husband and I had worked so hard for as his relatives took them all away. My husband did not leave a will behind. Worst still, I was accused by his relatives of killing him and my son so I could have boyfriends.....I do not have a shoulder to cry on, most of my family members have died and there are non functioning Government structures to support people like me. I only get refuge and some sort of support from the church I attend. To me, getting the HIV virus might be a blessing because if I die, I will be finally at peace and will join my family'.

The low rates in perceived severity of the epidemic by Harare residents was also caused by high death rates that even the researcher personally witnessed. It is astonishing to report that the researcher personally attended a total of six funerals in a period of nine months! The deceased were known as friends or relatives to the researcher's family, revealing a worst case scenario of the number of other unknown funerals that took place. The researcher experienced extremely disturbing observations in the way the funerals were now being conducted compared to a decade ago. At a young age, the researcher remembers funerals were sacred, secretive, with so much dignity and respect for the deceased. In the Shona culture, relatives and friends would gather for up to three days to mourn the passing away of an individual. Women would work around the clock cooking and making sure everyone gets fed at least three times a day. There was a lot of singing and preaching of the gospel and there would be a lot of women yelling and throwing themselves on the ground,

crying whenever they greeted anyone. Contrary to all this, now more than a decade later, the researchers observed that funerals were conducted very casually as a sign of relief from attending to a patient. Due to severe poverty levels in a crisis state, there was evidenced in the decline in the number of mourners, even for more than a day and scarce resources did not allow provision of food at funerals. Most would only meet at agreed times to organise logistics of how quickly they could bury the deceased. These findings were also noted at cemeteries where only 30 minutes time slots were imposed to bury the dead because of the increased demand of graves on any given day. In an interview conducted in Harare by Paul Cadenhead for the *New York Times* in March 2000, Wilson Chiperesa who oversaw the grave digging and grounds keeping for the country's biggest cemetery on the outskirts of Harare, Granville Cemetery, reported...

"...a few years ago, we were burying six or seven bodies a day, now we're doing 15, 16, 17 a day...When they built this cemetery, they said it would take 30 or 40 years to fill it up, now, it will take 15, maybe 20, years. Not even five years after it opened, this cemetery is filling up faster than planners ever expected. That is largely because of one of the few things the country unfortunately has no shortage of: AIDS. The cemetery, spread over about 250 acres of former farmland in 2000 already had over 8,000 people buried there just in five years. "

It is reported Paul Cadenhead took a look at one page in the cemetery's ledger from the week of February 11, 2000 to February 17, 2000 hints at the pattern. A sample of the ages was 32, 28, 70, 10, 17, 24, 29, 25, 37, 61 and 35. The listed causes only make it clearer: immuno-suppression appears only once, but pneumonia and tuberculosis, illnesses that prey on immune systems weakened by AIDS, appeared frequently.

Despite such alarming events in Harare, it is clear that research informants interviewed did not have knowledge of the statistics of the severity of the epidemic in Zimbabwe. When asked how many people they think are dying of AIDS each week in Zimbabwe, the responses ranged from as little as 2 people per week to as exaggerated as 6 million people per week when the entire population of Zimbabwe is just under 12 million people. Fig 6.1 below is a summary of the perceived numbers of those dying of HIV and AIDS in a week in Zimbabwe. One of the fundamental questions to ask in such statistical disparities is the type of HIV and AIDS information that is disseminated by implementing agencies. This will be dealt in detail in later sections of this chapter.

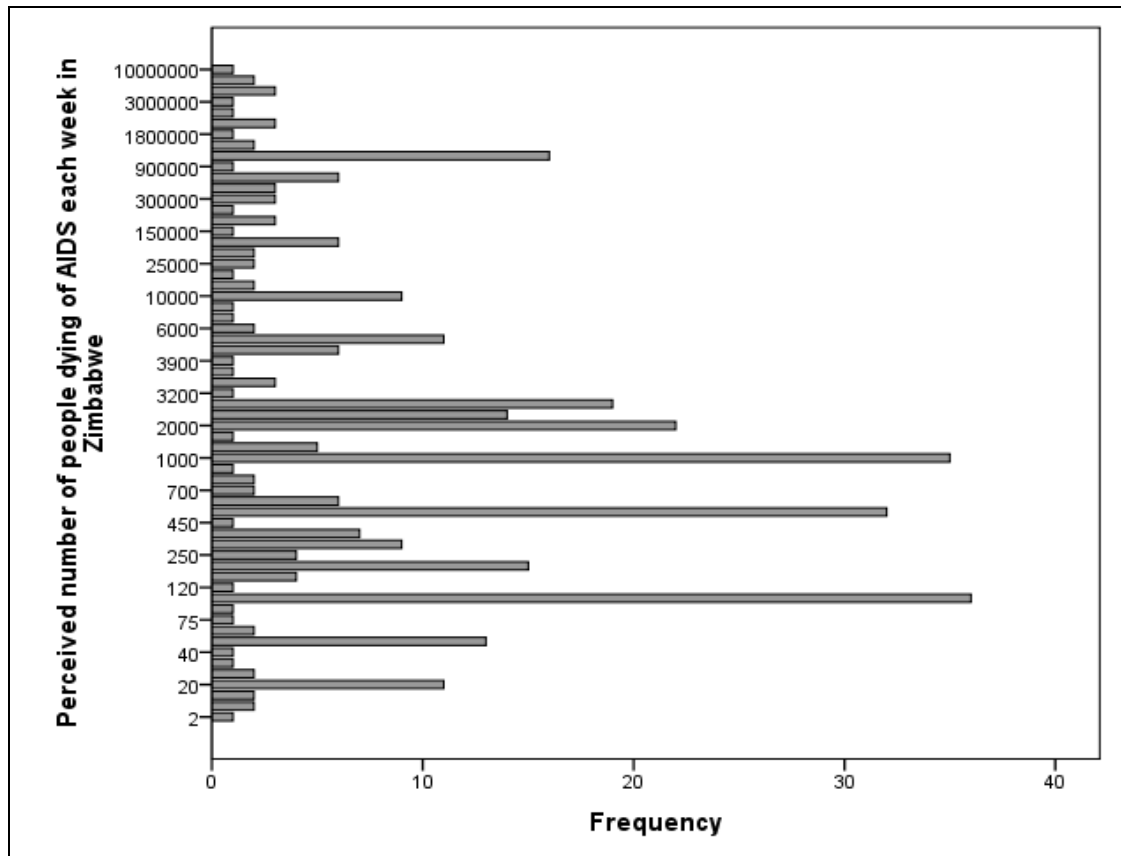


Fig 6.1 Perceived number of people dying of AIDS each week in Zimbabwe in 2007.

Some respondents during in-depth interviews reported that many people were resorting to saving their few resources to attend funerals than to visit terminally ill patients. Once

they are informed of a terminal illness of their loved ones, they instantly decide not to visit them while they are ill in an attempt to save money should there be a funeral. In the Zimbabwean cultural context, it is an obligation that all family members and relatives attend the funeral. If one does not attend, they risk the accusations of being responsible for killing the deceased as they will be blamed for having be-witched the dead person. If it does not get to such an extent, the non attendant relative will risk being accused of not caring for family affairs and will have no one caring for them should they need help. Some families take this practise so seriously that they would wait for several weeks for relatives located across the globe to travel back for the funeral. However some reported that as the death rates constantly rise creating a financial burden for families, those with relatives abroad are now asking them not to attend the funeral but send remittances instead. The severity of the crisis in Zimbabwe is resulting in the extinction of such cultural practices .

Another disturbing observations were a strange apathy that Harare residents possessed. The research found that normalization, in the sense of adjusting reality to take account of the miseries of the crisis situations in Harare was evident. One respondent associated effects of mass emigration by fellow Zimbabweans to other countries and high death rates as the same by commenting:

'... we cannot tell who is dead and who is in the Diaspora nowadays. As those in the Diaspora did not say goodbye to us in fear of embarrassment should they get deported, and those who have died of AIDS have secretly escaped to their rural areas and died quietly because of shame and stigma. We really do not know where people are going, but what we know is a lot of people have gone, where to, we do not know, dead or Diaspora does not make any difference to us, in particular to some of us who do not receive any remittances'.

Another explanation of the low level of public concern on the severity of the HIV and AIDS epidemic was due to the fact that the HIV prevalence is an abstraction. The time-lag between infection with HIV and illness with AIDS is so long averaging eight to ten years, an incremental process which can be equated to climate change and irrelevant to those living and making survival strategies on a daily basis.

6.2 Perceptions of vulnerability

People's behavioural responses are based very much upon their perceptions of vulnerability or risk. The ways in which people perceive risk within the context of a disease such as HIV and AIDS is influenced by their conceptualisation of certain key aspects of the syndrome and their lifestyles. Each individual has his/her own perception of the likelihood of experiencing a condition that would adversely affect one's health. Individuals vary widely in their perception of vulnerability to a disease or condition. Those at the low end of the extreme deny the possibility of contracting an adverse condition. Those individuals at the high extreme of susceptibility feel there is real danger that they will experience an adverse condition or contract a given disease.

Through asking various questions from the questionnaire and in-depth interviews, the study measured individuals' levels of knowledge regarding risks of infection and their willingness to be tested for the virus. Knowledge of HIV status helps HIV-negative individuals make specific decisions to reduce risk and increase safer sex practices so that they can remain disease free. Among those who are HIV infected, knowledge of their

status allows them to take action to protect their sexual partners, to access treatment, and to plan for the future.

To assess awareness of HIV testing services, research respondents were asked whether they had ever been tested for HIV. If they had never been tested, they were asked their willingness to be tested. Only 39.94% of the respondents reported to have been tested for HIV whilst 60.06% have never been tested as shown by Fig 6.2 below.

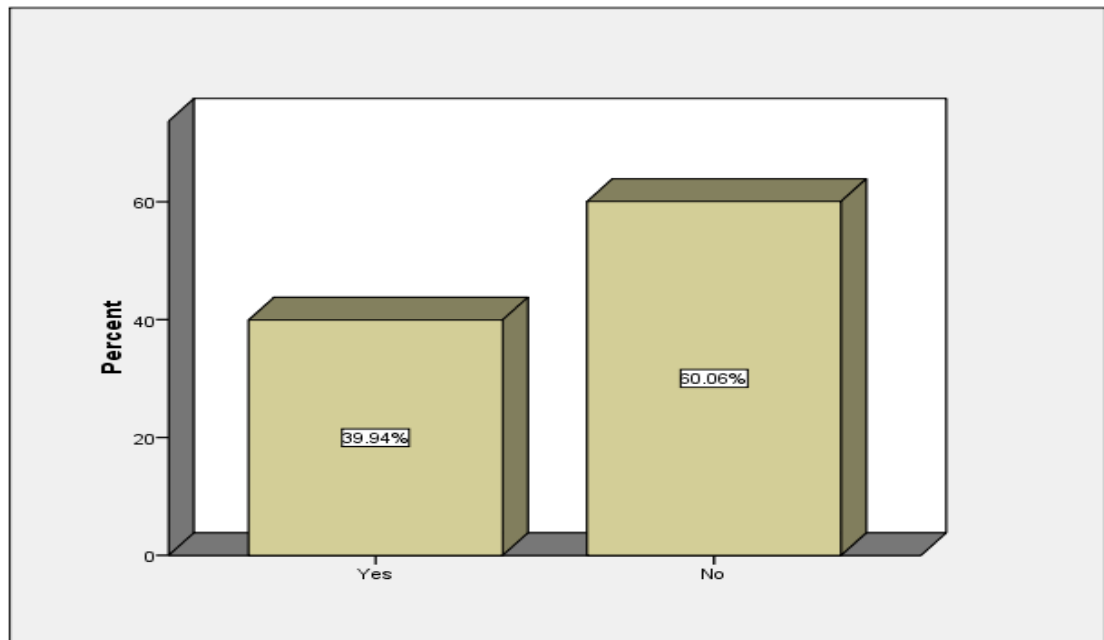


Fig 6.2 Percentage of respondents tested for HIV.

(Source : Survey Data, 2007)

Reasons for getting tested include; just knowing one's status, partner initiating the suggestion of going for HIV tests, doctor's requirement, company policies at work and antenatal clinic requirements. Only 37.5% of those not yet tested were willing to be tested whilst the majority declined with reasons such as ; getting an HIV test is a stressful process and if discovered to be HIV positive, one is more likely die of stress well before developing AIDS. Others were very ignorant and boastful that they knew they were negative and will

never get infected. Table 6.1 below shows that 67.2% of the respondents were confident it was very unlikely that they already were HIV positive.

Table 6.1 The likelihood that respondents think they are already HIV positive

	Frequency	%	Valid %	Cumulative %
Valid	1	.3	.3	.3
Very Likely	6	1.7	1.7	1.9
Likely	45	12.4	12.4	14.3
Unlikely	67	18.5	18.5	32.8
Very Unlikely	244	67.2	67.2	100.0
Total	363	100.0	100.0	

(Source : Survey Data, 2007)

Such perceptions can be due to the fact that 89.9% of the respondents identified themselves as Christians. Christianity plays a significant role in people's beliefs in Zimbabwe and it is common to proclaim positive declarations and prophecies over their lives hence some believing they will never be infected with the HIV virus because God is protecting them. Only 34 respondents were simply not interested in getting tested and believed that the whole HIV epidemic is someone else's problem and not theirs. All interviewees who were not tested for HIV were asked if they thought they were at the risk of infecting others without their knowledge and only 18% said yes. All respondents were asked how often they worry that they might get HIV, if to their knowledge they were negative and 47% admitted they never worry about it as shown in Fig 6.3 below. This is an extremely worrying attitude towards the epidemic, in a country reported to have one in every four adults infected with the virus.

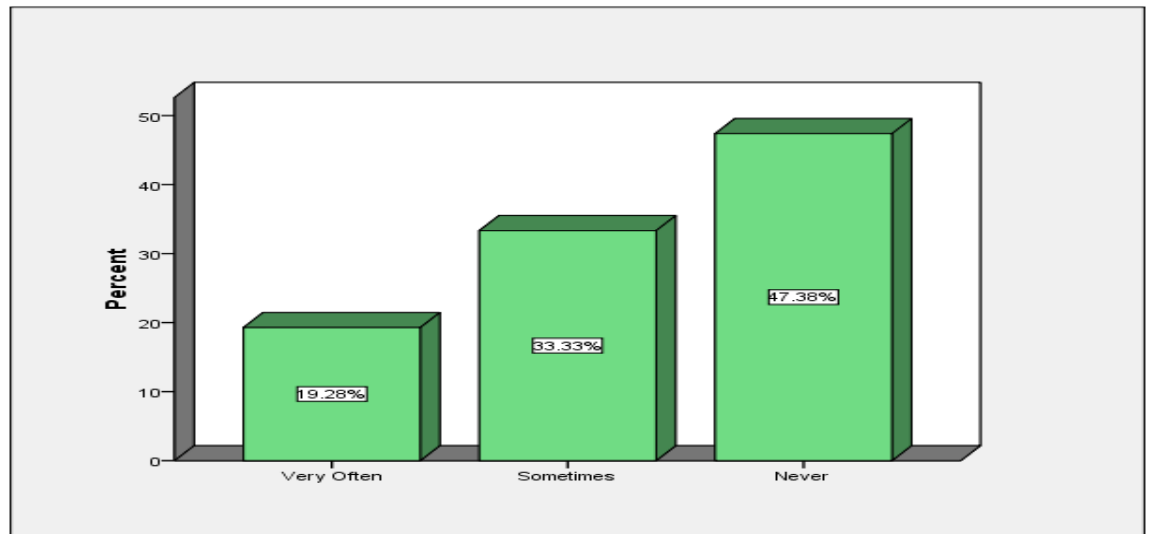


Fig 6.3 Percentage of respondents concerned about getting the HIV virus.

(Source : Survey Data, 2007)

To examine the validity of such claims, the study also asked how likely it is that they will get infected by the HIV virus in the next five years and the results are shown in Fig 6.4 below:

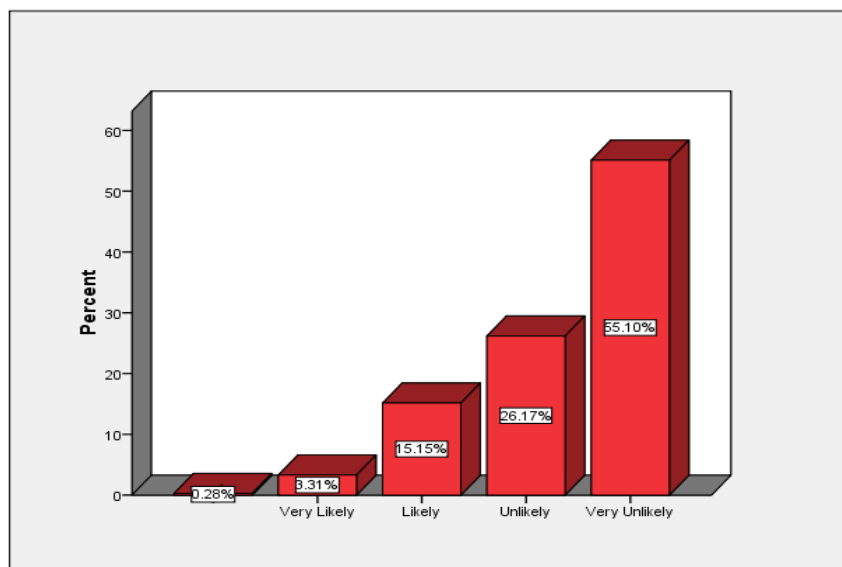


Fig 6.4 Perceived likelihood of getting infected in the next five years

(Source : Survey Data, 2007)

The research also assessed the levels of agreement to the statement that one gets HIV and AIDS if engaging in high risk sexual behaviour¹⁰¹ as shown In Table 6.2 below:

Table 6.2 You can get HIV and AIDS if you engage in high risk sexual behavior

		Frequency	%	Valid %	Cumulative %
Valid	Strongly Agree	217	59.8	59.8	59.8
	Agree	123	33.9	33.9	93.7
	Uncertain	6	1.7	1.7	95.3
	Disagree	9	2.5	2.5	97.8
	Strongly Disagree	8	2.2	2.2	100.0
	Total	363	100.0	100.0	

(Source : Survey Data, 2007)

Those who strongly disagreed with this statement gave an example of commercial sex workers (CSW). There are wide reports in Harare that those in the commercial sex industry were found to have lower HIV prevalence rates as compared to married couples or committed relationships. The National AIDS Council key informant explained that that CSW being aware of their vulnerabilities have the highest percentage of condom use than those in a stable relationship.

There were discrepancies between adequate levels of HIV and AIDS knowledge and inadequate levels of risk reduction behaviour. Eighty two percent of respondents admitted

¹⁰¹ High-risk sexual activity includes any behaviour that would cause participants emotional or physical harm. High-risk sexual activities include unprotected sex, sex before the legal age of consent, and multiple sex partners that can result in contraction of the HIV virus.

having high risk groups¹⁰² in their areas of residence such as commercial sex workers, truck drivers, cross border traders, peers, rich people, young people, single mothers and night club goers.

Perception of risk also depends on the individual's own self perception and self categorization. It also appears that an individual's response to health education campaigns also depends on his or her view of him or herself in relation to at-risk groups. Fifty three percent of the respondents agreed that both the rich and poor in socio-economic class system were equally vulnerable to contracting HIV. However, a total number of 99 respondents argued that rich people were more at risk than the poor. On a personal level, only 26.4% of the respondents reported that their present standard of living or their quality of life makes them vulnerable to being infected.

In the Central Business District (CBD) of Harare, at *Fourth Street* bus terminal, The researcher interviewed public transport drivers and their conductors, commonly known as Mahwindi in Shona. The minibuses run shuttle services to different suburbs around the city centre and they depart from their designated places at the old run down bus station. A significant number of these drivers and conductors claimed that they were being approached by professional female workers who have to commute to work offering them

¹⁰² A group of people in the community with a higher-than-expected risk of being infected by the HIV virus, which may be defined on a measurable parameter—eg, lifestyle, habit, socioeconomic and/or educational feature, as well as environment.

sexual intercourse in exchange for free transport. One of the drivers reported to have agreed to such arrangements with more than five women; three of them were school teachers. In trying to validate such claims, the research findings suggest that such arrangements are in fact taking place due inadequate monthly salaries which is less than the cost of transport in just one week.

The Zimbabwean National AIDS Strategic Programme (ZNASP) tends to be focussed at high- risk groups hence creating stereotypical beliefs about people at risk, suggesting to the thinking that they simply recognise others who are HIV positive. A more psychological obstacle is the fact that the onset of the disease may be delayed for several years following exposure to the virus. Thus, the negative consequences of unprotected sex are uncertain and removed in time from the sexual act.

6.3 Environmental Cues and Access to preventive information

An individual's perception of the levels of susceptibility and seriousness provide the force to act. Benefits (minus barriers) provide the path of action. However, it may require a cue to action for the desired behaviour to occur. There is a triggering device, stimulated by private, perception or by communication from the media or other people. These cues may be internal or external. This research focuses primarily on external forces through exposure to mass media because of its potential role in determining knowledge, attitudes and beliefs in HIV prevention strategies.

6.3.1 Knowledge of HIV and AIDS and Prevention Strategies

Knowledge of how HIV is transmitted is crucial to enabling people to avoid HIV infection and the relationship between the knowledge and behavioural change is complex, configured through a combination of discourses, interests and actor agencies. In his study of how individuals and societies deny knowledge of atrocities, Stan Cohen (2001), distinguishes between three types of denial. The first is '*literal*': people simply refuse to accept what is happening although this is rare. A second is '*interpretative*', in which the basic outline of events is acknowledged, but the patterns and meanings are disputed. The last is '*implicatory*' denial, in which people absolve themselves of responsibility for what has happened. However in Cohen's schema, the most sophisticated form of denial is '*normalization*'. The intolerable becomes 'no longer news' and people invest in 'not having an inquiring mind about these matters'. Marguerite Daniel (2005), who studied orphans in Botswana and the household that foster them shows that 'denial' is not a passive activity of failing to look, but an active task of struggling to maintain 'normality' when it is assaulted at every turn.

Knowledge of the HIV and AIDS is an essential tool for measuring the effectiveness of prevention strategies. Knowledge levels were found to be high (98%) among both women and men. However, there were intra-population variations in the levels of knowledge where less than half women (44 %) and men (47 %) have what can be considered comprehensive knowledge about the modes of HIV transmission and prevention. Comprehensive knowledge means knowing that use of condoms and having just one uninfected, faithful partner can reduce the chance of getting HIV, knowing that a healthy-

looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission or prevention.

Although the majority of participants claimed that HIV infection is not visible to the naked eye, 31% of the participants said they used a person's appearance to decide whether or not he or she was HIV positive. Ninety percent had the knowledge that HIV infections can be prevented. Table 6.3 presents differences in the levels of knowledge of prevention methods.

Table 6. 3 Knowledge of HIV Prevention Strategies

Prevention Strategy	Frequency	Percentage
Abstinence	214	59%
Faithfulness	201	55.4%
Condom Use	236	65%
Not sharing sharp instruments	24	6.6%
Preventing blood contact	4	1.1%
Antiretroviral (ARVs)	2	0.6%

(Source : Survey Data, 2007)

HIV and AIDS prevention programmes in Zimbabwe focus their messages and efforts on four important aspects of behaviour: use of condoms, limiting the number of sexual partners or staying faithful to one partner, male circumcision, and delaying sexual debut among young people. Fifty five percent recognised that the risk of getting HIV can be reduced by limiting sexual intercourse to one uninfected partner. However, the findings suggest the youngest (age 15-19) respondents and respondents who have never been married and never had sex were less likely to have comprehensive knowledge of HIV and

AIDS than older respondents, never-married women and men who have ever had sex, and those who have ever been married.

Given that misinformation on HIV transmission could lead to poor adoption of preventive practices, it now appears that a more effective measure of an HIV education campaigns to a certain degree would be sustained reductions in the prevalence of specific misperceptions rather than measuring overall AIDS knowledge.

6.3.2 – Media as an agent of action in HIV prevention

Mass media interventions aim to prevent HIV by increasing knowledge, improving risk perception, changing sexual behaviors, and questioning potentially harmful social norms. Campaigns may utilize radio, television, and other outlets and ideally operate as part of multi-level efforts, in which mutually reinforcing messages are offered through interpersonal, community, and national channels. Mass media interventions are a critical part of an effective prevention approach and they offer a cost-efficient way to reach large numbers of people, including people who may be difficult to reach through interpersonal approaches, such as migrants and people living in remote areas. These interventions have the potential to influence social norms, engendering productive dialogue at the population level.

For the effectiveness of this prevention strategy, mass media programs should be implemented through multiple channels with mutually reinforcing messages. Radio and television, the most commonly used mass media, have been used creatively to target various populations through formats such as dramas, serials, and diaries. “Edutainment,” a

combination of education and entertainment, can be used to model and demonstrate behavioral patterns that affect people's risk of HIV, such as partner communication¹⁰³.

The question is how the epidemic has come to be known in Harare and what knowledge is privileged and how it gets deployed. In Zimbabwe, mass media initiatives are one of the key components of HIV and AIDS control and prevention programmes. Media representations of the disease are likely to be particularly powerful in influencing the lay beliefs about AIDS that people share. Hence mass media is increasingly becoming recognized by those concerned with educating the public as offering an extremely effective channel for communicating health messages. It provides the possibility of reaching more people, including those who might not otherwise be contacted, and it allows for a more sophisticated presentation of material than do many processes. There was therefore the need in this research to enquire more critically into the nature and consequences by what is popularly termed 'health education' in relation to AIDS.

The research questionnaire collected information on respondents' exposure to common print and electronic media. Respondents were asked how often they read a newspaper, listened to the radio, or watched television. This information is important because it indicates the extent to which Zimbabweans are regularly exposed to mass media, often used to convey messages on family planning, HIV and AIDS awareness, and other health topics. Specific items of information were included such as frequency of newspaper readership, radio listening and television viewing. The findings from the questionnaire show that 84.3% of the respondents agreed that they listen to the radio although there are

¹⁰³ SAfAIDS, 2006

variations in the frequency of listeners with only 53% reporting to listen to the radio every day. Similarly, 88 % of the respondents do watch television with 66% watching on a daily basis. Newspaper readership was almost at similar levels with 82% reporting to read newspapers, although at this stage, only 34% respondent to be reading the newspapers every day as shown in Table 6.4, Table 6.5 and Table 6.6 respectively:

Table 6. 4 Frequency of Radio Listeners

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	.3	.3	.3
Less than once a week	8	2.2	2.2	2.5
About once a week	34	9.4	9.4	11.8
2-3 days a week	56	15.4	15.4	27.3
4-5 days a week	16	4.4	4.4	31.7
Everyday	193	53.2	53.2	84.8
Occasionally	3	.8	.8	85.7
88	52	14.3	14.3	100.0
Total	363	100.0	100.0	

Table 6. 5 Frequency of TV Watching

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	.6	.6	.6
Less than once a week	4	1.1	1.1	1.7
About once a week	19	5.2	5.2	6.9
2-3 days a week	36	9.9	9.9	16.8
4-5 days a week	17	4.7	4.7	21.5
Everyday	242	66.7	66.7	88.2
Occasionally	4	1.1	1.1	89.3
88	39	10.7	10.7	100.0
Total	363	100.0	100.0	

Table 6. 6 Frequency of Newspaper Reading

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than once a week	12	3.3	3.3	3.3
	About once a week	68	18.7	18.7	22.0
	2-3 days a week	70	19.3	19.3	41.3
	4-5 days a week	14	3.9	3.9	45.2
	Everyday	125	34.4	34.4	79.6
	Occasionally	12	3.3	3.3	82.9
	88	62	17.1	17.1	100.0
	Total	363	100.0	100.0	

The research findings suggest the main reason for this drop in the frequency of readership is the inaccessibility of the papers due to exorbitant prices which the majority of Harare residents can not afford. Buying a newspaper was seen as a luxury commodity at the time the research was done. The study also notes that the majority of those who read the newspapers on a daily bases mostly access them at work and would not have paid for the papers themselves.

Exposure to media campaigns may alert people to health threats and thereby trigger preventive behaviour after other cognitive prerequisites are in place. According to the data analysis, 69% of the respondents reported that they have either heard or seen information about HIV and AIDS in the past month. Sources of information include radio, television, workplace, newspapers and magazines, posters, billboards, N.G.Os, health workers, counsellors as well as friends and relatives. Main thematic areas that were reported to have been heard about included campaigns for 'Positive Living' and encouraging disclosure of one's status, mobilisation for HIV voluntary testing, stigma and discrimination as well as condom use.

One of the significant findings is that the media is still a long way from the kind of open and honest reporting necessary to counter the problems of stigma and shame still prevalent in various communities in Zimbabwe. HIV and AIDS is still being reported as primarily a health issue, much reporting centred on speeches and workshops and statistics. Main issues are reported simplistically or in poorly argued features, which lead to erroneous or uncertain conclusions. Such reporting reflects widespread awareness of the disease that expose weak journalistic skills. Various respondents argued that HIV and AIDS is not a news item that can be reported in a retroactive fashion, that is telling what happened yesterday as it is an ongoing battle. Therefore the challenge for the media is how to ensure sustainable reporting in a way that continues to inform, educate and encourage behaviour change as well as encouraging society to incorporate new beliefs and ideas in fighting the disease.

In places where there was previously limited information from only few authoritative sources, many messages are now being passed between growing numbers of individuals and organisations in increasingly networked societies. Multiple technologies of the internet and mobile phones are also changing how people communicate. Harare now has a growing trend of people sending each other biblical text messages via mobile phones and e-mails. Employed respondents interviewed admitted sharing e-mail messages not job related with colleagues. They also admitted forwarding gospel messages they receive to various networks they are signed up to. Such findings suggest that Information Communication Technology (ICT) can potentially become one of the effective avenues of HIV and AIDS information dissemination in Harare. The city however is in need of a vibrant, professional, free and independent media which is vital to bringing HIV and AIDS related problems under control.

There has been an increased focus on 'Positive Living', a campaign that encourages HIV positive individuals to learn to accept their HIV-infection and look after themselves in the best possible way. Survey respondents reported that the HIV prevention messages as unrealistic and unbelievable and many actors were well known to the audience through their previous roles on the screens. This implies that the personal relevance of health communication and socio-cultural factors may strongly affect an audience's response to health communication.

The research findings, through participatory observation noted that news, stories and on-air discussions set the agenda for what people discuss at home, in public transport and at other social events. However a growing consensus that most people are no longer afraid of the epidemic was evidenced, some to the extent of stating that HIV and AIDS adverts on radio and television are now boring and non-educative. Thus, development of a communications campaign must be strategic and aligned to the achievement of specific and measurable outcomes. Critical elements to a campaign's success include understanding the target audience, including the most efficacious media to reach them; pre-testing messages; modifying the campaign, if needed, based on post-test results; and measuring the cost-effectiveness of the media used.

The research findings also suggest the size of the impact can be small to moderate. The effects of mass media may be short term, and reinforcement of messages is needed to sustain behavior change. Moreover, individuals need to be exposed to a variety of prevention messages, because risk factors for HIV change over an individual's lifetime.

6.4 Perceived Effectiveness of Preventive Behavioral Strategies

Just as combination treatment attacks the HIV virus at different phases of virus replication, combination prevention includes various safer sex behaviour strategies that informed individuals who are in a position to decide for themselves can choose at different times in their lives to reduce their risk of exposing themselves or others to HIV. These are often referred to as the ABCs of combination prevention¹⁰⁴. ‘A’ means abstinence—not engaging in sexual intercourse or delaying sexual initiation. Whether abstinence occurs by delaying sexual debut or by adopting a period of abstinence at a later stage, access to information and education about alternative safer sexual practices is critical to avoid HIV infection when sexual activity begins or is resumed. ‘B’ means being safer by being faithful to one’s partner or reducing the number of sexual partners. The lifetime number of sexual partners is a very important predictor of HIV infection. Thus, having fewer sexual partners reduces the risk of HIV exposure. However, strategies to promote faithfulness among couples do not necessarily lead to lower incidence of HIV unless neither partner has HIV infection and both are consistently faithful. ‘C’ means correct and consistent condom use, condoms reduce the risk of HIV transmission for sexually active young people, couples in which one person is HIV-positive, sex workers and their clients, and anyone engaging in sexual activity with partners who may have been at risk of HIV exposure. Research has found that if people do not have access to condoms, other prevention strategies lose much of their potential effectiveness¹⁰⁵.

¹⁰⁴ Global HIV Prevention Working Group, 2003

¹⁰⁵ UNAIDS, 2005 - http://www.unaids.org/epi/2005/doc/docs/en/QA_PartII_en_Nov05.pdf

6.4.1 Abstinence

Abstinence is often targeted at the youth. Virginity, particularly of girls, is a traditional standard, reinforced by religion, which has been the bare sexual advice that most parents were, and remain uncomfortable to give to their children. It is usually not easy for people to sustain changes in sexual behaviour. In particular, young people often have difficulty remaining abstinent, and women in male-dominated societies are frequently unable to negotiate condom use, let alone abstinence. Some societies find it difficult to discuss sex openly, and some authorities restrict what subjects can be discussed in the classroom, or in public information campaigns, for moral or religious reasons. This means that efforts to spread the abstinence messages may prove fruitless. A significant number of 221 respondents reported it was easy to abstain from sex until marriage. A staggering 80% went on to agree with the fact that sexual abstinence is the best method of preventing HIV infections as shown in Table 6.7 below;

Table 6. 7 Sexual Abstinence is the best method in preventing HIV infections.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Agree	292	80.4	80.4	80.4
Uncertain	15	4.1	4.1	84.6
Disagree	56	15.4	15.4	100.0
Total	363	100.0	100.0	

The research suggest this is not a surprising outcome in a society largely guided by Christian values and morals. Another possible explanation is the relatively lower levels of age at first marriage, under 20 years. However, one needs to bear in mind that these are only perceptions of the best prevention method and do not necessarily translate into practice.

6.4.2 Be Faithful

Forty seven percent of the respondents admitted only to have had one sexual partner in the last 12 months, and only 8% had two partners as shown in Table 6.8 below.

Table 6. 8 Number of sexual partners in the last 12 months.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0	26	7.2	7.2	7.2
1	172	47.4	47.4	54.5
2	30	8.3	8.3	62.8
3	11	3.0	3.0	65.8
4	6	1.7	1.7	67.5
5	3	.8	.8	68.3
6	3	.8	.8	69.1
10	3	.8	.8	70.0
13	1	.3	.3	70.2
15	2	.6	.6	70.8
20	2	.6	.6	71.3
24	1	.3	.3	71.6
27	1	.3	.3	71.9
52	1	.3	.3	72.2
88	101	27.8	27.8	100.0
Total	363	100.0	100.0	

The responses varied with those above three sexual partners at less than one 4%. Only one respondent out of 363 claimed to have had as many as 52 sexual partners. Only 16% admitted to have had sex with a person other than their spouse or steady partner in the last 12 months as shown below in Table 6.9.

Table 6. 9 Sex with a person other than spouse/steady partner in the last 12 months.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	61	16.8	16.8	16.8
No	195	53.7	53.7	70.5
Dont Remember	4	1.1	1.1	71.6
Not Applicable	103	28.4	28.4	100.0
Total	363	100.0	100.0	

It is interesting to note that half of the sample population (a significant 49.6%) reported to have had a constant number of sexual partners in the last 12 months, with 17.9% on the decrease and only 4% reporting to have increased the number of sexual partners. To understand the factors and attitudes influencing this pattern of sexual behaviour, the respondents were asked if it is customary to indulge in casual sex and only 21% agreed to this claim.

Reduction of sexual partners and or monogamy ¹⁰⁶ is a strategy which is targeted mostly at adults who are in some form of union yet to many women, this message is irrelevant because they are already monogamous. What is alarming is that the data collected from Ministry of Health and Child Welfare showed HIV infection rates among ante-natal mothers as high as a result of being infected by their spouse. However, the complex interaction between the economic marginalization of women, the increase in the number of female-headed households and the deterioration of the economic situation in Zimbabwe has also rendered multiple sexual partners necessary and sometimes the only option to obtain any source of income.

Whilst 82.3% believe a person can prevent HIV infection through faithfulness, 66% disagreed that the Zimbabwean man of today can be faithful, whilst it was 57% for women. Twenty two percent believe it is natural for a man to have multiple sexual partners. Others who totally disagreed that faithfulness can prevent HIV infection pointed out other forms of transmission such as, mother to child transmission and infected blood transfusion products. Respondents argued faithfulness was also being hampered by the current regional

¹⁰⁶ Marriage with only one person at a time.

and international migration trends that have become characteristic of the Zimbabwean society.

One of the significant findings in the research is that the crisis conditions in the country forced a significant number of men to become faithful unwillingly. This was reported during in-depth interviews and noted during participatory observations that men began returning home straight after work and have stopped drinking alcohol due to exorbitant prices. In the past, such men would be coming home in late hours of the day after having passed through the community beer-halls. Others who were open about having many mistresses could no longer afford to maintain two separate households. Such findings coincide with those later found by various African researchers including Michelle Faul (2009), who argued fewer Zimbabweans are getting infected with HIV due in part to a battered economy that's leaving men short of money to be sugar daddies and keep mistresses. Presenting a study of the infection rates among pregnant women at 2009's International AIDS conference in South Africa, Dr Michael Silverman also reported the prevalence of the virus that causes AIDS fell from 23% in 2001 to 11% at the end of 2008. His study was based on tests of 18 746 women at a prenatal clinic in rural Zimbabwe over that period. Silverman, a Canadian infectious disease expert, works at Howard Hospital in Zimbabwe, where the women were tested. He concluded that;

'... a lot of the effect of the decline in HIV infections is from the collapsing economy. Aids experts have long noted that the richest countries in Africa are also those with the highest infection rates. You can't pay the sex worker if you have no currency and it is hard to have a concurrent relationship if you're always

*in earshot of your spouse, because you can't afford to travel. Because of the economic collapse, people are forced to stay home, like being in quarantine*¹⁰⁷."

6.4.3 Condom Use

One of the behavioural change indicators is increased condom use which is view as one of the main strategies for combating the spread of HIV and secondary sources revealed that the main objective of the ZNASP 2006 -2010 under condom distribution is to make more widely available both re-branded public sector and socially marketed condoms in rural and remote areas. Condom promotion and distribution is spearheaded by both the public sector, the Ministry of Health and Child Welfare and the Zimbabwe National Family Planning Council (ZNFPC) and civil society organisations such as the Population Services International (PSI). The National Female Condom Strategy 2006 to 2010 was also developed and is currently being implemented.

Condom procurement and supply is done by ZNFPC, which carries out systematic forecast of condom consumption needs. All procured commodities are assessed for quality by the Medical Council of Zimbabwe and all commodities that fail the test are destroyed. Distribution of commodities is through a Delivery Team Topping-Up System (DTTU), where visits are made bi-monthly to health facilities for replenishment of commodities according to consumption data¹⁰⁸.

¹⁰⁷ National HIV/AIDS/ STI/TB Council, Zambia in *AIDS Matters*. No. 78, 2009.

¹⁰⁸ ZNASP 2006-2010 MTR, July 2009

In the early 1980s, Zimbabwe became one of the first countries in the Sub Saharan African region to implement programmes to manage sexually transmitted infections, and condom distribution began in the early 1990s, steadily increasing over the years. Then, the public sector was the principal provider of male condoms but today, the international non-Governmental organizations now account for more than a half of all condoms distributed. The fact that most condoms were now purchased rather than freely distributed, makes it more credible that people really do use them.

It is worth noting that despite high levels of knowledge about condoms in Zimbabwe, statistics from the Zimbabwe Demographic Health Survey (2005-2006) reports show that on a national level, only about 16.4% and 43.7% of women and men respectively aged 15 – 24 years used condoms at first sexual encounters¹⁰⁹ Additionally, repeated studies show that the overwhelming majority of people fail to use condoms consistently and correctly despite appropriate knowledge and education. However, making a comparative analysis with regional countries in Sub-Saharan Africa with high levels of HIV prevalence rates, it is argued that condoms are a huge success story in Zimbabwe where 900 000 female condoms were sold in 2005 alone, the highest sales per capita in the world¹¹⁰.

There are however slight variations when comparing the above Government statistics with the results in our findings. There is no dispute to the fact that the condom use programme was relatively a ‘success story’ in Zimbabwe. Our research findings suggest that the levels of consistent condom use and trust on it as an effective prevention strategy is decreasing.

¹⁰⁹ ZHDS, 2006.

¹¹⁰ UNAIDS, 2006

Fig 6.3 presents the percentages of the condom users amongst our respondents where 49% reported never having used a condom during their sexual encounters.

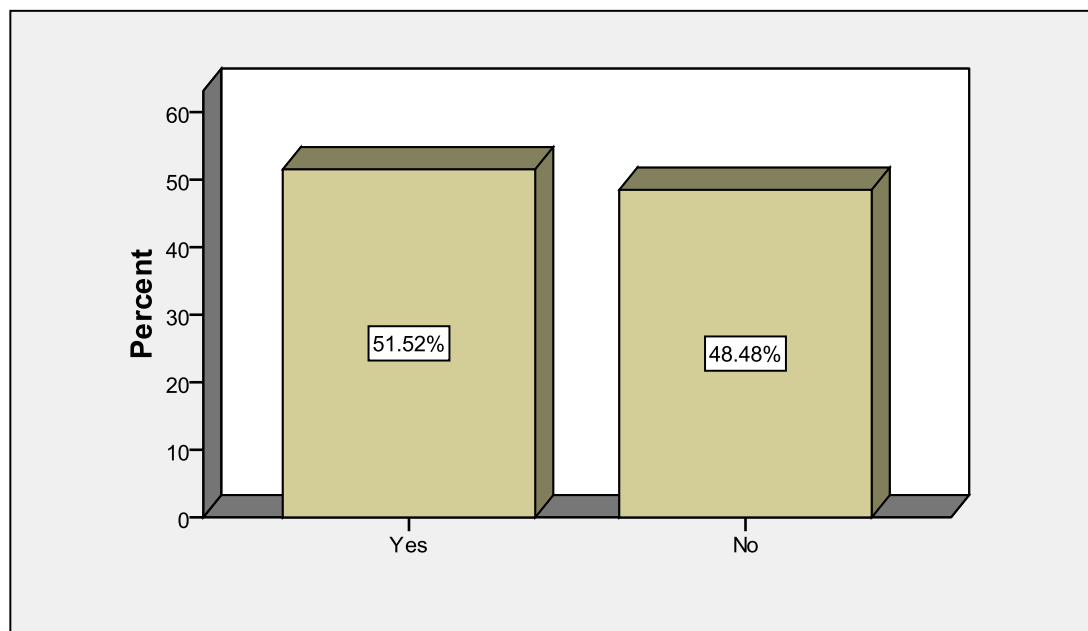


Fig 6.3 Have you ever used a condom?

(Source: Survey Data)

Table 6.10 shows the perception respondents have on condoms as an effective tool for prevention of HIV infection.

Table 6.10 Condoms can effectively prevent HIV and AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	149	41.0	41.0	41.0
	Uncertain	68	18.7	18.7	59.8
	Disagree	146	40.2	40.2	100.0
	Total	363	100.0	100.0	

Those that reported to have used a condom accessed them through purchasing, freely distributed by prevention advocates or their partners had them despite the fact that only 19% of this group use the condoms consistently every time they engage in sexual

intercourse. It is to some extent a fact that a significant number of Harare residents have considered or actually have changed their sexual behaviour if we apply the commonly used measurement rod of condom use. Through in-depth interviews, searching for behavioural change one young Zimbabwean commented,

“...I am not sure if sexual attitudes are changing altogether, but I tell you around the streets of Harare you will see lots of used condoms on the ground”

However, there are also various reasons of non-condom use including abstinence, being faithful and trusting partners in particular those that are married. Others do not believe the effectiveness of a condom, whilst some reported having used them once and did not like them at all. Only 19.6% of respondents that do not use condoms intend to use them in the next 12 months despite the fact that almost everyone interviewed (93.4%) knew where to get the condoms if they happen to need them. When given a scenario to test their attitude on condom use, nearly 60% reported that should an opportunity of having sex arose without a condom, they would let it pass until they secure a condom.

Despite repeated media warnings about the association between unprotected sex and AIDS transmission, there are indications that consistent use of condoms is not a typical practice for large numbers of the sexually active. It is universally acknowledged that consistent and careful condom use is a far more effective method of reducing HIV infection than is reducing the number of sexual partners. Therefore, changing sexual practices, and particularly convincing people to use condoms every time they have intercourse has become a central goal of AIDS prevention and educational programmes. Most programmes have focused on bringing about individual behavioural change.

Among heterosexuals, condoms are considered methods for birth control rather than a means for preventing sexually transmitted diseases. Therefore, sexually active couples tend to use other forms of contraception, such as birth control pills, hence increasing the risk of exposure to AIDS. The in-depth interview with the Zimbabwe Aids Network informant suggest that married women are now able to address condom protection with husbands indirectly, through discussion of family planning for the welfare of children. The wives are careful not to bring up the subject of infidelity; instead, they talk about preventing pregnancy in view of the economic hardships involved in raising the children they already have. The danger comes when the husbands insists on the wives to take contraceptive pills or having the injection instead of using condoms.

One of the significant hindrances to the faithfulness strategy is that some evidence points to the deterioration of the moral fibre in Harare as evidenced by the sprawling of brothels and night spots and increases in the number of commercial/casual sex workers (CSWs) on the streets. The deteriorating economy is also to blame for the increased prostitution as more and more women are becoming vulnerable by the day. A 2006 study carried out in Harare revealed that the majority of the CSWs (90%) were single mothers and divorcees¹¹¹ (IDS, 2006). What is encouraging however this that the majority of CSWs are not afraid of insisting on condom use, a practice not common among married women. The focus of vulnerability is gradually shifting to the marriage institutions given the fact the just over half of the respondents agree that it is acceptable for a woman to bring a condom in a sexual relationship, as discussed below:

¹¹¹ Institute of Development Studies, 2006.

More recently, the medical community has begun shifting from the condom approach and placing a greater emphasis on risk-avoidance techniques. AIDS educators often publicly promote approaches that would not be normally met in real lives, such as the notion that it is acceptable for our spouses or children to have multiple partners, provided condoms are used. What is interesting to note is that the issue is not whether the condom do or do not protect against AIDS, but about the sort of culture which 'condomisation' promotes, and the sort of people we become as a result. Condomisation becomes a metaphor for incursion of postmodern culture in Africa. This has not been received very well in the African context as the following statement suggests:

'Teaching our children to use the garment of whoredom (condom) that was designed by the "whiteman" to promote fornication amongst their kindred is not the answer to HIV and AIDS in Africa. Have you not seen the town's most notorious harlot pregnant often. Were there no garments of whoredom to put on while whoring? The garment of whoredom is often put on once or twice and the third time there is already some fake degree of trust between the fornicators. So nomatter how many of those garments you litter in all public toilets, people will catch AIDS and other diseases of the bed. The answer is the return to Unbu/ubuntu - African cultures of our fathers and leave fornication alone. If we grill our children in Ubuntu, none would die of AIDS, there is no wisdom in giving children freedom to die. Children do not know anything, we need to force that on them. Also we need to be more strict with our women as African culture has done for years because if they do not open it means no fornication (Katangole ,2000).

In conclusion, whilst prevention messages regarding correct and consistent condom use as an effective method against HIV are highly important, most participants are aware of this and are still not using condoms. These results suggest there may be other important factors that may explain lower condom use amongst Harare residents. However, the

perception that condoms make sex less enjoyable was the correlate most strongly associated with lower condom use. These findings suggest that it would be beneficial to focus future researches on reasons why condoms make sex less enjoyable, including the physical characteristics of a condom that discourages use.

6.5 Anticipated barriers to performing preventive behavior.

In any given health campaign for behavioural change, it is important to bear in mind that action may not take place, even though an individual may believe that the benefits from taking action are effective. This may be due to barriers which relate to the characteristics of a treatment or preventive measure such as inconvenient, expensive, unpleasant, painful or upsetting. These characteristics may lead a person away from taking the desired action. Other possible reasons include negative consequences of these changes. These are potential negative aspects of performing the preventive behaviour, including estimates of physical, psychological, financial and other costs incurred in performing the behaviour. This section highlights factors that have to a larger extent influenced the resistance in sexual behavioural change in amongst Harare residents.

6.5.1 Voluntary Counseling and Testing Programmes

The Government emphasised the importance of voluntary counselling and testing for HIV (VCT) with its National AIDS Policy in 1999, which highlighted VCT as a central part of Zimbabwe's AIDS prevention strategy. Between 2004 and 2005 the total number of VCT sites increased from 292 to more than 430, with every health district now containing at least one site that provides the service.

Despite these advances, there is still a strong reluctance to access testing amongst much of the population as reported earlier in this chapter that only 39% of the respondents have been tested for HIV. In Harare, the findings suggests that the HIV Testing centres are still a long way in convincing the residents that finding out that one is HIV positive is the best thing one can do for themselves. It is believed that this will encourage what is commonly known as 'Positive Living', where infected persons continue living their lives positively and productively. The worst thing that people are still practicing is choosing not to know their status, and wait until they are really ill, almost dying, before getting tested, which might be too late.

One possible explanation of the low numbers of people going for VCT is the type of mass media campaigns that were disseminated at the beginning of the AIDS campaigns in the early 1990s. The adverts carried very frightening messages and being HIV positive was said to be equal to a death sentence. As a consequence, very few dared to find out whether they were infected or not. This has become one of the biggest obstacles to fighting the epidemic simply because as long as a small fraction of the population gets tested and the rest do not, the preventive strategies will remain ineffective. Policy makers have no idea what kind of realistic figures they are working with.

The researchers argues the singling out of HIV and AIDS as a special kind of disease in turn contributes to its bad reputation and turns into a negative spiral of silence and denial. It is a normal procedure to test leukaemia, brain tumours and other potentially more fatal illnesses, and afterwards, the doctors consult the patients on the options open to them, but HIV is treated very differently. Koblanck (2005) tells a story in her book, *'A Few Days More: The story of a young woman living with AIDS in Botswana'* of a grandmother who came to

the hospital several times with her grandchild who had different infections. On one occasion, the doctors sat down with her to suggest she should have the child tested for HIV. She just looked at the doctor and said:

‘...but doctor, I’ve been here four times already. You have taken blood samples from my grandchild, you have x-rayed him, you have done all kinds of tests and you have stuck a needle in his back to take a sample of his spinal fluid, but you did not ask for permission for any of those things. Why are you asking me for permission for this?’

This medical policy has been a hindrance in fighting HIV and AIDS. How then can doctors only try to find causes of certain kinds of disease, and have to ask a patient for special permission concerning HIV? It is becoming commonly known that some public health specialists regret this ‘*AIDS exceptionalism*’ and argue that it is inappropriate, especially in Africa¹¹². Instead they argue for a normalization of AIDS, namely treating HIV and AIDS more like other infectious disease for which early diagnosis is essential for appropriate therapeutic and preventive measures, within the requirements of informed consent and respect for confidentiality. As a result, if HIV and AIDS is recognised as the emergency that it undoubtedly is, people would be much more forthright in recognizing that the rights of the individuals must be balanced against the well-being of the majority

¹¹² Koblanck, 2005.

6.5.2 Denial

Under high stressful conditions, denial is a response often used to protect against anxiety and worry. It can also reduce emotional distress, but can also hinder direct behavioural actions which may be necessary to reduce one's risks. Defensive denial may occur primarily when people already have some reason for believing they are at risk. Denial of personal risk appears to occur in spite of fairly accurate knowledge of the ways in which HIV is transmitted. Personal denial was encountered during the interviews. Individuals deny that they or their partners have HIV in the face of good reason to believe that they might be infected. But very few people dispute the existence of the HIV and AIDS epidemic altogether. Most people readily accept that HIV and AIDS exists, even though many refuse to accept the possibility that they might have contracted the virus.

6.5.3 Antiretroviral Therapy (ART)

Since ART¹¹³ became available in the mid- 1990s in the developed world and later in the developing world, HIV and AIDS has come to be viewed more like a chronic disease. Although HIV treatments are not effective for, adhered to, or tolerated by everyone over time, many promising new drugs being developed, a relatively low incidence of AIDS deaths may continue in the future. The HIV epidemic now faces challenges that other preventable chronic disease such as heart disease and diabetes similarly rooted in behaviour choices have faced for decades. The challenge for prevention is that people

¹¹³ Antiretroviral drugs are medications for the treatment of infection by retroviruses, primarily HIV. When several such drugs, typically three or four, are taken in combination, the approach is known as Highly Active Antiretroviral Therapy, or HAART.

appear to be more likely to knowingly put themselves at risk for a disease if morbidity and mortality from that disease are relatively distant outcomes.

Therefore, what this shows is that the advent of ARVs is slowly eroding people's fear of the disease and replacing that fear with the belief that HIV and AIDS is one of the very many infectious diseases. The in-depth interviews conducted show certain elements which suggests that ARVs are not regarded as life prolonging but rather as a cure to the epidemic by some Harare residents. Thus, those who have access to the ARVs such as the wealthy and financially able, the ruling elite and others are mostly polygamous and chances are that they practice unprotected sex with all their partners. The basic reason is that should they fall sick then they can purchase ARVs and other immune boosters that have flooded the market. Therefore there is a breeding ground and infrastructure for the continued transmission of HIV among the city's population, unless a new paradigm comes into effect that can see a reversal to current sexual behaviour and practices. There is the need for the realisation that ARV may help in alleviating the suffering, but will not help contain the scourge and that disproportionate emphasis on ARVs and condoms in public debates could result in complacency and a false perception that there is a panacea for HIV and AIDS.

6.5.4 Migration

The impact of colonially driven social reorganisation saw spouses forced to live apart because of male labour migration from rural to urban areas. This trend in migration patterns continued after independence with the majority of people migrating to towns being men who were the breadwinners. However the migration patterns have started to

follow a different pattern since then with women also migrating in order to earn a living. Such migration has enabled the spread of HIV in cities including in Harare.

Migrants who come to reside in Harare usually do not have a place to stay so they look for temporary accommodation in the event that they do not have relatives to put up with. Men can survive in bad accommodation conditions but in most instances women look for men to live with and they cohabit. This is a major driver of the HIV virus amongst people who migrate because once they earn their income; they go back to their original areas and infect their spouses in the process. Male labour migration also fuels the spread of HIV and AIDS through prostitution. As far back as the 1930s, men created second homes, which were called ‘deuxieme bureaux’ in Francophone Africa (sarcastically meaning second office), and in Zimbabwe, ‘mapoto’ now called small houses (ZHDR 2003). This behaviour fosters the spread of the HIV and AIDS epidemic because most of the men involved in such practices are married men who go back to their wives during holidays and weekends, thus creating an efficient transmission mode of HIV and sexually transmitted infections.

The worst economic crisis in Zimbabwe since independence in 1980 also has created categories of people known as “Diaspora orphans, widows and widowers,” people whose other family members fled the country as economic refugees and are living and working in neighbouring African countries, in Europe, Asia, the United States and Australia. An estimated four million¹¹⁴ Zimbabweans, a quarter of the population are believed to have left the country to find work abroad. The leader of the *Faith Based Council of Zimbabwe*, a Christian organization, said deepening poverty destroyed traditional family “safety nets”

¹¹⁴ IOM, 2012.

and eroded age-old African family support mechanisms. This has also hindered the HIV prevention efforts as most spouses are living for several years without seeing their partners, who are illegal immigrants or asylum seekers in various countries and are unable to return home.

6.6 Measure of Health Motivation

The final section in this chapter will give an account of the factors that motivate Harare residents to behavioural change. Specific questions were asked to measure the extent the respondents are likely to change their behaviour because of AIDS. In addition to the threat level, the HBM proposed that a person's willingness to engage in preventive health behaviour is influenced by the perceived benefits of performing the behaviour weighted against the potential negative aspects of not doing so.

This is the positive outcomes of performing the preventive health behaviour hence taking action toward the prevention of HIV infection is the next step to expect after an individual has accepted the susceptibility of a disease and recognized it is serious. The direction of action that a person chooses will be influenced by the beliefs regarding the action. The benefits are then weighed against perceptions of physical, financial and other costs or barriers inherent in the recommended health behaviour.

Being faithful and using the ABC approach might seem a simple solution, but our social natures are a little more recalcitrant than that hence the need of self-empowerment¹¹⁵. It is

¹¹⁵ Can be described as the process by which people develop skills, understandings, awareness so that they can act on the basis of rational choice rather than irrational feelings (Aggleton and Homans, 1988).

a process in which the individual uses his or her personal resources to the full thereby maximising their chances of leading a healthy life. The research findings suggests that some of Harare residents have failed to incorporate prevention message into sexual behaviour. They do not see the benefits of preventing themselves from dying of AIDS when they have much pressing survival issues to tackle. People's perceptions of their own health are likely to be related to their education, occupation and household income, self reported information on health obtained from the interviews was interpreted with caution. Fig 6.4 shows whether respondents have changed their sexual behaviour because of AIDS.

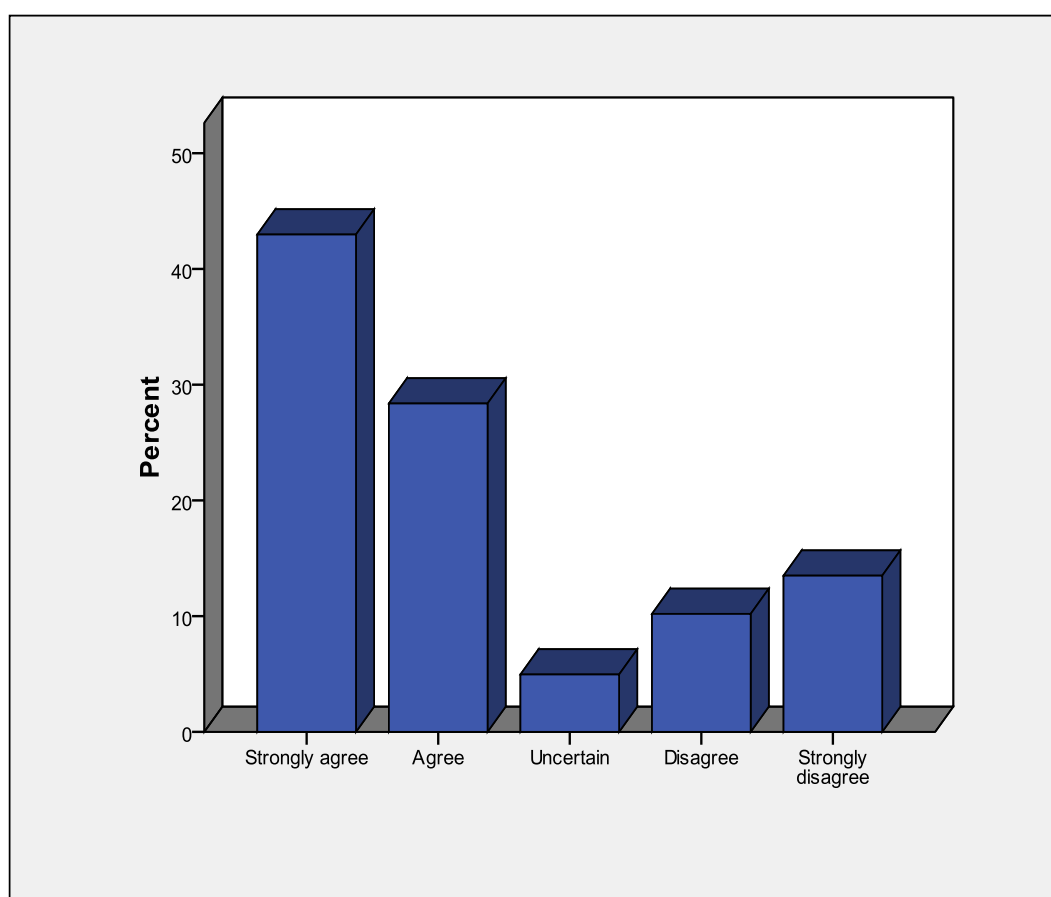


Fig 6.4 Changed Sexual Behaviour because of AIDS

(Source: Survey Data)

The motivation for sexual behavioural change includes, fear of HIV and AIDS and STIs, religion, background and upbringing, faithfulness and personal experiences of HIV illness or deaths from AIDS within the family and amongst friends. Personal experience is a powerful stimulus to action and lack of previous personal experience tends to increase unrealistic optimism about vulnerability. Personal contact with someone who has HIV and AIDS also personalises the sense of risk.

The people in Harare are surviving through a process of 'involution', which refers to short-term adaptations that they make in the face of such problems they feel they are powerless or cannot do anything to resolve them. Central to these findings is that some of the people respond by clinging to the past and maintaining a reassuring familiarity. Over time, these stratagems become fixed and maladaptive, institutionalising pervasive resistance to recognising that HIV and AIDS demands some far reaching changes in individual behaviour and social traditions. Anticipated longevity of individuals in Harare is a function of cultural, religious norms, individual outlook, and life experience, including observing the ages of death of one's elders and one's peers.

Sixty three percent reported to have personal knowledge of someone living with HIV through the patient disclosing their status to them, physical health observations, rumours and medical reports. Thirty two percent of those who know someone said it was someone in their family. The increased in the number of people who personally know someone who died of AIDS to 84% is disturbing with 67% of those being family members. Only 38% of the respondents have provided care to a relative or friend suffering from AIDS with 80 respondents reporting that their patients were not on ARV treatment. Those that reported

not having had a personal experience or do not know anyone who had died of AIDS gave possible reasons such as the effects of ‘reverse migration’ that occurs when one becomes ill. The sick and orphaned from urban areas tend to return to their rural areas. This occurs to reduce the financial costs of living in a city without an income. Others avoid experiencing stigma and discrimination by shying away.

Another encouraging motivational factor to the prevention of HIV is that over 70% said they discuss HIV and AIDS issues with their family members and relatives and 91% with friends bringing the issues closer home. Table 6.11 gives a summary of the perceptions people have on how easy it is to discuss such issues with various social groups. This is a fundamental motivational factor as they tend to learn from others.

Table 6. 11 How easy is it to discuss HIV and AIDS issues with these groups?

Variable	Very Easy		Easy		Difficult		Very Difficult		Total	
	Fre* ¹¹⁶	%	Fre	%	Fre	%	Fre	%	Fre	%
Family Members	156	43.0	122	33.6	49	13.5	36	9.9	363	100
Relatives	119	32.8	140	38.6	65	17.9	39	10.7	363	100
Friends	286	78.8	56	15.4	7	1.9	13	3.6	363	100

¹¹⁶ **Fre*** – Frequency

In conclusion, this chapter brings out important insights gained from applying theories of the Health Belief Model in HIV and AIDS prevention programmes. The most significant available weapon is prevention through public education and persuasion. Because of the sensitive subject matter surrounding AIDS and the stigmatised target audiences, health communicators have faced some new challenges, such as the fact that knowledge is a necessary but not sufficient condition for behaviour change.

Although theories can offer guidance for motivating behaviour change, media campaigns have traditionally been used to stimulate awareness, leaving the subsequent steps of the behaviour change process to more interpersonal sources. However, the media targets the general public without acknowledging the difference among such segments as the segmentation of audiences is a fundamental part of the social marketing. The general findings of such a model conclude that many of the respondents interviewed in Harare did not seem to approach the AIDS issue from such a logical perspective, but they seemed quite capable of discounting risks and optimistically perceiving themselves as invulnerable to infection. There is still a missing link in HIV and AIDS behavioural change which is the fact that people overwhelmingly acknowledge that there is an AIDS epidemic, but do not necessarily take the next steps of accepting the consequences. In other words, knowledge about how HIV is transmitted and the danger of certain kinds of practices do not seem to translate into behavioural change.

CHAPTER 7

PERCEPTIONS OF THE CITY'S POLICY MAKERS AND IMPLEMENTERS ON BEHAVIOURAL CHANGE STRATEGIES.

The previous chapters have reported on the research findings of secondary data collected as well as responses from 363 Harare residents interviewed using a structured questionnaire. What tends to dominate the research agenda for behavioural change is a focus on policy content and policy process of the fight against the HIV and AIDS epidemic hence this last chapter will give the findings from the key informants, key societal influential figures including senior Government officials, who are the key policy makers in Harare. This is because the more that researchers can learn about the determinants of health-related behaviours, such as sexual risk taking, the more likely it is that policy-makers and practitioners can better understand the phenomena, develop and implement effective interventions.

Individual's knowledge, attitude and behaviour regarding HIV and AIDS is to some degree determined by the structure and functions of systems of influence organized to induce social change. By understanding the system, its genesis, its political constraints and its role in the meta-system for the fights for HIV and AIDS, we have a better context in which to evaluate its impact and effectiveness at the individual level of analysis.

Therefore, this final chapter is a compilation of all the in-depth interviews conducted with various key informants as well as secondary data the researcher was given by the interviewees. What is interesting to note is the fact that the interviews were conducted after all questionnaires were administered with the public. This helped to formulate specific questions¹¹⁷ to be asked using the preliminary findings from the analysis of questionnaire responses. Each key-informant was approached well in advance for their consent to participate in the interview. It was a significant challenge securing appointments with these top officials for various reasons. As discussed in the Chapter 3, this research was conducted during the violent pre-general election period in Zimbabwe. Those approached questioned the specific intentions of the study whilst others simply thought the study was a disguise to gain entry into their political thinking fearing that the research would expose who they supported to be the next president.

As a result, a number of the key-informants asked to see the set of questions before they decide whether or not to grant the researcher permission. A significant number of the targeted top officials brusquely denied us access to them giving excuses that they were not participating in any interviews until after the elections simply for security reasons. Another theory that this study has come up with regarding the inaccessibility to interview top officials is the fact that the level of corruption and mismanagement in various organisations in Harare is so high that participating in interviews results in increasing one's risk of exposing such activities. For this rationale and also taking ethical issues into consideration, this chapter will highlight the opinions compiled during various interviews without revealing the specific identity of who the response was from. The chapter will not

¹¹⁷ See the Appendix section for the generic guideline of the in-depth interviews.

chronologically give an account of one interview after another in so doing making it less obvious as to who specifically said what.

7.1 Key Informants interviewed

However, surprisingly under such dangerous circumstances, there are a few who granted us permission to reveal their identity and their responses whilst the rest of them were uncomfortable revealing their names but were happy for us to use their occupations. The section that follows, gives a short overview of 6 informants interviewed, followed by thematic interview responses. Appendix 2 provides examples of interview guides that were used. The researcher however interviewed key informants from the Ministry of Health and Child Welfare, the Ministry of Education and other private sector institutes who asked to remain anonymous including mentioning their companies or institutions for reasons cited above.

7.1.1 Zimbabwe Television Talk Show Host

Mrs Chisamba¹¹⁸ (commonly known as *Mai Chisamba* in native Zimbabwean language) is a dynamic modern woman with many faces to her personality. She is a first and foremost a mother and a wife, a church leader, a social counsellor, a teacher by profession, a broadcaster among the many caps that she wears. Among many of her achievements, Mai Chisamba was named the 2003 *Zimbabwe's Communicator of the Year* in an event hosted by the Zimbabwe Institute of Public Relations in conjunction with the British American Tobacco Company (BAT). This award is particularly prestigious as it has enabled Mai Chisamba to

¹¹⁸ The only key-informant who gave consent to reveal her identify by name.

join social icons such as President Robert Mugabe, the opposition leader Morgan Tsvangirai and the late Vice-President, Simon Muzenda who are also recipients of this award.

The *Mai Chisamba Show* has evolved over the years, starting off the television programme *Zvakanangana ne Madzimai* (*What Women Face*, a women's programme). The Programme was subsequently renamed *Nguva YeMhuri* (Family Time) in order to make it more gender holistic and family oriented. In recognition of the immense success and viewership, the programme was subsequently re-launched as *The Mai Chisamba Show*; aimed primarily at profiling a broad spectrum of social issues. Mrs Rebecca Chisamba became the Producer, Researcher and Host of the programme.

The *Mai Chisamba Show* is a uniquely interactive show that brings to one platform diverse voices from across Zimbabwe to interrogate social challenges and pave a way for a better and healthier society. It attracts over one million viewers per show making it a platform for an uncensored social forum. The show is based on the underlying concordial philosophy that whatever happens at the political and economic levels melt down to the social forum and hence can be discussed at that level.

The show highlights social issues such as problems in marriage, in the nucleus family, the extended family, the workplace and the society at large. It also highlights such contentious issues such as child sexual abuse, same sex marriages, rape, cremation in the African culture

and developmental issues such as micro financing, social responsibility and society empowerment through adult education and entrepreneurial skills development as well as HIV and AIDS. When asked if she has ever received any form of opposition to her role, this is what she had to say:

Yes I have, especially the people who have their ardent beliefs regarding certain issues, for example, men may oppose my approach and advocacy for gender equality. Some even call me names saying, handina murume (I do not have a husband) that's why I am an advocate.

The show has held various discussions on HIV and AIDS issues such as the impact of AIDS on family and how it has resulted in extended families, especially grandparents caring for the orphans. Other topics discussed include the deterioration in morals of the young people and the dichotomy of the tradition versus modern ways of life and how they are contributing to the spread of the epidemic as well as stigma and discrimination and home based care. Participants in the show respond freely to HIV and AIDS discussions and there is not much difference between the ways they respond to any other issues. One possible explanation she gave is that her selection process tends to choose only active participants because it is purely voluntary in nature.

7.1.2 Zimbabwe Broadcasting Corporation (ZBC)

The study was also a success in securing a high profile interview with the Zimbabwe Broadcasting Corporation (ZBC) **Production Manager**, a state-controlled broadcaster. It succeeded the Zimbabwe Rhodesia Broadcasting Corporation (ZRBC) in 1980, which in

turn had succeeded the Rhodesian Broadcasting Corporation (RBC) in 1979. Like the RBC under the white minority rule Government of Ian Smith.

The ZBC operates four radio networks, *Spot FM*, *Radio Zimbabwe*, *Power FM* and *National FM* providing a mix of news, current affairs, educational programming and music, in English, Shona, Ndebele and a variety of other minority languages. Differences are in the target populations hence variations also in the type of languages used and the specific content of programs. It also launched *Community Radio Stations* in Harare and Bulawayo which are already on the air. The Corporation is a parastatal¹¹⁹, although largely owned by the Government. It also generates its own revenue through advertisements. The manager boasted the ZBC is one of the few profit making parastatals in Zimbabwe.

Television was introduced into the then Southern Rhodesia in 1960. It was the first such service in the region, as South Africa did not introduce television until 1976. Color television was introduced in 1984, with a second channel, available only in Harare, being introduced in 1986. This channel was discontinued in 1997 and replaced by the first independent channel in Zimbabwe known as *Joy TV*. This channel lasted until 2002, when it was controversially taken off the air for allegedly failing to pay fees to ZBC. It is believed that Joy TV was killed off, because it posed a threat to the monopoly enjoyed by ZBC. The main ZBC TV News bulletin opens with a man in traditional tribal costume beating a drum, before more people beat the drum.

¹¹⁹ A government-owned corporation, state-owned enterprise or government business enterprise. It is a legal entity created by a government to undertake commercial or business activities on behalf of an owner, who is the government.

The news bulletins include the morning *Good Morning Zimbabwe*, lunch time News, *Nhau Indaba* and *News Hour*. The local radio stations also run hourly news bulletins which range from two minutes to the longest being a ten-minute bulletin on weekends and holidays. ZBC currently runs only one station, Zimbabwe Television (ZTV) but the study learnt that plans are at an advanced stage to launch two more channels. ZTV has 25% foreign and 75% local content. The manager gave this remark,

'We are Zimbabwean, we need to be Zimbocentric. But we are looking at reducing the local content to 60%.'

In the interview room, the production manager was asked on any available records showing statistics of media coverage trends. The response to this question was that it is very difficult to track media coverage because of the overhaul that is constantly taking place within the corporation. Departments mix and mingle over time and in the end it is difficult to establish who has done what, where and when. Also, programmes are only aired for specifically short periods of time hence a constant revamp of programmes to suit dynamics that are in the world.

It is very astonishing that the ZBC does not have a system that monitors the number of viewers and listeners at any given time. They only rely on feedback programmes, the number of licences bought, surveys conducted in collaboration with *Target Research International* although they give an allowance for defaulters and liars. As at 2010, the estimated number of ZTV viewers is at 7 million people. Generally on TV, the most watched programmes are sports, soccer in particular, *Studio 263*, *News Hour*, *Morning Zimbabwe* and *Face the Nation*. The least are the late viewing programmes when people are asleep.

The ZBC does have a department or team that is responsible for health issues coverage. In the interview, the researcher learnt that any journalist can come up with any health issues to report on as long as it is news-worthy. For example some present their programmes and concurrently give vital information that touches on people's health matters. There are health programs currently aired on various radio stations such as *Pambepo naChiremba* (On air with the doctor) on Radio Zimbabwe as well as *Talking Health* on Spot FM radio station.

7.1.3 Zimbabwe Media Monitoring Project

The Media Monitoring Project (Zimbabwe) is an independent Trust that works to promote freedom of expression and responsible journalism in Zimbabwe. It aims to achieve this through monitoring and analysis of the news and current affairs output on domestic radio and television, and in the print media. Its findings are made public through the publication of weekly media updates. In this study, the researcher managed to secure an interview with an **Advocacy and Information Officer**, whose main role involves distributing information about the organisation, organising dissemination workshops and compiling the monitoring reports.

7.1.4 Population Service International (PSI)

The **Research and Data Manager** of the Populations Service International (PSI) also granted his consent to be interviewed. PSI is a leading global health organization with programs targeting malaria, child survival, HIV and reproductive health. Working in

partnership within the public and private sectors, and harnessing the power of the markets, PSI provides life-saving products, clinical services and behaviour change communications that empower the world's most vulnerable populations to lead healthier lives. In 2007, PSI estimates that its programs directly prevented more than 156,000 new HIV infections, 2.6 million unintended pregnancies, almost 150,000 deaths from malaria and diarrhoea and 19 million malaria episodes globally. In addition, roughly 25,000 patients were treated for TB. In Zimbabwe, one of its programmes is the behaviour change communication programs: nationwide with a special focus on youth and high-risk populations. Their target population is sexually active men and women, high risk populations like migrant labour, truck drivers and commercial sex workers. They offer various products and services as shown in Table 7.1 below;

Table 7.1 Population Service International Products

New Start HIV voluntary counselling and testing (VCT) centres	since 1999
New Life post test support network	since 2003
Protector Plus male condoms	since 1996
Care female condoms	since 1997
SupaNet long lasting insecticide treated nets	since 2004
Marvelon and Exluton oral contraceptives	since 1999
Depo Provera injectable contraceptives	since 2000
DuoFem oral contraceptives	since 2001
E'Pap nutritional supplement	since 2004

When asked whether PSI is more concerned with the populations already infected by the HIV virus or those who are still negative, below is the response obtained:

Both. That's why we have New Start Centres and New Life Centres to cater for everyone. Remember if one is negative today, it does not mean they stay like that forever. Put this on record that it is easier to be HIV positive than to remain negative.

7.1.5 The National AIDS Council (NAC)

The study also secured a significantly high profile interview with the then **National AIDS Council Director**. The job description entails organising research that focuses on the effects of AIDS on the affected and infected in Zimbabwe. NAC is an organization enacted through the Act of Parliament of 1999 to coordinate and facilitate the national multi-sectoral response to HIV and AIDS. It is also mandated to administer the National AIDS Trust Fund (NATF) collected through the AIDS Levy, which is 3% collected from every worker's taxable income (PAYE) and corporate tax and also received funding from the Global Fund. The organisation's mandate is to provide for measures to combat the spread of HIV and management, coordination and implementation of programmes that reduce the impact of HIV and AIDS. (The National AIDS Council Act Chapter 15:14 of 2000). In assessing the strengths that NAC possess in the fight against HIV and AIDS, the director had the following response:

We are at the centre, the hub of the fight against HIV and AIDS. In today's language we say "tiri panyanga" (we are at the bull's horns). All activities by all organisations regarding HIV and AIDS issues in Zimbabwe are sanctioned by NAC. Without us, 99% of the battle against the epidemic is lost right there'. On NAC's weaknesses... People expect miracles from NAC yet we work with the rest of the organisations and our failure is a cumulative effect of the failure of all other HIV and AIDS organisations. However we have never failed this far to deliver as far as our mandate. In-fact we have done

well, if we look at the Monitoring and Evaluation reports that are compiled daily, weekly, monthly and yearly.

7.1.6 Religious Leaders

Ahlberg (1994) sees a moral confusion, outlines four moral regimes in contemporary Africa, the Christianity, the Traditional African, the Administrative or Legal and the secular 'romantic love'. Many of the AIDS education programs are only based on the first three, all of which discourage pre-marital sexual activity. But many young people embrace the romantic love moral regime which dictates that sexual activity is all right as long as people are in love regardless of their marital status. In Harare, the young respondents to the survey questionnaire also highlighted the fact that the economic crisis has forced them to embrace the love moral regime as they can no longer afford to pay the bride price and wedding bills required for the Christianity, traditional and administrative or legal regimes. The traditional cultures are increasing getting diluted in African cities with only a smaller percentage still practising such cultures due to continued ties with relatives from rural areas.

There are African discourses on AIDS fundamentally different from the West discourses hence the need to learn the African discourses in order to avoid already too many 'white elephants' existing in Africa¹²⁰. Christian churches in general have also remained curiously silent and tragically apathetic about the implications of the plague that has killed millions of people. Sexuality is a topic the church has found difficult to address. Some argue the

¹²⁰ Too many development projects that have missed the mark.

church's silent and joyless condemnation of sexuality in general has been a contributing factor in the spread of HIV and AIDS. The church's reasons for resistance and reticence as Messer (2004), noted are that they believe it is not their problem and it is not Christian to talk about sex. Sex talk has long been a forbidden topic among Christians almost everywhere in the world. Judgemental attitudes and shunning behaviour have only prompted greater secrecy and shame, forcing people to hide their illness and keeping them from openly seeking prevention, treatment and care.

This survey interviewed the Bishop of the Methodist Church in Zimbabwe. The Methodist Church in Zimbabwe (MCZ) is the fruit of British Methodist mission activity in former Southern Rhodesia which began in 1891, while the United Methodist Church in Zimbabwe is of American origin. The church gained its autonomy from the Methodist Church in Britain in 1977 and now has an 8 District Bishops, 1,541 congregations and an estimated membership at 112,529. Since independence in 1980, the MCZ has been making strong efforts to build up its membership again. One of its major problems at present is growth, which necessitates large efforts to nurture the new persons coming into the church and places heavy demands on the church leadership. Another major problem is the high death rate from HIV and AIDS and the many orphans who are in great need. In order to cope with the growing needs of the members there has been a great emphasis on training. Whereas in 1982 there were just over 16,600 young people participating in church activities, in 2003 the number was almost 54,000. The MCZ has eleven primary and nine secondary schools. In addition, there are four multipurpose community centres which are used with women, youth and non-church groups. The schools and centres, though belonging to the MCZ, are used ecumenically.

7.2 Perceptions on the effectiveness of the 'ABC' Approach

The question asked in this thematic area was if the key-informants agree or have confidence in the effectiveness of Abstinence, Be Faithful and Condom Use (ABC) approach and if they think the strategy is working. In their response, the majority of them reported to have belief in the 'ABC' approach and believe it is somehow working although there are loopholes in the approach.

Abstinence was reported to be working to those who received the gospel of prevention whilst very young. However, it is not working in regard to teenagers as they are failing to abstain because of peer pressure, hormonal changes in their bodies, need for luxury lifestyles (nicknamed as the life of *bling bling*). Some key-informants reported that some people are being faithful to their partners but the majority are not, simply because of dissatisfaction and unfulfilled desires in the marriage institutions. It is however important to note it is difficult to measure *Faithfulness* and *Abstinence* as some people say what they do not practice. *Condomisation* was reported to be the least effective as most men do not want to use condoms. One interesting finding from the interviews was that the majority of Commercial Sex Workers (CSW) insist on condom use better than the married couples. Women do not want the female condom because it is difficult to wear making the male one a better option.

In 1997, PSI successfully launched a branded female condom, the *Care* contraceptive sheath, and began selling it in pharmacies and other outlets nationwide. Following the results of extensive formative research, PSI decided to position *Care* primarily as a family planning product that protects couples from disease. The *Care* social marketing programme

is one of the most successful programmes of its kind in sub-Saharan Africa, with nearly 900,000 sheath distributed in 2004¹²¹. Female condom social marketing program uses innovative sales channels such as the hair salon network and home meetings (among women), to educate potential consumers on correct use of the product and increasing personal risk perception. The researcher also learnt that Zimbabwe is one of seven African countries participating in *Corridors of Hope*, a programme designed to proliferate and strengthen condom social marketing activities for the prevention of HIV and AIDS at key cross-border locations in Zambia, Zimbabwe, Lesotho, Swaziland, South Africa, Mozambique and Namibia. Activities of this programme focus on high-risk target groups namely commercial sex workers, truckers, informal traders, uniformed officials, and adolescent girls¹²².

What is interesting to note is that the NAC director reported that they even go further than the 'ABC' approach in their Behavioural Change Campaign (BCC) strategy. Their director went on to report all the three 'ABC' approach are working well and yielding results that are reflecting in the continued decline in HIV prevalence rate. The Behaviours Change Campaign strategy in this case has seven components but the first three are the major namely;

¹²¹ PSI, 2005

¹²² PSI, 2005

- A** Abstain until marriage
- B** Be faithful to your uninfected partner.
- C** Consistent and correct use of condoms.
- D** Delay having sex.
- E** Early treatment of STIs
- F** Feel free to discuss sexual issues
- G** Get real.

7.3 HIV Voluntary Testing and Counseling (VCT)

PSI introduced the *New Start Network* which provides voluntary counselling and HIV testing (VCT) for general and high-risk populations in Zimbabwe. New Start VCT services were developed using best practices in Zimbabwe and around the world to create a service network that is professional, anonymous, confidential, accessible and client-oriented. More than 370,000 clients have been counselled and tested for HIV through a network of 20 centres operating nationwide. In 2005 over 12,000 clients are going through VCT services every month in Zimbabwe through the New Start network. Since mid-2004, staff from the New Start centres have been conducting regular outreach missions in order to reach rural Zimbabweans. In 2004, 24% of VCT clients were from these outreach missions. According to one informant, everyone from across the demographic spectrum has been coming to get tested, all ages, sexes, the married, single, expectant mothers and some of our centres daily report overwhelming attendance. Some are new clients altogether while others will be coming for retesting, the percentages vary by centre and by day.

The main question asked during the in-depth interviews regarding HIV testing was that with the economic situation in Zimbabwe at present, why would anyone trouble themselves to get tested with the knowledge of the collapsing health delivery systems, and also with the knowledge that those tested will not afford to pay for any treatment or eat healthy foods to sustain their lives. In responses, there was a strong emphasis that people should just know their status to enable them to live positively against the economic hardships. One highlighted point is that most of the healthy foods advised by nutritionists are Zimbabwe's traditional dishes, which are not entirely unaffordable and most of the healthy foods are easily obtained from 'our rural areas' and they do not necessarily have to be bought. In analysing this response, one can notice the significant ignorance of some of the key informants to the fact that most people in Harare can no longer afford to travel frequently to their rural areas. Those in rural locations would also be resistance in allowing their only survival strategies to be accessed freely by relatives from urban areas. Distance to most rural areas was also a factor that was overlooked. From the researcher's personally experience, where her family's rural areas are in *Sburugwi* (Midlands Province), which is more than 400kilomemtres, travelling all the way from Harare in search of traditional food is unpractical.

Concerning the health delivery system, some respondents argued that it is without the people's capacity to change it but lies with the authorities. They therefore believe there is still enough incentive for people to be tested, so that they know their status. Knowing one's status is crucial for positive living and positive prevention and also, for one to access antiretroviral treatment (ART), they need to know their HIV status. Basically it is for positive prevention for the negative and positive living for the infected.

From analysing the 363 questionnaires from residents, one of the key messages that emerged is that those who have not yet been tested are not willing to be tested because of the stress it brings. The key informants' response to this finding was that they appreciate the stress that goes with being tested and that is the major reason why the providers of VCT services make the process very much voluntary and not forced. They are also several referral options available to everyone regardless of the outcome of the test. It remains in the key informants' agenda to encourage VCT to almost every Zimbabwean so that people live informed lives. It is basically lack of information and a failure on the policy makers' part to educate about the advantages of knowing one's HIV status. If one gets tested and is stressed after the results, there are professional counsellors who offer post test counselling at both the New Start and New Life centres.

Population Service International's future plan on New Start Centres is to expand VCT outreach activities and include all border towns as part of its outreach program. It will also introduce the peer post-test model to increase impact without expanding the existing post-test sites. This model uses HIV positive individuals to form post-test clubs to motivate other members of their community to seek VCT services and provide follow up support services. The model will be rolled out with technical input from New Life counsellors. The objective of the post-test support network is to improve linkages to care and support organizations for those who know their HIV status. The centres provide a range of services for those infected and affected by HIV and AIDS: nutritional counselling, adherence counselling, and support with disclosure. In 2004, PSI/Zimbabwe launched *E'PAP*, a high-energy food supplement. The product is available as part of a nutritional package: counselling on nutritional needs of HIV positive people and nutritional booklet.

7.4 Antiretroviral Treatment

There was a general consensus amongst the key informants that the ARVs are not easily accessible. They reported that out of the one and a half million people in need of ARVs, only 400 000 are accessing them and the Government has about 150 000 on its scheme, the rest are buying them on their own. The National AIDS Council Director reports that they have done their best under the current situation to roll out ARVs to any deserving patients regardless of their political standing or financial muscles. He added:

'...the procedure is straightforward, get tested and register at the nearest hospital and one is entitled to receive ARVs if they are available. It must be put to the record that we as NAC are the only organisation that avail ARVs to the public at subsidised prices. All other ARVs on the market are sourced by individuals therefore are exorbitant for the ordinary patient. At the same time, no-one can block the rich from securing the drugs even from outside because it is their money, their health. But for the ARVs that we secure using the ratepayers' money and donations from the Global Fund, these are very affordable, right now its only ZW\$150,00 per month. To date up to 86 000 people are on ART while 260 000 who need treatment have no access out of an estimated 1.3million infected people'.

The PSI manager reported that his organisation is not yet distributing ARVs but are at an advanced stage of completing the infrastructure and system for rolling them out.

7.5 Communication Strategies

Mass media communication strategies are not well monitored in Zimbabwe hence it was very difficult to assess the number of people reached and impact. The Advocacy and

Information Officer of the Media Monitoring Project was asked to what extent they monitor and analyse media reports on HIV and AIDS, this is the response obtained:

'To be honest with you, we rarely monitor HIV and AIDS issues as our main thrust is the socio – political and economic reports (news and current affairs issues) and other unusual one off publications. Recently though I can say we have established a unit to try and deal with Health issues monitoring'

The analysis of questionnaire responses showed that a significant number of people criticised the mass media HIV and AIDS awareness campaigns, arguing the adverts promote the spread of HIV infections instead of preventing it. This argument highlight the fact that the message coming across from the campaigns is that one can still live a positive normal life after contracting the virus.

The key informants however disregarded this statement claiming that the adverts have in fact resulted in increased condom use and cannot give accurate information on the other two components of the 'ABC' as it is difficult to measure abstinence and faithfulness at any given time-frame. The 2007 Zimbabwe Demographic Health Survey (ZDHS) reported that 98% of Zimbabweans have information about effectiveness of condoms in HIV prevention. The distribution networks have also expanded in the past years, distributing about 55% of the 88 million condoms in 2006, meaning there is wider acceptance of condoms by the society and the target population. Their argument is that in actual fact, the HIV and AIDS adverts target different groups of people in the community, such as the affected, the infected and the would-be affected and infected and in that regard, the adverts are relevant to the specific targeted groups. One key-informant believes there are more

residents in Harare who have benefited from the media campaigns than those who have not.

7.5.1. The silence surrounding the epidemic

The key informants were also asked various questions on the silence surrounding HIV and AIDS issues within communities. Two contradicting views emerged as most of them agreed that there is silence around HIV and AIDS issues and one of the key-informants commented;

It is true because rarely do we hear relatives openly telling people that their relative, child, parent or partner has died of AIDS. What we are only told is that they died after a long illness. Even the death certificates are quiet about that. Even the infected themselves are quiet. There is just too much silence, a sign maybe that there is still high stigma and discrimination'.

Others pointed out that it is more so in rural areas and farming communities in Zimbabwe than in the urban areas such as Harare. Even in urban areas, what tends to happen is that the residents are surrounded with adverts and campaigns but through observations, people are not free to discuss among themselves about HIV and AIDS issues, for fear of victimisation, stigma, discrimination and finger pointing. This is partly because of the failure of infected persons to disclose their status and also the myth that those who are HIV positive are prostitutes. One informant repeatedly asked the interviewer to note that commercial sex workers or prostitutes have ceased to be the core infectious group or the high at risk populations as they have embraced condom use. The vulnerable are now the married women and the youth.

On the other hand, the claim of silence on the epidemic was disputed by others based on the fact that Zimbabweans are not where they were regarding silence around HIV and AIDS a decade ago particularly in urban settings as highlighted by one respondent;

‘Opening up has improved very much but we are still far from total control. People are slowly doing away with the stigma associated with one’s HIV status. It is not only the HIV positive who were not opening up about their status but even the negative, but right now all that has changed. There is more openness and less silence. There will be a continued effort to promoting awareness and encourage non – discrimination until a point is reached where HIV and AIDS will be regarded as one of the very many infectious diseases such as TB and Malaria’.

The interviewee was very confident this point will be reached and encouraged People Living with HIV and AIDS (PLWHA) and those negative to form interact clubs where they share their experiences with others. However, the majority of the key informants highlighted that the breaking of silence around HIV and AIDS should start with people in high posts, celebrities and the respected in society. If these open up, then the rest will follow. But as long as they are quiet, then silence will be there forever. It is pointless for them to encourage ordinary citizens to open up about their status while they are quiet about your own status hence becoming ironic.

7.5.2. The Zimbabwean crisis and access to HIV and AIDS messages.

In the midst of all the political turmoil and economic crisis currently covering the headlines everyday in Zimbabwe, one question that was necessary to ask was if HIV and AIDS programmes are regarded as newsworthy. The motive was to assess to what extent the coverage of HIV and AIDS issues had received attention by the media personnel. In

response, all the key informants agreed it cannot be disputed that there are several issues that are newsworthy in Zimbabwe. Some went on to applaud the media both print and electronic for the constant coverage of HIV and AIDS issues such as the decline in prevalence rates over the years and projects benefiting PLWHA. They certainly confirmed that indeed HIV and AIDS issues are newsworthy despite the political and economic challenges being faced.

The Zimbabwe Broadcasting Corporation representative emphasised that HIV and AIDS is an important aspect at the corporation because they realise it is a national epidemic. The ZBC has been constantly monitoring the prevalence rates and reporting on the achievements made in reducing the rates. They also sell airtime to organisations that have advertisements on HIV and AIDS at subsidised rates that are not in line with what others are made to pay. Other HIV and AIDS related programmes are aired on television as *Studio 263*, which was started to encourage openness about HIV and AIDS in Zimbabwe and to inform the population on how to integrate this epidemic in everyday life. The production manager insisted that HIV and AIDS related issues command a priority position in all media coverage. One of the shortfalls in the organisation is that they confirmed not to have any statistics on the HIV and AIDS media coverage but confirmed the coverage has increased with the increase in the number on organisations that focus on HIV and AIDS issues. There has been an increase in adverts and programmes both on TV and radio and even the print media, for example, the Saturday Herald's *City.com* has four columns on HIV and AIDS and health issues.

The response corresponds with that from the Population Service International manager who highlighted the point that yes; there has been significant increase in the air time given

to HIV and AIDS adverts and also the quantity of programmes produced to tackle this phenomenon. For example, PSI adverts have increased from one 30 second adverts for every 3 hours in 2000 to an hourly frequency on all radio and T.V stations. The adverts have also increased in diversity and language. The most reported issues are prevalence rates, positive living, elimination of stigma and discrimination and home based care and the respondent was confident the general public is still interested in the coverage of HIV and AIDS issues.

However, findings from the questionnaires administered to the general public show that Harare residents are getting annoyed and fed up with endless mass media coverage of HIV and AIDS issues. They complained that everywhere they go, they are likely to be encountered with an HIV and AIDS poster on the trees, billboards, bus stations, public school walls, churches, beer- halls and the list is endless. This is said to have resulted in Harare residents not paying any more attention to the messages disseminated arguing they have always heard it all before and is becoming meaningless to their daily survival strategies in such a harsh economic environment.

These findings were shared with key-informants who in response insisted they have not yet achieved enough on information dissemination. However, one of them agreed to the fact that perhaps those in urban area were getting more annoyed by such messages as compared to their rural counterparts where there is still a huge gap in HIV and AIDS knowledge. Another commented:

I think people have the misconception that they now know about HIV and AIDS issues. The truth is that people have the information but the quality of information they have is not sufficient considering the new dimensions that the epidemic is revealing itself in.

The coverage of HIV and AIDS has become a moribund issue since people are focusing more on bread and butter issues and also their security politically than to worry about AIDS. If there are any HIV and AIDS reports, the main focus would be on prevalence rates, donor funds for HIV and AIDS activities, and the World AIDS Day on the 1 December every year as well as the availability of ARVs.

One key-informant highlighted the fact that the general public are not interested in the coverage of HIV and AIDS issues. Only specific individuals and organisations have such an exception and it is fundamental to understand that issues of sexuality cannot be dictated on people. The following statement was the respondent's concluding remarks:

Issues of AIDS, whether from NGOs or govt, are not effective as long as people are not willing themselves to change their behaviour; people are difficult to deal with'.

PSI highlighted this has impacted negatively on the way they disseminate information, despite the fact that they have embarked on other information dissemination techniques like t- shirt printing, posters and billboards.

Despite the increase in HIV and AIDS mass media coverage, the critical economic conditions in Harare have impacted on general access to media including access to televisions and radios. The situation in Zimbabwe has resulted in two groups of media audiences influenced by one's economic status. Those who have extra cash to spend have resorted to foreign television stations. Participatory observations conducted during this research learnt of significant and increasing numbers of Harare residents resorting to foreign Television stations via satellite dishes such as the South Africa Broadcasting Corporation (SABC). The main reason behind this phenomenon was that the Zimbabwe

Broadcasting Corporation (ZBC) is becoming increasingly unbearable due to heavy politicisation of the programmes aired. This view was also shared by the key-informants. Surprisingly, this has not worried the PSI representative as he argued that the printed daily press has been fairly distributed across the country. Their network of implementing partners and organisations has spread to cover almost the whole of the country making the information universal and accessible to everyone.

Due to constant power cuts in homes which mainly take place when people return home from work or school, the majority of residents no longer have access to television and radio programmes. Others have had their television sets and radios electrically blown up due to high voltages when electricity supplies are switched back on. Because of the unaffordability of such gadgets, they have not been able to replace the wrecked ones. The key informants interviewed agreed with this finding highlighting that people are now failing to get access to the media, as it is now costly to do so. They are now prioritising basic commodities especially foodstuffs at the expense of accessing media. This is a challenge also acknowledged by key informants who agreed the levels of viewership are dramatically decreasing due to frequent power cuts and the unaffordability of batteries. The majority of the population are unable to replace their television sets or radios when they stop to function hence reducing the viewership levels. This has resulted in contrasting dynamics between ZTV media coverage and viewership as shown in Fig 7.1.

In this attempt to understand how the current economic situation has impacted on general access to media, the ZBC representative argued that reports and statistics show that readership and general TV viewership has increased over the years. What has however decreased is the number of print media available on the streets after the banning and

closure of the independent media organisations. Television viewership has increased, although people now view other foreign channels as compared to the national ZTV. The unfortunate thing is that they only monitor the public broadcaster, ZTV and its viewership has been on a decline country wide as mentioned previously.

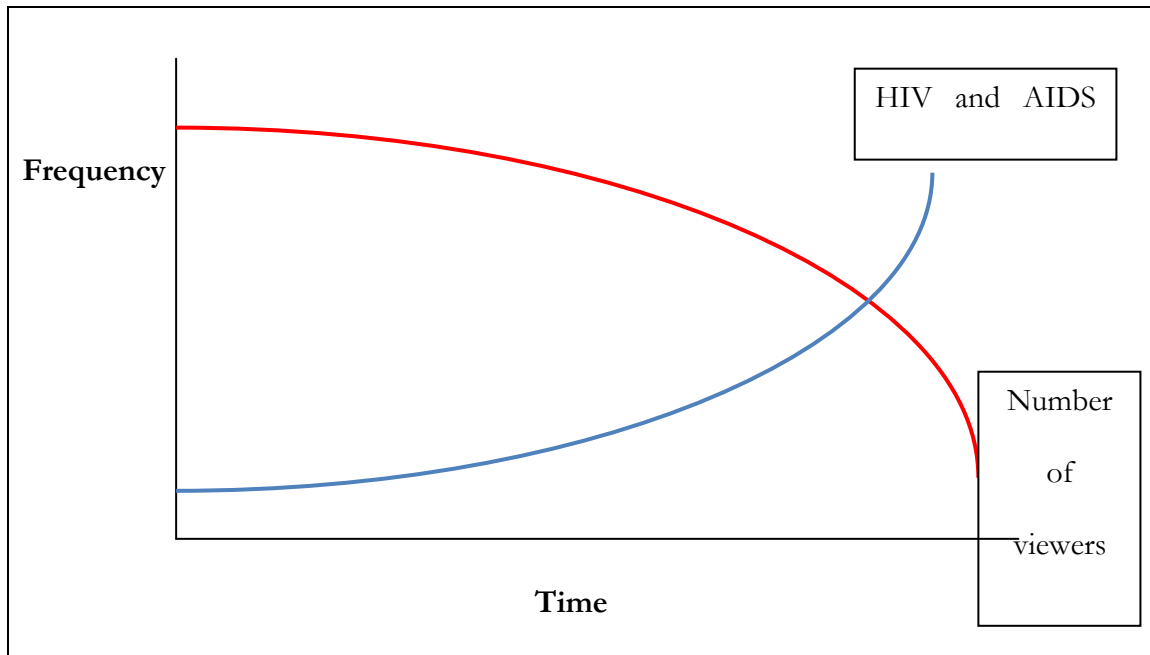


Figure 7.1 The trends in ZTV media coverage and number of viewers in Harare
(Source, Survey Data)

One key informant responded by saying;

‘...there is nothing in the power of the journalists or management that can be done to make sure people have electricity in their homes. We strive to improve the quality of our programming and efficiency and that is within our jurisdiction. Anything outside of that is out of our ability to manipulate’.

Some of the factors leading to inaccessibility of media coverage are very political. The respondent who highlighted this point refused to elaborate on this claim. Other key-informants not involved in the media industry argued that there still is not much or enough

media coverage on HIV and AIDS issues. They reported that they read only one or two articles about AIDS per week and put all the blame on journalists, whom they believe are busy with other issues that sell, neglecting such health issues. ZBC was also accused of being heavily politicised and busy following the President's whereabouts and agendas to the expense of other internal affairs.

7.5.3 Programme Quality

During the interview, one of the fundamental questions asked concerns reasons why visually shocking adverts are not produced, showing people with full blown AIDS, dying of AIDS, at grave sites, the effects it is having on the country and the families. There was need to understand why there are no real life documentaries about people with AIDS, telling it like it is aired on television. These questions emerged after the findings from questionnaire survey showed that a significant number of people do not know the severity of the epidemic in their community (See Chapter 5 and 6), they do not know how many people are dying of AIDS each week in Zimbabwe. This was evidenced by the shock in their facial expression after revealing the actual figures to them. Key-informants were asked if disseminating such statistics would be an effective strategy to achieve behavioural change. The majority of them argued such measures would not change anything and gave an analogy of how many drivers see for themselves crashed cars or accident victims on the road (not adverts or pictures), but they continue speeding. It does not matter what one sees, if they do not want to change, they cannot be forced.

Only one key informant acknowledged the significant positive impact of having such programmes aired on television and reported they will look into the idea of adopting such a

strategy and monitor the impact over a given period of time. The logic behind is that naturally, people would change their sexual behaviour. Nevertheless, experience remains the best teacher, that is, a person who has not been infected or affected by the death of a close relative continues to regard HIV and AIDS issues as mythology.

PSI's approach has been gradual persuasion which they argue has worked effectively. The strategy starts with information dissemination and awareness, augmenting this with condom distribution in selected areas before widening the network to cover almost every part of Zimbabwe. They identified partners and have successfully established relations over the years. They however admitted being ignorant to the use of HIV and AIDS statistics and agreed to the fact that people are ignorant of the magnitude of the HIV and AIDS crisis.

Population Service International (PSI) conducts social marketing projects on behalf of the Ministry of Health and Child Welfare and its agencies such as the National AIDS Council (NAC). One argument is that it would be more effective if the Government tells its own people what to do as opposed to international organisations. When asked why PSI does not fund the Government directly for such programmes, this was the response obtained:

We are part of the Government because we work hand in glove with several Government departments, Hospitals and Clinics and off course even NGOs. Put this on record that there is no single programme we started on our own without involving the Government. Sometimes it's simply facilitation of Government projects that we do as a social partner in the area of health'.

In comparison, the National AIDS Council (NAC) only publishes some monthly and quarterly digests, which trace the progress of running programmes and communicates new

projects. They also disseminate information using T- shirts, posters and billboards. This response caused the interviewer to ask an *impromptu* question, asking to what extent the NAC has influence over the HIV and AIDS programmes aired by the Z.B.C and whether they have the capacity to increase the quality and quantity of programmes shown to achieve sexual behavioural change. In a surprising response, most if not all programmes aired on HIV and AIDS are funded entirely by NGOs. As a Government sponsored council what they do is to only participate in programmes that try to evaluate Government intervention in HIV and AIDS issues. Therefore they are unable to influence neither the content nor the quantity of programmes aired through mass media and they can only work within the jurisdiction and influence of people's opinion and behaviour from their own mandate.

On the other hand, PSI, an international organisation that operates in several other countries outside of Zimbabwe has a mandate that is not country specific. PSI has not implemented any single programme without Government approval. Its projects are not a substitute of Government projects but rather complements them. The key-informants confirmed the fact that the Zimbabwe Government has always communicated with the citizenry through NAC and they argued that people are taking heed. Emerging from these answers is a gap between the Government and the international organisations operating in Zimbabwe. The PSI is implementing a one size fit all policy using their international mandate without taking into account the socio-economic and political dynamics taking place.

7.5.4 Knowledge on disseminated information versus Behavioral Change

Other fundamental questions asked were the reasons behind the hindrance of HIV and AIDS knowledge translating into behavioural change amongst residents and one summarised the reason simply as:

‘Absence of the right kind of knowledge, the right quality of knowledge and the need to consistently update that knowledge’.

One of the key-informants was very poetic and philosophical when answering this question as shown below:

‘A plethora of social, economic, intellectual and cultural factors. People are rational when out of a situation and irrational when faced with a situation. We talk about condom use when we have no partner but when we bump into a sexual encounter, we cease to be rational and we can do anything, even the irrational’.

Others had such unclear responses arguing the Behaviour Change Communication (BCC) strategy is working to some extent, if one considers the increasing levels of HIV and AIDS knowledge that has been attained regarding condom use, abstinence and faithfulness. They however believe there is still room for better coverage and programmes and argue that generally people are difficult to manipulate. Currently health issues are not at the forefront of people’s concerns, that is, they are worried more with getting bread on the table than thinking of the risks of contracting HIV by engaging in high risk sexual behaviour.

In addition, one informant emphasised that naturally, people are difficult and it is unfortunate that they cannot have a policy that will work for everyone. It is wise and

sensible to segment the approach to HIV and AIDS issues so as to target everyone but with different approaches. There is need for a coordinated approach. The Government, Non Governmental Organisations (NGOs), Community Based Organisations (CBOs), churches and traditional leaders all need to be actively involved in HIV and AIDS issues to ensure that a wider spectrum of community is addressed to control the prevalence rates. There is also the need for a holistic approach to address all residents with a single strategy but multi – faceted. The respondents reported that more can be done by the Government on HIV and AIDS media dissemination particularly in the print media, which will be more effective in the absence of electricity when residents are unable to access televisions and radio stations.

To sum up, one of the major strengths highlighted is that in the presence of electricity, a large proportion of the population can access the media which is central and vital in influencing opinion. However, the most significant weakness is when residents cannot access the media resulting in inaccessibility of information. Another challenge is that the media addresses different sectors in society hence of the programs may seem contradictory from one person to another. For example, some movies appear to promote teenage delinquency whilst at the same time we are trying to discourage such behaviour. This therefore requires viewers to be highly selective and sensitive in their tastes.

All key-informants reported that their organisations were extremely knowledgeable about HIV and AIDS issues. The interviewer then went on to assess if they are aware of any of their work colleagues, whom they claim knew about HIV and AIDS and yet are promiscuous and ignorant to the preaching of sexual behaviour change. With a very loud claim, one responded:

Plenty of them! Kwenyu kubasa bakuna here? Kana imimi muri kundibrunza ndimi muri pamberi ku spreader. (Does your work place not have such people? Even you, the interviewer, you are the one in the fore-front of spreading the HIV infection).

Only one of the key-informants reported not to be sure as they live worlds apart even if they work together within an organisation and are too busy to understudy each other's off work characters and behaviours. Zimbabweans are part of a socio-psychological environment or social reality in which they live. In case of AIDS, they encompass not only rational constructs (that is, the concepts of such a disease), but also societal beliefs and attitudes, deep-seated socially shared anxieties, cultural values and moral norms. For example, insufficient knowledge of the problem or no personalization of the risk. This will help the policy makers to design and target messages that will prompt a change in attitudes and subsequent action.

7.6 Perceptions on behavioral change programmes and declining prevalence rates in a crisis state?

Earlier chapters have highlighted the point that the National AIDS Council (NAC) published a report that the declining of HIV prevalence rates in Zimbabwe was due to behavioural change. However there have been speculative arguments disregarding these claims. Arguments are that it is only a political gimmick and other conclusions are due to very high death rates and low birth rates and as well as nearly 3 million¹²³ people, a quarter

¹²³ IOM, 2011.

of the entire population who emigrated from Zimbabwe. During the in-depth interviews, this question was a major highlight in the interview process and in answering the main research objective. The interviewer attempted to understand the key-informants' perceptions and if they really believe the rates are declining taking into account their own experience working in this field.

Unsurprisingly, only one key-informant from the in-depth interviews unwaveringly agreed that the rates have declined due to behavioural change and argued they will continue to do so for as long as the momentum of their concerted efforts does not dissipate. He went on to argue that it is not politics at all, unless it was political that the HIV prevalence rate was at 34% in the early 1990s. It is not so much of a single factor but interplay of both methodological adjustments and increased mortality due to the scourge. It is more important right now to be focusing on incidence rates, that is, the number of new cases recorded and aim to reduce them and that is when we can talk of a meaningful reduction on future HIV prevalence rates.

However, contrary to his previous statements, the respondent acknowledged that the present system of collecting HIV prevalence rates is flawed and not one of the best available and suggested a need for continuous fine tuning. The response includes the following direct statement and worryingly at this point, the key-informant in question was beginning to show visibly angry facial expressions:

‘Yes the rates are declining. A question I would ask you is, do you think the rate was at one point 34%? If yes then it is that same rate that is now 15.6% because of Government intervention through NAC and other organisations working hard in the country to STOP AIDS. Just like inflation, people

believe in figures and statistics when they are going up, if they are falling then its politics! We need to be objective not subjective....

He went on to say...

'...people who are on the ground understand the strides we have made to influence people's behaviour. The decline is only a surprise to those who wish everything bad for Zimbabwe but we have made quite some progress. Uganda had declines but nobody proffered theories to explain it but when it is Zimbabwe recording the decline then there is need for theories. We are not testing ground and we are doing great work that has manifested itself in the declines. Both the rate at 15.6%. We know that our seven – pronged strategy is working and has produced these results. Of theories and theorists, which I don't know....'

Such remarks were followed by a question on the methodologies applied to measure such a drastic decline in prevalence rates and how they reached to the conclusion that it was behavioural change. The response was that they do have indicators of behaviour change that forms the 'ABCDEFGH' approach and no doubt have there have been increases in all these indicators, which then translates to reduced opportunities to contract HIV.

Mrs Chisamba does not believe that the rates are in fact declining to begin with as behavioural change strategies being implemented are not that effective as seen by high levels of promiscuity, infidelity, teenage pregnancies and commercial sex work going on. She argues that people are not changing their behaviour but rather are becoming worse, so the decline is difficult to believe in, as a large number of residents now view commercial sex work as a survival strategy especially the orphaned, divorced, separated, widowed and single mothers who have no alternative forms of income. One's economic status makes residents arguably equally vulnerable as that poor can use sex as income generating activity,

with no access to medication and drugs in the event that they are HIV positive. The rich are also finding themselves vulnerable by recklessly engaging in sexual relationships with commercial sex workers to splash their cash with.

Another key-informant also admitted the claim not to be entirely true. However, he reported that from his observations, there is a move towards safer sex and HIV and AIDS fearing approach, because almost every person is infected or affected or both. It is a 50-50 (equal) situation as most teenagers and the economically empowered middle aged are actually on a sexual rampage whilst the rest seem very reserved and cautious. The main highlighted point is that everyone is vulnerable to HIV infection despite one's economic status and there is a campaign that informs AIDS does not discriminate.

In conclusion, one should bear in mind that writing up this thesis has been a journey and from the data collection of this study to the finishing off the writing process, so much would have happened in Zimbabwe. This study was conducted in 2007 and what is encouraging to know is that two years later, in 2009, the findings of this study share the same results of a study conducted by Shango (2009) and was published in a newspaper article as shown below;

Zimbabwe AIDS statistics dismissed as fake

Published on: 28th September, 2009

ZIMBABWE – HARARE – Zimbabwe's National AIDS Council (NAC) has been accused of lying by claiming the HIV prevalence rate in the 15 to 49 age group has declined to 13.7 % in 2009 from 18.1 % recorded two years ago.

The statistics have been met by skepticism. The statistics were described as spin meant to give kudos to the sullied National Aids Council, recently at the centre of a scandal involving embezzlement of ARV funds. Funds were said to have been diverted to buy cars for executives and bankroll holidays for senior staff and other obscene perks.

Deputy Minister of Health and Child Welfare Dr Douglas Mombeshora confirmed the statistics and said the HIV incidence declined from 4.33 % in the mid-90s to 1.95 % in 2007, before further downing to 0.96 % in 2009, ZBC News reported on Friday. An estimated 1.1 million adults and children were living with HIV and AIDS at the end of 2008, of whom nearly 10 % were children below 14 years.

There is also reduced mortality due to the use of antiretroviral drugs, it was claimed. As a matter of fact, there is a critical shortage of ARVs, with many dying without access to treatment.

“They are lying,” said a senior medical researcher. “There is high level of sexual contact because of the dearth of recreation as a result of the liquidity crunch. These statistics do not tally with the reality on the ground.” Officially launching the antenatal clinic surveillance and HIV estimates for 2009, Mombeshora said the nation should redouble its efforts and commitment to achieve single digit prevalence.

“As a nation, we should be excited that Zimbabwe continues to experience declining trends in HIV prevalence both in general population and young age groups. However the prevalence of 13.7 % is still very high so as we get closer to our MDG and ZNASP targets of a single digit,” said Mombeshora.

It has also been noted that the HIV prevalence among the economically active who are also the sexually active group remains very high.

Stakeholders are optimistic that a combination of increased awareness, scaling up of prevention and treatment programs is expected to lead to the sustained decline of HIV. While the decline in the HIV prevalence is encouraging, more than one in every seven Zimbabweans is still infected with HIV.

Due to its long latency and the resulting pathological manifestations, HIV and AIDS have dramatically highlighted those systemic inadequacies, many of which existed long before the epidemic even began. Capacity is largely the sum of commitments past and no amount of money can instantly rectify a heritage of such underdevelopment. Another point to note is that contrary to developed countries, Baldwin (2005) notes that AIDS can only be tackled and overcome by gaining the active consent and support of everyone who is at risk or infected. This is part of a wider shift in public health strategies in developed countries, away from control-based measures towards placing responsibility on the individual. Its efficacy should depend on other parallel social changes, including high levels of health

awareness. A climate of liberal individualism and universal access to good-quality health services.

7.7 Perception on HIV and AIDS solutions in Zimbabwe

In conclusion to these intense interviews, there was need to ask on possible future strategies to tackle the HIV and AIDS epidemic in Zimbabwe. After all, these are the Harare's influential elite responding to these questions, hence what better chance of gaining their insight about the future of innocent and vulnerable citizens in Harare. In line with this, the question asked was a situational concept; if the key-informants were to be the head of the HIV and AIDS prevention strategy in Zimbabwe, what kind of solutions would they have? In other words, what strategies would they come up with to achieve a successful fight against this epidemic?

In response, Mrs Chisamba believes the 'ABC' approach is Zimbabwe's only way out regardless of the loopholes, the only point she emphasised is that we have to make sure it works. There are also other key-informants who emphasised on the scaling up strategy of the 'ABC' approach by encouraging and promoting condom use for everyone including the married as no one knows who brings HIV into the home. They also argue that people should be tested before sexual encounters. Others went on to suggest a combination of Male Circumcision, Condom Distribution, VCT and Anti - Retroviral Therapy arguing they are pragmatic, practical and can really give results.

On the contrary, one respondent highlighted the fact that the current prevention strategies are ineffective and not ideal to the socio-economic and political context currently faced by Zimbabweans by saying:

It is important to emphasise the fact that some of the strategies we implement and we expect people to follow are not practical. They are ideal, but not real. I would convene an all-stakeholder meeting and come up with population segment-specific strategies from the Government, church, traditional leaders, health professionals and civic society. I would proceed to implement their approaches to the different segments of the population that they appeal to'.

One of the key significant findings in this research is that despite the devastating consequences AIDS has brought in Zimbabwe, the disease remains as the periphery of the political landscape. HIV and AIDS were not a major focus for either party during the parliamentary elections of 2000 or the presidential campaign in 2002 and also the 2005 elections, where prominent issues were land reform, the plummeting economy and transparent governance. The control programmes in Africa are largely dominated by a mechanism of social control and mobilization within a leftist tradition of revolutionary warfare and patrimonial governance. Basic HIV prevention, treatment, care and support services in Harare are not accessible to key populations because of restrictive policies and laws, poor service design and limited availability. Prohibitive laws and policies also pose as significant barriers to universal treatment.

CHAPTER 8

DISCUSSION AND CONCLUSION

The data collected from Government departments indeed indicate a fall in Zimbabwe's adult HIV prevalence. The research findings have shown that indeed, there is evidence that Zimbabwe's HIV prevalence has fallen. The challenge is in agreeing to the suggestions that this was entirely as a result of successful behavioural interventions. Caution should thus be taken when interpreting data as it is not yet known whether the trend is a sign of long-term change or merely a temporary movement. Although, the Government has championed its behavioural change strategy as the main catalyst of such a significant drop in prevalence rates. This research however noted that, given the large number of homeless and displaced people living in Zimbabwe who are not likely to have been surveyed, the results cannot be taken as wholly representative of the situation as will be highlighted in the following sections.

8.1 Approaches to Prevalence Rates Estimations

Official statistics are usually quite alarming, published as 'facts' when they are based only on estimates, computer modelling and calculations rather than counting. Before AIDS tests were readily available in Africa, the diagnosis was usually made clinically, seeing a combination of symptoms that were typical in AIDS patients. Unfortunately, these symptoms (cough, diarrhoea, weight loss) were so common in other diseases that an individual presenting them could simply have pneumonia and amoeba, not AIDS (Dowing, 2005). Even when tests became available, there were many false positive results.

Consequently, when epidemiologists put together statistics for Africa, they based them on the only information that they had which included clinical guesses and the false positive tests.

News of Zimbabwe's declining HIV prevalence rates has always been met with scepticism and confusion, particularly in view of the country's economic and political climate. Zimbabwe has been and is arguably still experiencing one of the harshest AIDS epidemics in the world. In a country with a growing tense political and social climate, it has become difficult to effectively implement HIV and AIDS responses. Zimbabwe has become increasingly isolated, both politically and economically. The economy was suffering from a rapidly growing rate of inflation that was around 15 000% in November 2007¹²⁴. The economic decline that fuelled food shortages at a time when poverty was already rife, lead to a desperate situation where one would assume an overlook of the HIV and AIDS agenda in the face of more immediate survival concerns.

Analysts then wonder whether the decline in prevalence rates can be attributed to behavioural change or skewed statistics. Earlier, findings from the Zimbabwe Demographic Health Survey for 2005-06 revealed that the prevalence rate had declined from 20.1 % to 18.1 % among adults. Women were still the hardest hit, with prevalence figures reaching 21.1 %, while 14.5 % of men were HIV-positive. The latest from Sentinel surveillance shows a further reduction of the HIV prevalence rate to 15.6% (MOHCW, 2007).

¹²⁴ The Zimbabwean, 2007. <http://www.thezimbabwean.co.uk/>

It is fundamental to note that United Nations Programme on HIV and AIDS (UNAIDS), World Health Organisations (WHO) and the Reference Group on Estimates, Modelling and Projection comprehensively reviewed their methodologies and monitoring systems to provide epidemic estimates that reflect improvements in country data collection and analysis, as well as a better understanding of the natural history and distribution of HIV infection. Notably, the average number of years the people living with HIV are estimated to survive without treatment has increased from nine to eleven years. This longer average survival period has resulted in lower estimates of new HIV infections and deaths due to AIDS (UNAIDS, 2007).

On a Global scale, this reviewed methodology resulted in HIV prevalence reported to have fallen to an estimated 33.2 million in 2007¹²⁵. This figure is more than six million fewer people than the 2006 estimate of 39.5 million. The main reason for this reduction in global HIV prevalence was the recent downward revision of estimates in India. This combined with further revisions of estimates for five sub-Saharan African countries (Angola, Kenya, Mozambique, Nigeria and Zimbabwe) account for 70% of the reduction in HIV prevalence as compared to 2006. The decline largely reflected the changes in the way the HIV prevalence is estimated. The latest figures were argued to reflect improved and expanded epidemiological data analyses that presents a better understanding of the global epidemic.

¹²⁵ UNAIDS, 2007.

8.2 Understanding Prevalence Rates

Prevalence can go up and down for many reasons, including changes in surveillance methods, population migration and deaths of people living with AIDS, as well as new infections. In relying on prevalence figures, we have only the vaguest grasp of whether prevention measures are having any impact at all as the Governments do not have the tools to assess if their measurements are having any impact at all. Fig 8.1 below provides the researcher's illustration of what contributes to the prevalence rates.

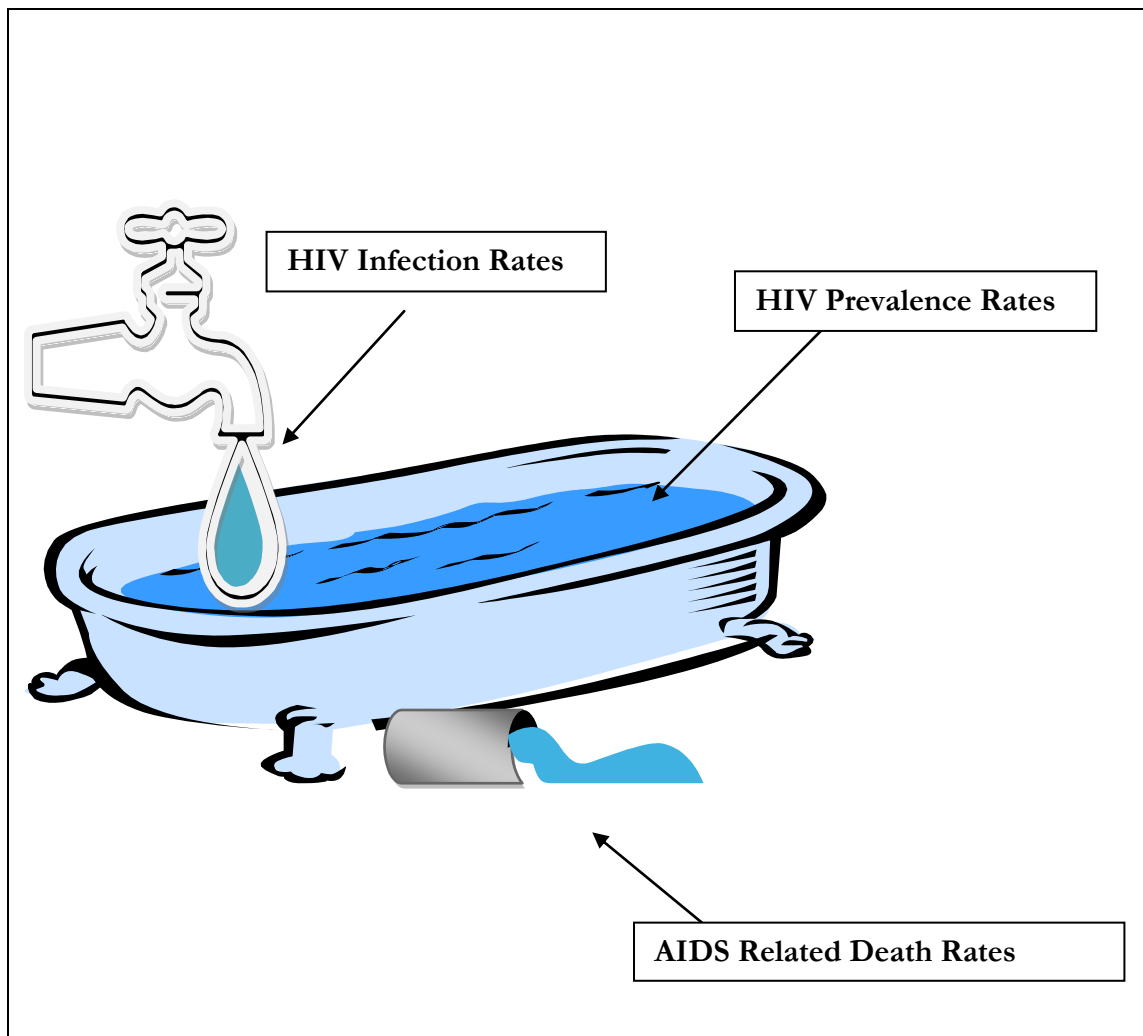


Fig 8.1 Illustration of HIV Prevalence Rate
(Source: Survey Data Analysis)

This illustration of a bath tub attempts to explain the fundamental dynamics of the HIV prevalence and its relationship with HIV incidence rates¹²⁶ and AIDS related Death. The bath tub illustrates that HIV prevalence rates are influenced by the rate of HIV Incidence and Death rates. From the interviews conducted in this study, there are significant indicators to show that despite the fact that the levels of knowledge on HIV and AIDS is significantly high, a number of people do not know the technical meanings or definitions of incidence and prevalence rates and a very small percentage knew the difference between the two terminologies. This was also noted in some interviews conducted with key Government informants hence one will have to question the significance of this confusion on the decreasing statistics on HIV prevalence rates in Zimbabwe.

The diagram below from the UNAIDS 2006 Report is the reflection of the bath tub illustration showing real figures of the global epidemic.

¹²⁶ The number of new HIV infections in the population during a certain time period.

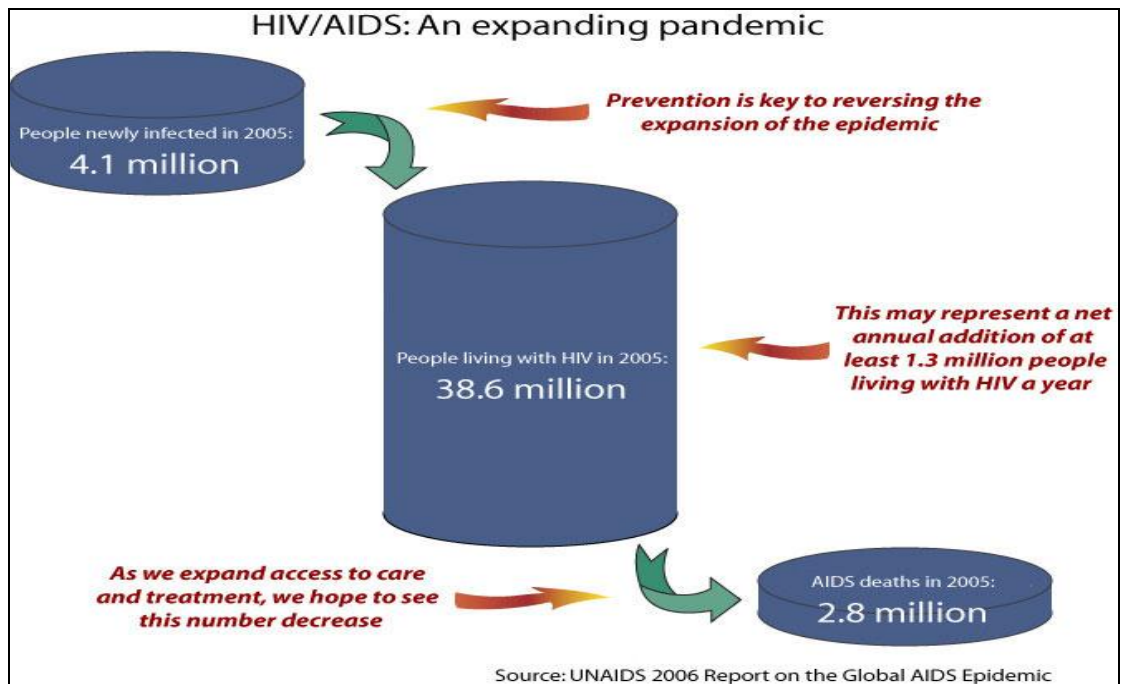


Fig 8.2 An Expanding Epidemic

The HIV and AIDS burden has continued to increase globally and more so in Africa. Africa harbours nearly 70% of all infections and yet has a small proportion of the world's population (UNAIDS, 2007). Although, the global prevalence of HIV infections appears to have levelled off based on the new estimates, the total number of people living with HIV is still increasing due to new HIV infections, combined with longer survival times.

The illustrations above demonstrate that if incidence rates decline possibly due to increase in condom use and sexual behavioural change, and the death rates remains constant, the prevalence rates will decline. However, if incidence rates decline and death rates decline possibly through longer survival rates as a result of Antiretroviral Therapy (ART), there will be a stagnant prevalence rate, which will not necessary, translate into failure of HIV and AIDS strategies.

Another possible dynamic is if incidence rates decline but with an increase in death rates, this will result in a significant decline in prevalence rates, which is thus confused as success in HIV and AIDS programming. This, as the research has learnt can be the possible logical explanation to the significant declining prevalence rates in Zimbabwe. The following sections provide other possible explanations of the declining rates in Zimbabwe.

8.2.1 Increased mortality rates

A rise in the number of people dying from AIDS is thought to have played a role in the decline. Given the economic and food security difficulties faced by Zimbabweans, it may be suggested that falling prevalence rates might point to factors other than sexual behaviour change, such as mortality, which could mean that the numbers of people dying from AIDS were outnumbering those newly-infected with HIV. Malnutrition might have also played a part in accelerating an HIV patient to develop AIDS as lack of food in the blood affects effectiveness of ARVs medication.

In the in-depth interviews, HIV and AIDS analysts agreed to the fact that severe economic and food security difficulties; a falling prevalence rate might indicate that the number of people dying from AIDS was outnumbering those newly infected with it. However, in a presentation at a conference on HIV and AIDS, Dr Owen Mugurungi, head of the US Government's HIV and AIDS unit, told delegates that after the dramatic decline was announced in Zimbabwe, further investigations revealed that the high mortality rate could not cause a reduction¹²⁷ Another AIDS activist, Ms Chaza, director of Zimbabwe's AIDS

¹²⁷ www.thebody.org

Network, highlighted that if the decline in prevalence rate can be attributed to behaviour change, there was need to find out what behaviour change took place and why, so that policymakers can capitalise on this and see what works and what does not¹²⁸.

Zimbabwe has seen the withdrawal of international aid because of its political instability. Because of the cuts in donor funding, Zimbabwe in 2007 received the lowest donor support in Southern Africa for people living with HIV, at only \$4 per person per year. This fell short for the people who were HIV positive; in comparison to neighboring Zambia receives the figure of \$184 per person per year¹²⁹. While campaigns to prevent and treat HIV in other African nations benefit from international aid, the political situation in Zimbabwe's political and economic crisis caused most foreign donors to either decrease aid for the country or halt it altogether whilst at the same time, the United States, Australia and the European Union have also imposed economic sanctions¹³⁰ on Zimbabwe.

8.2.2 Emigration

An increase in the number of emigrants, both HIV positive or otherwise from Zimbabwe might also be considered as a fundamental factor on the declining prevalence rates. Inevitably, comparisons have been drawn between wealthier countries, such as South Africa and Botswana, which have failed to record any significant declines, while cash-

¹²⁸ The Zimbabwean, 2007.

¹²⁹ UNDP Country Programme Document, 2009

¹³⁰ Domestic penalties applied by one country (or group of countries) on another for a variety of reasons

strapped Zimbabwe has managed to bring down its level of HIV infections. Questions have also been raised about whether the large numbers of Zimbabweans leaving the country, have affected the prevalence rates of neighbouring countries and other destinations where Zimbabwean have emigrated to. The UNAIDS review of the Zimbabwe's declining rates stated that international migration is believed to have been extensive and the possibility that it contributed in a small way to the decline in HIV prevalence could not be ruled out given the limited data available. (UNAIDS, 2007).

8.2.3 The Government's Operation Restoring Order (*Murambatsvina*)

Given the large number of homeless and displaced people living in Zimbabwe who are not likely to have been surveyed, the results cannot be taken as wholly representative of the situation. A number of these people had previously been receiving antiretroviral drugs (ARVs) to delay the onset of AIDS, but now had no access to them as treatment centres and clinics had been demolished and some were forced to live far away from their local health centres. The interruption of ARV treatment can lead to drug resistance, declining health, and in some cases death.

As well as affecting people who were already living with HIV, the campaign may also have contributed to the spread of infection. Factors such as increased population mobility, the separation of couples and an increased number of women turning to sex work in order to survive are likely to have increased the frequency of unsafe sex in many areas. Access to education and information about HIV decreased, and nationwide sales of condoms fell.

Between May and June 2005, sales of male and female condoms dropped by over 20% and 40% respectively¹³¹.

8.2.4 Declining numbers attending HIV Testing

The researcher also noted that there has been a significant decline in the number of people getting HIV tests, from hospitals and Voluntary Testing Centres (VCTs). A majority of those interviewed expressed the fact that they are pre-occupied with trying to feed their families and survive the economic crisis to an extent that getting an HIV test was deemed irrelevant to the current situation. Those who admitted getting a recent test reported they were initially ill and were referred to get tested by medical doctors. Others were forced by their work policies where they are employed. Some of the respondents who would consider the test simply cannot afford to travel the long distances to the hospitals or testing clinics. They mentioned they would rather use the money to put food on the table. With the large numbers of health personnel emigration, this brain drain phenomenon has also resulted in a shortfall in the capacity to conduct HIV testing services.

8.3 In conclusion...

The researcher concludes by arguing that the fall of HIV prevalence rates did not occur exclusively as a result of HIV behavioral change programmes. There are other factors that should be considered, those mentioned in the previous sections above. Although survey results do indeed indicate a fall in Zimbabwe's adult HIV prevalence, caution should be taken when interpreting the data available; it is not yet known whether the trend is a sign of long-term change or merely a temporary movement as the figures do not reflect a regional

¹³¹ UNFPA, 2005.

trend. In Botswana, HIV prevalence among pregnant women aged 30-34 is still on the rise, even though it has fallen somewhat in women aged 16-24. In Swaziland, one in three adults is still now living with HIV¹³².

Additional research still needs to be done to assess how big each factor has contributed to the decline. A number of key informants argued that what remains factual is that combined Government and NGOs behavior-change strategies throughout the 1990s were absorbed and applied by Zimbabwe's educated populace and that the evidence clearly indicates that mortality alone is not responsible for the drop. This is proven by the fact that Zimbabwe has one of the highest rates of condom use in Southern Africa

The study also concludes that we do not know how far back sexual behaviour change began to feed into fewer infections. It is important to note that measuring success is technically complicated. The key indicator for success is prevention efforts in HIV incidence. This had been hard to measure and is not in fact monitored anywhere consistently. As a proxy, leaders say things are getting worse when prevalence rates go up, and claim the credit for success when they go down. What is not widely understood is that prevalence estimates vary for many reasons, including the death rate of people with HIV (as people live longer with ART, prevalence rates will increase), migration and the commonest reason of all, methodological changes in the way of collecting and analysing data. The analytical models and evidence base are very poor and inadequate, which leaves the door for the opportunistic exploitation of fragments of good news for political ends.

¹³² UNAIDS, 2009.

As Harare experienced critical conditions, most civil society organisations and activists were non operational hence the voice of the poor is was not effectively heard on issues of about HIV and AIDS. The POSSA rule and suppression of freedom of speech in Zimbabwe makes it harder for anyone to voice their concerns, so they just accept things as they are.

The research has shown that higher levels of knowledge are substantially unrelated to safer sex practices; it does not result in greater intention to use condoms nor in greater actual use. Attitudes and knowledge, while important preconditions of safer sex behaviour, do not tell the whole story hence a need to go beyond these two variables. Zimbabwe's behavioural change strategies will not make sustainable progress until the country acquires coherent, legitimate and effective national strategies. The state is a complex of institutions that provide the foundation on which health care, education and economic activity depend. In the absence of a capable state or in a crisis state, and culture of healthy institutional practices, advancement in major social sectors will be uneven and uncertain.

The recent crisis has highlighted the increased interaction between politics, the economy and social environment including HIV and AIDS in Harare. Unsafe sexual practices are not entirely a result of deficit of knowledge, motivation or skills, but instead have meaning within a given personal and socio-cultural and economic context. Because of the costs and complications involved, it is important to note that Zimbabwe collects very little comprehensive data on health status of the general population.

The incessant economic problems have negatively affected the efforts to curb the HIV and AIDS epidemic. Though there are adverts and lessons being dished out on prevention

strategies and behaviour change, they are falling on deaf ears in Zimbabwe because of the economic situation. People, especially women and girls are now forced to marry early so as to secure a comforter and a financial provider in these harsh economic times when most women cannot make ends meet on their own. Early age at first marriage increases the risk of the spouses to HIV. Others women and girls are now engaged in transactional sex as a way of making a living. This makes the conventional 'ABC' approach a difficult behavioural strategy to follow in the face of the economic breakdown. Commercial sex work for women and girls is not usually voluntary but it is a coping strategy in response to the poverty and famine that has been brought about by the hard economic times.

Efforts to prevent the spread of HIV in Zimbabwe have been spearheaded by the NAC, NGOs and religious and academic organisations. Although HIV prevalence has probably fallen, indicating a change in sexual behaviour, it is difficult to say how significant the role of prevention programmes has been in achieving this trend. Prevention schemes have been significantly expanded since the turn of the millennium, but remain critically under-funded.

There has also been conflict between the messages promoted by different programmes; for instance, some religious or traditional campaigns discourage the use of condoms and place emphasis on abstinence, contrasting with the strategies of some other organisations. This has led to confusion about how it is best to prevent HIV infection, particularly amongst young people.

This study has also shown that behavioural attitudes that result from knowledge and HIV and AIDS policies are multi-directional, giving a conclusion that there is a serious knowledge –policy divide in Zimbabwe. Individual's knowledge, attitudes and behaviour

regarding HIV and AIDS is to some degree determined by the structure and functionality of the state. It seems also fundamental to differentiate prevention strategies between various groups. Community oriented strategies are good but this tends to conjure up images of homogeneous groups of people living in similar environments. The research finds a need for the Zimbabwean Government to avoid addressing its citizens in abstract and over-generalized terms. Zimbabwe at present, needs to find ways to reduce the likelihood that people will engage in behaviours that will put them at risk and increase the likelihood that they will engage in safer behaviours.

Whilst the debates and criticisms are still being brought up regarding the actual figures of the prevalence rates in Zimbabwe, this research has noted that it is very difficult for any Government or any organisation to implement policies they really do not have actual statistics on. There are ongoing debates on implementation of compulsory testing on every citizen in countries with high prevalence rates, but making it optional for anyone tested to know their results. This ideology has not been favourable to many Human Rights Organisations; however, there are very fundamental strengths that this approach might potentially bring to HIV and AIDS prevention programmes. Just like in a battlefield, the army has to know the number of enemies they are dealing with to make effective strategies, as such, HIV and AIDS key policy makers will eventually get to work and address the issue with the closest possible and most realistic statistics.

The effective prevention strategies to HIV and AIDS do not depend solely on the individual, but on the quality of the state, as an institution, changes in culture, economy as well as the political structures. What this study has successfully learnt is arguably the fact that with the current economic situation in Zimbabwe, the Government is giving its people

prevention messages that are unrealistic courses of action. Important questions arise when trying to account for widely different experiences of the Zimbabwean population at present. Public policy approaches of the 'ABC' prevention strategies are showing little evidence of behavioural change which can be entirely be credited to the campaign and not accounting for the high death and immigration rates that have significantly altered the figures.

Therefore, rather than a single, specific disease prevention program, broad health promotion and healthy lifestyle programs may be beneficial. Broad health promotion programs would address HIV prevention in the context of other important health, economic, political and even social issues. In fact, there is evidence that health behaviours may be linked; that is, broad health promotion or healthy lifestyle programs may work to prevent chronic diseases and other health concerns. Perhaps self empowerment programmes for Zimbabwean citizens might be beneficial. This form of learning is advocated as being more successful because the learner is actively encouraged to participate in the learning programme, to explore their own values and beliefs and to develop an understanding of the extent to which factors such as past socialisation and position in society affect the choices that each of us make. However, self-empowerment alone can be insufficient to effectively resist the constraints imposed by socio-economic structures. Hence, one may feel powerful and self important after the health education, but unless the conditions which led to their original feelings of worthlessness and powerlessness are changed, these positive feelings enhances may evaporate on the next occasion that their cause is encountered.

The scope and character of one's broader social network, the array of contacts upon who one relies for support, who serve as reference groups and who establish group standards of conduct (social norms) and sanction behaviour, is central to understanding the behaviour that puts one at risk for HIV infection (Klovdal, 1985, Neaigus et al, 1994). Social networks and norms that govern those behaviour of Harare residents exist within communities, including those defined by culture, hence sensitivity to the values and historical experiences of cultural communities is essential for designing and implementing appropriate AIDS interventions. A social network is composed of an individual's relationships in the immediate social world. The number and the type of relationships and the degree of closeness are part of the structure of the network which is a fundamental element in the fight against HIV and AIDS.

Through social networks, individuals are linked to neighbourhood and communities both geographic and culturally thus, networks are indicators of social integration, how extensively and how tightly one is woven into the fabric of social life. They are a source of emotional and instrumental support, providing companionship, information and reference groups. Both the content (such as friendship, professional) of the interactions in the network and the form of structure of the network itself (such as close knit or loose, extensive or limited) can affect behaviour profoundly.

As recommendations, from what this research has attempted to show, there is a need for the Zimbabwean Government to develop different priorities and different values that are practical in such a crisis time. There is a need for constant review of policies implemented and constant change if the need arises as the HIV and AIDS crisis in Africa must be treated holistically. The cofactors, such as the living standards and poverty are as important

as the virus itself. The study has also highlighted a confusing finding that may suggest HIV infection rates are evidently, in the case of Zimbabwe declining as the country becomes poorer.

In conclusion, this dissertation allowed us to better understand why HIV prevalence rates have declines and it is an exclusive attribution to behavioural change strategies. It also provided better insight regarding the extent to which populations regard HIV and AIDS as something that warrants their attention when a nation is on a political, financial and economic crisis. The researcher hopes this thesis will serve as a valuable source of information for other researchers who are committed to reducing the impact of HIV/AIDS.

BIBLIOGRAPHY

- Abraaham, C.** 1992. 'Health Belief and Promotion of HIV-Prevention Intentions Among Teenagers : A Scottish Perspective', in *Health Psychology* (11) 6, 363-370.
- Aggleton, P, Davies, P. and Hart, G.** (eds). 1992. *AIDS: Rights, Risk and Reason*. The Falmer Press, London.
- Ainsworth, M. and Teokul, W.** 2000. 'Breaking the Silence: Setting Realistic Priorities for AIDS Control in Less- Developed Countries', *Lancet* 356 (1 July) : 55-60.
- Allen, T.** 2004. 'Why don't HIV and AIDS Policies Work', in *Journal for International Development* (16), 1123-1127.
- _____. 2004. 'HIV and AIDS Policy in Africa: What has worked in Uganda and what has failed in Botswana?'. in *Journal of Internatioanl Development* ,(16), 1141-1154.
- Altschull, J.A.** 1984. *Agents of Power: The Role of News Media in Human Affairs*. Longman, New York.
- Alwang, J. ,Ersado, L. and Taruvinga, N.** 2001. 'Changes in poverty in Zimbabwe between 1990 *Africa* 18 (5): 553-79. and 1996: worsening outcomes under adverse conditions', in *Development Southern*.
- anderson, J.E.** 1975. *Public Policy Making*. Praeger, New York.
- Barnett, T. and Blaikie, P.** 1992. *AIDS in Africa: its present and future impact*. Belhaven Press: London.
- Barnett, T. and Clement, C.** 2005: HIV and AIDS impact: so where have we got to and where next? *Progress in Development Studies* 5 (3), 237-247.
- Baylies, C.** 2002: The Impact of AIDS on rural household in Africa : a shock like any other? *Development and Change* 33, 611-32.
- Bernays, E.L.** 1930. *Propagand*. Horace Liveright, New York.
- Bisseker, C.** 2002. 'AIDS Epidemic Runs Wild' in *Financial Mail Zimbabwe* (July 5 2002), Health. 30.
- Bolton, P. and Wilks, C.** 2004: How do Africans view the impact of HIV? A report from a Ugandan community. *AIDS CARE* 16, 123-28.
- Bond, G. C and Vincent, J. (eds)** 1997. 'AIDS in Uganda : The First Decade', in *AIDS in Africa and the Caribbean*, pp. 85-98. Boulder, CO : Westview Press.
- Bowra, R.** 1999. 'Media and Polical Communication in Thailand : The role in policy advocacy' in *Thai Development Newsletter*, (36) January-June,29-34.

- Brattan, M. et al.** 2005. 'Proganda and Public Policy Opinion In Zimbabwe' in *Journal of Contemporary African Studies*, 23 (1) January, 77-107.
- Bryman, A.** 2004. *Social Research Methods*. Oxford University Press, Oxford.
- Caldwell, J.C.** 1995. ' Understanding the AIDS Epidemic and Reacting Sensibly to it', *Social Science and Medicine* 41 (3): 299-302.
- Campbell, C.** 2003. 'Letting them Die; Why HIV and AIDS Prevention Programme Fail' in *African Issues*. The International African Institute. South Africa.
- Cauvin, H.** 2001. 'Zimbabwe Fund for AIDS Patients is Frozen in Bureacracy'. *New york Times*, August 19, 2001.
- Cernea, M.** 2000. 'Risks, Safeguards and Reconstruction: a Model for Population Displacement and Resettlement', in Cernea, M. and McDowell, C. (eds.) *Risks and Reconstruction: Experiences of Resettlers and Refugees*. Washington DC: World Bank.
- Chabal, P.** 1992. *Power in Africa*. London : Macmillian.
- Conner, M. and Norman, P. (eds).** 1998. *Predicting Health Behaviours*. Open University Press, Buckingham.
- Dube, L.** 1997. 'AIDS-risk patterns and knowledge of the disease among street children in Harare, Zimbabwe' in *Journal of Social Development in Africa* 12 (2): 61-73
- Duffield, M.** 1994. 'Complex Emergencies and the Crisis of Developmentalism', *IDS Bulletin* 25 (4) : 37-45
- Epstein, H.** 2001. 'AIDS: The Lesson of Uganda', *New York Review of Books* 48 (11): 18-23.
- Ersado, L.** 2005. 'Income diversification before and after economic shocks: evidence from urban and rural Zimbabwe', in *Development Southern Africa*, 22 (1): 27-45
- Fahim, F.** 1983. *Egyptian Nubians : Resettlement and Year of Coping*. University of Utah Press: Salt Lake City.
- Foster-Rothbart, A. et al.** 2002. 'Effective strategies for preventing HIV and AIDS in developing countries : lessons from Brazil, Senegal, Thailand and Uganda'. University of Wisconsin. U.S.A
- Gillham, B.** 2000. *Developing a questionnaire*. Continuum, London.
- Government of Zimbabwe.** 1999. *National HIV/ AIDS strategies framework for national response (2000-2004)* Government Printers, Harare, Zimbabwe.
- Gregson, S, et al.** 2006. 'HIV decline associated with behavioural change in Eastern Zimbabwe'. *Science* 311 (5671): 664-666.
- Haacker, M.** 2002. 'The Economic Consequences of HIV and AIDS in Southern Africa. *IMF Working Paper WP/02/38* (Washington D.C ; International Monetary Fund, 2002), 12.
- Hargrove, J.W. et al.** 2005. *Declining HIV prevelence and incidence in women attending Maternity clinics in greater Harare*. Zimbabwe

- Hartnack, A.** 2005. 'My Life Got Lost': Farm Workers and Displacement in Zimbabwe' in *Journal of Contemporary African Studies* 23 (2): 173-192
- Health Action International.** 2002. 'Drug Policy at the 54th World Health Assembly. WHO's Growing Partnership with the Private Sector : Addressing Public Health Needs or Corporate Priorities?'. Amsterdam : Health Action International.
- Hill, M. and Hupe, P.** 2002. *Implementing public policy: Governance in Theory and Practice*. Sage, London.
- Hogwood, and Gunn, .** 1984. *Policy Analysis for the Real World*. Oxford University Press. Oxford.
- Janz, N.K. and Becker, H.M.** 1984. 'The Health Belief Model: A decade later', in *Health Education Quarterly* (11):1-47
- Kalu, K.A.(ed).** 2004. *Agenda Setting and Public Policy in Africa*. Ashgate, England.
- Kent, R. (ed).** 1994. *Measuring Media Audiences*. Routledge, London.
- Korn, D.** 1999. *Exodus Within Borders: An Introduction to the Crisis of Internal Displacement*. Brookings Institution Press, Washington D.C.
- Love, R.** 2004. 'HIV and AIDS in Africa: Links, Livelihoods and Legacies', in *Review of African Political Economy* No. 102 (639 - 48)
- Lynn, L.E. et al,** 1999. '*The Empirical Study of Governance : Theories, Models and Methods*', A paper presented at the Workshop on Models and Methods for Empirical Study Of Governance. University of Arizona, Tucson.
- Mahomva, A. et al.** 2006. HIV prevalence and trends from data in Zimbabwe, 1997 – 2004. *Sexually Transmitted Infections* 82 (2) April.
- Makumbe, J.M.** 1998. *Democracy and Development in Zimbabwe*. SARES Trust, Harare.
- Maltelart, A. et al.** 1998. *Theories of Communication : A Short Introduction*. Sage, London.
- Marquette, C.M.** 1997. 'Current poverty, structural adjustment and drought in Zimbabwe', in *World Development*, 25 (7): 1141-50.
- MISA.** 2002. *So This is Democracy? State of the Media in Southern Africa*. An Annual Report of The Media Institute of Southern Africa (MISA), Namibia.
- Melkote, S.R et al.** 1992. *Communication Gap in Development*. Rawat, Jaipur.
- MISA.** 2004. *HIV and AIDS and the Media Journal*. Media Institute of Southern Africa, Nairobi.
- Montaike, S.** 2003. World Asia Pacific, in *Christian Science Monitor* November 20, 2003, edition
- Mugwetsi, T. and Ballies, P.** 1994. ' The Forgotten People : The Living and Health

Conditions of Farm Workers and Their Families'. *Silveira House Social Series No.*
6. Mambo Press and Silveira House, Gweru.

Newbold, C. et al. 2002. *The Media Book*. Arnold, London.

Okigbo, C.C. 2004. *Development and Communication in Africa*. Rowman and Littlefield, U.S.A.

Parkhurst, J.O. 2001. 'The Crisis of AIDS and the Politics of Response : The Case of Uganda'. *International Relations* 15 (6): 69-87.

_____. 2002a. 'The Ugandan Success Story? Evidence and Claims of HIV- 1 Prvenetion', *Lancet* 360 (6 July) :78 –80.

_____. 2002b. ' HIV Prevention Policy in Sub- Saharan Africa : The Ugandan Experience'. PhD Thesis, Department of Sociology and Social Policy, University of Oxford.

Patterson, D. 2001. 'Political Commitment, Governance and HIV and AIDS' in *Canadian HIV and AIDS Policy and Law Review* 6(1): 39-45.

Peil, M., Mitchel, P. and Rimmer, D. 1982. *Social Science Research Methods : An African Handbook*. Hodder and Stoughton, London.

Price, A.T. and Daly, J.L. 2004. *HIV and AIDS , State Capacity and Political Conflict in Zimbabwe*. Institute of Peace, U.S.A.

Richter, L. and Swart –Kruger, J. 1995. 'AIDS- risk among street children and youth: Implications for intervention', in *South Africa Journal of Psychology* 25 (1): 31-38

Rhods, R.A.W. 1997. *Understanding Governance : Public Networks, Governance, Reflexity and Accountability*. Open University Press, Buckingham.

Rutherford, B. 2001. *Working on the margins: Black Workers, White Farmers in Postcolonial Zimbabwe*. Weaver: Harare.

Sachikonye, L. 2003. 'The Situation of Commercial Farm Workers after Land Reform in Zimbabwe'. Report prepared for the Farm Community Trust of Zimbabwe: Harare.

Save the Children Fund (UK). 1999. 'Do Not Look Down On Us: Children's Voices from Informal Settlements in Zimbabwe'. Save the Children (UK)

Schneider, H. and Stein, J. 2000. ' Implementing Aids Policy in Post- Apartheid South Africa'. *Social Science Medicine*.52 .723-731.

Scoones, I. Et al, 1996. *Hazards and opportunities, farming livelihoods in dryland Africa: Lessons from Zimbabwe*. Zed Books :London.

Spenser, J. E. 2005. 'Zimbabwe: future imperfect?' in *Conflict, Security and Development* 5 (3): 363-70.

Storey, D. and Scheyvnes, R. 2003. *Development Fieldwork: A Practical Guide*. Sage, London.

Strategic Survey. 2004/05. 'Zimbabwe: Mugabe's Impunity'. International Institute for Strategic Studies, London.

UNAIDS, 2002. *AIDS Epidemic Update, December 2002*. World Health Organisation, Geneva.

____ 2002. 'Epidemiological Fact Sheets : Zimbabwe .2002 Update (revised).Geneva .

____ 2002. *Report of the Global HIV and AIDS Epidemic*. UNAIDS, Geneva, p23.

____ 2004. *Report on the Global AIDS Epidemic*. UNAIDS, Geneva.

____ 2006. *Report on the global AIDS epidemic, May 2006*. UNAIDS, Geneva.

UNAIDS/WHO. 2006. *AIDS Epidemic Update, December 2006*. UNAIDS, Geneva.

United Nations. 2001. 'HIV and AIDS Group Accuse Government of 'Playing Politics'', United Nations Integrated regional Information Networks, November 15, 2001.

Norwegian Refugee Council. 2000. *United Nations Guiding Principles on Internal Displacement Internally Displaced People: A Global Survey*. Second Edition. Earthscan. London.

Vambe, M.T. 2003. ' HIV and AIDS, African Sexuality and the problem of representation in Zimbabwean Literature' in *Journal of Contemporary African Studies* 21 (3) : 473-489.

Waal De, A. 2003. 'How will HIV and AIDS Transform African Governance?' in *African Affairs*, Royal African Society .102.

Wamsley, G.L. et al. 1990. *Refounding Public Administration*. Sage, California.

Webb, D. 1997. *HIV and AIDS in Africa*. Plunto Press, London.

Pinkerton SD, Abramson PR. Effectiveness of condoms in preventing HIV transmission. *Social science & medicine* 1997,44:1303–1312.

Weller SC. A meta-analysis of condom effectiveness in reducing sexually transmitted HIV. *Social science & medicine* 1993,36:1635–1644.

Allen S, Meinzen-Derr J, Kautzman M, Zulu I, Trask S, Fideli U, et al. Sexual behavior of HIV discordant couples after HIV counseling and testing. *AIDS* 2003,17:733–740.

UNAIDS. Report on the Global AIDS Epidemic. In: Joint United Nations Program on HIV/AIDS; 2008.

16. Joint United Nations Programme on HIV/AIDS (UNAIDS). Monitoring the Declaration of Commitment on HIV/AIDS : guidelines on construction of core indicators : 2010 reporting. In. Geneva: UNAIDS/07.12E / JC1318E; 2009.

Janzand Becker (1984). The Health Belief Model: A Decade Later. *Health Education and Behavior*, 11, 1-47.

Glanz, K., Rimer, B.K. & Viswanath, (2008). *Health Behavior and Health Education: Theory, Research, and Practice*. (3rd edition), Jossey-Bass.

Rosenstock, I. (1988). Social Learning Theory and the Health Belief Model. *Health Education Quarterly*, 15, 175-183.

Rosenstock, I., Stretcher, V., & Becker, M. (1994). The health belief model and HIV risk behavior. In DiClemente, R. & Peterson, J. (Ed), *Preventing AIDS: Theories and methods of behavioral interventions* (pp. 5-22). Plenum Press, New York.

Glanz, K., Rimer, B.K. & Viswanath, (2008). *Health Behavior and Health Education: Theory, Research, and Practice*. (3rd edition), Jossey-Bass.

Conner, M. & Norman, P. (1996). *Predicting Health Behavior. Search and Practice with Social Cognition Models*. Open University Press: Buckingham

Gregson S et al. *HIV decline in Zimbabwe due to reductions in risky sex? Evidence from a comprehensive epidemiological review*. Int. J. Epidemiol advance online edition April 20, 2010. doi:10.10193/ije/dyq055

Seeger, M. W.; Sellnow, T. L.; Ulmer, R. R. (1998). "Communication, organization, and crisis". *Communication Yearbook* 21: 231–275.

Borodzicz, E. P. 2005 'Risk, Crisis and Security Management' John Wileys, Chichester.

¹ Weiss R.A. 1993. "How does HIV cause AIDS?". *Science* 260 (5112): 1273–9.

² Douek D.C, Roederer M, Koup R.A .2009. ["Emerging concepts in the immunopathogenesis of AIDS"](#). *Annu. Rev. Med.* 60: 471–84.

¹ Sepkowitz KA (June 2001). "AIDS--the first 20 years". N. Engl. J. Med. **344** (23): 1764–72.

^{a b} Taylor C. Boasand Jordan Gans-Morse, Neoliberalism: From New Liberal Philosophy to Anti-Liberal Slogan, Studies in Comparative International Development (SCID), Volume 44, Number 2, 137-161

- Wiarda, Howard J. (1997) [*Corporatism and comparative politics*](#). Armonk, NY: M.E. Sharpe, [ISBN 978-1-56324-716-3](#).
- IDS, 2006, HIV and AIDS issues among CSWs Report, IDS – Univ of Zimbabwe, Harare.
- MOHCW, 2007, Ministry of Health and Child Welfare Bulletin, Zimbabwe 2007, Zimbabwe National HIV/AIDS Estimates
- National AIDS Council/ Ministry of Health and Child Welfare/ USAID (May 2007), The HIV and AIDS epidemic in Zimbabwe
- The Zimbabwean, 2007, HIV/AIDS Statistics, Zimbabwe, The Zimbabwean Ltd, London
- UNAIDS, 2007, www.unaids.org
- WHO, 2005, Dec 2005 Zimbabwe Country Profile For HIV/AIDS Treatment Scale Up.
- www.thebody.org
- CDC, 2006, HIV/AIDS in Zimbabwe Report,
- FACT, 2006, www.fact.org
- NAC, 2005, www.nac.org
- UNAIDS, 2007, www.unaids.org
- www.thebody.org
- ZDHS, 2006, Zimbabwe 2005 – 2006 Demographic and Health Survey, Macro International, Maryland.
- <http://www.avert.org/aids-zimbabwe.htm>
- <http://www.unicef.org/infobycountry/zimbabwe>
- NSSA, (2005), Annual Statistical Report, The Statistics Department, Harare.
- The Zimbabwean 20- 26 December 2007
- Zimbabwe Demographic and Health Survey 2005-2006
- Ministry of Health AND Child Welfare, Zimbabwe. Zimbabwe national HIV and AIDS estimates, 2003. Health information and surveillance unit, Department of Disease prevention and Control, AIDS and TB Programme

- www.unaids.org
- Zimbabwe Demographic and Health Survey 2005 to 2006
- Zimbabwe Human Development Report, (2003), Redirecting our responses to HIV and AIDS, Poverty Reduction Forum, Institute of Development Studies, University of Zimbabwe.
-

103. Are you in a serious relationship?

1. Yes

2. No

104. Highest Level of Education.

1. None

2. Primary

3. Secondary

4. 'A' level

5. First degree

6. Masters

7. Doctorate

8. Professorship

9. Other (specify) _____

105. What is your Religion?

1. Christianity

2. African Tradition

3. Muslim

4. Hindu

5. None

6.

Other

(specify) _____

106. Occupation

1. Formally Employed

2. Informally Employed

3.

Unemployed

4. Student

107. If employed, what is your profession? _____

108. Average monthly income? Z\$ _____

109. Place of Permanent Residence _____

SECTION 2: SEXUAL MATTERS AND HISTORY

Many of the questions I will be asking relate to sexual matters and it is possible that you may feel uncomfortable. But please remember, that your responses are completely confidential and that you may indicate if there are any questions you do not wish to answer.

For the purpose of this research I will use these definitions for the terms below:-

A steady partner as a person one has sex with in an ongoing relationship.

A casual sexual partner refers to a person one does not know very well and has sex with only once or a few times.

200. Have you ever had sexual intercourse?

1. Yes

2. No

2→206

201. What was your age at first sex? _____

202. How many sexual partners (spouse, steady or casual partner) did you have during the past 12 months?

203. What is the relationship with your last sexual partner?

1. Spouse 2. Steady partner 3. Casual partner
4. Other (specify)_____.

204. Did you have sex with another person other than your spouse or steady partner in the past 12 months?

1. Yes 2. No 3. Don't Remember

205. Have you increased or decreased the number of sexual partners in the past 12 months?

1. Increased 2. Decreased 3. Constant

206. Do you think it is normal to indulge in casual sex?

1. Yes 2. No 3. Don't Know

207. In this community, do you think it is normal for a man or a woman to have an extra marital relationship?

1. Yes 2. No 3. Don't Know

SECTION 3: KNOWLEDGE OF HIV/AIDS AND PREVENTION STRATEGIES

300. HIV is spread by *(Please list all answers given)* _____

301. Can you tell that someone is HIV positive?

1. Yes 2. No 3. Not Sure

302. Can AIDS be prevented?

1. Yes 2. No 3. Don't Know

303. Can you name all HIV/AIDS prevention methods that you know? *(multiple response)*

1. Abstinence

2. Faithfulness

3. Condom use

4.

Other _____

304. Have you ever heard of the National AIDS Council (NAC).

1. Yes

2. No

SECTION 4: CONDOMS AND CONDOM USE

Now I would like to ask you questions about condoms and about your experiences with them and other sexual activities.

400. Have you ever used a condom?

1. Yes

2. No

2.→402

401. If yes, how did you get the condoms?

1. Bought

2. Given for free

3. Partner had them

4. Other (specify)_____

→404

402. If no, why do you not use a condom? _____

403. In the next 12 months, do you intend to use condoms?

1. Agree

2. Uncertain

3. Disagree

404. Do you know where to get condoms if you need them?

1. Yes

2. No

405. How readily available are condoms if you need them?

1. Found everywhere

2. Have to carry them

3. Not available

406. How often do you use condoms during sexual intercourse with your partner?

1. Always

2. Sometimes

3. Never

407. What will you do if an opportunity to have sex arises but you cannot access a condom?

1. Go ahead and have unprotected sex

2. Let the opportunity pass till I can secure a condom

2. I am not sure

408. Do you think condoms are only for men who have sex with casual sex workers?

1. Yes

2. No

3. Not Sure

409. Is it acceptable for a woman to bring a condom in a sexual relationship?

1. Yes

2. No

3. Don't Know

410. Would you be able to refuse to have sex if your partner did not want to use a condom?

1. Yes 2.No

411. What would you do if your partner suggests using a condom?

1. Discuss why a condom should be used
2. Seriously think about breaking the relationship
3. Accept the use of condoms
4. Don't know

SECTION 5: PERCEIVED SEVERITY.

I am going to ask you questions regarding beliefs that concern the consequences and severity of the HIV/AIDS disease in Zimbabwe.

500. Do all people who get HIV actually develop AIDS?

1. Yes 2. No 3. Don't Know

501. How many people do you think are dying of AIDS each week in Zimbabwe?

502. Do you think getting HIV is one of the worst things that you can imagine happening to you.

1. Yes 2. No

503. Do you think AIDS is such a serious disease that warrants your attention?

1. Yes 2. No

504. Do you believe that the consequences of getting HIV are significant enough to try to avoid?

1. Yes 2. No

505. Is AIDS a serious problem in your community?

1. Yes 2. No 3. Don't Know

SECTION 6: PERCEIVED VULNERABILITY

In this section I am going to ask you questions regarding beliefs that concern the likelihood that you may contract HIV.

600. Have you been tested for HIV?

1. Yes 2. No

2.→602

601. If yes, why were you tested? _____.

→605

602. If no, would you like to be tested?

1. Yes

2. No

3. Not Decided

603. If no, why would you not want to be tested? _____

604. Do you think you are at risk of infecting others without your knowledge?

1. Yes

2. No

3. Don't Know

605. How often do you worry that you might get HIV?

1. Very often

2. Sometimes

3. Never

606. How likely is it that you will get HIV in the next five years?

1. Very Likely

2. Likely

3. Unlikely

4. Very Unlikely

607. How likely do you think it is that you already are HIV positive?

1. Very Likely

2. Likely

3. Unlikely

4. Very Unlikely

608. Do you think you can get HIV/AIDS if you engage in high-risk sexual behaviour?

1. Strongly Agree

2. Agree

3. Uncertain

4. Disagree

5. Strongly Disagree

609. Do you think there are high-risk groups in your area of residence?

1. Yes

2. No

3. Don't know

610. If yes, what are the groups?

1. Commercial sex workers

2. Truck drivers

3. Cross -border traders

4. Other

(specify)

611. Which socio-economic class is more vulnerable to contract HIV?

1. Rich

2. Poor

3. Both

612. Do you think your present standard or quality of life makes you vulnerable to getting HIV?

1. Yes

2. No

613. Please give an explanation for your answer

SECTION 7: PERCEIVED EFFECTIVENESS OF PREVENTIVE BEHAVIOUR STRATEGIES

700. It is (was) easy for me to abstain from sex until marriage.

1. Agree 2. Uncertain 3. Disagree

701. Sexual Abstinence is the best method of preventing HIV/AIDS and other STIs.

1. Agree 2. Uncertain 3. Disagree

702. It is difficult nowadays to be faithful to one partner.

1. Agree 2. Uncertain 3. Disagree

703. Do you agree that a Zimbabwean man of today is faithful?

1. Agree 2. Uncertain 3. Disagree

704. Do you agree that a Zimbabwean woman of today is faithful?

1. Agree 2. Uncertain 3. Disagree

705. Can you prevent HIV/AIDS through faithfulness?

1. Agree 2. Uncertain 3. Disagree

706. If you disagree, what are your reasons?

707. Is it natural for man to have multiple sexual partners?

1. Agree 2. Uncertain 3. Disagree

708. Do you think condoms can effectively prevent HIV/AIDS and other STIs?

1. Agree 2. Uncertain 3. Disagree

709. Do you mind being seen carrying condoms with your partner?

1. Agree 2. Uncertain 3. Disagree

710. Do you think the "Abstinence, Be Faithful and Condom use" (ABC) approach is being effective in Zimbabwe?

1. Yes 2. No 3. Somehow 4.

Don't Know

711. In your own opinion, do you see any indications of sexual behavioural change in Harare?

1. Yes 2. No

712. Do you think the economic conditions in Harare offer an environment for sexual behavioural change?

1. Yes 2. No

713. Does Harare provide an environment in which people are not scared of talking about their HIV/AIDS status?

1. Yes 2. No

SECTION 8: ANTICIPATED COST OF BARRIERS TO PERFORM PREVENTIVE BEHAVIOUR.

The factors that will hinder one from practising the preventive behaviour

800. If you meet a new partner, do you inquire about their sexual history?

1. Yes 2. No

801. Would it seem rude to ask a new partner about their sexual life?

1. Yes 2. No 3. Depends

802. If you use a condom, would you feel guilty?

1. Yes 2. No 3. Not Sure

803. Do you think the condom would feel uncomfortable or too tight?

1. Yes 2. No 3. Not Sure

804. Do you think the condom might break?

1. Yes 2. No 3. Not Sure

805. If you used a condom, would you worry less about getting HIV infection?

- 1. Yes 2. No 3. Indifferent*

806. If you used a condom, would it lead the steady partner to think you had sex with someone else?

- 1. Yes 2. No 3. Not Sure*

807. If you insisted on using a condom, do you think a steady partner would be angry?

- 1. Yes 2. No 3. Not Sure*

808. Do you think a steady partner would refuse to have sex with you?

- 1. Yes 2. No 3. Don't Know*

809. Would you be angry if a casual partner insisted on condom use?

- 1. Yes 2. No 3. Not Sure*

810. Imagine that you carry condoms in your pocket/wallet. Do you think your friends would think bad of you?

- 1. Yes 2. No 3. Don't Know*

SECTION 9: ENVIRONMENTAL CUES AND ACCESS TO PREVENTIVE INFORMATION.

900. Do you ever listen to the radio?

1. Yes 2. No

2→902

901. How frequently do you listen to the radio?

1. Less than once a week 2.About once a week 3. 2-3 days a week
4. 4-5 days a week 5. Every day 6. Other

902. Do you ever watch television?

1. Yes 2. No

2→904

903. How frequently do you watch television?

1. Less than once a week 2.About once a week 3. 2-3 days a week
week
4. 4-5 days a week 5. Every day 6. Other

904. Do you read newspapers?

1. Yes 2. No

905. How frequently do you read newspapers?

1. Less than once a week 2.About once a week 3. 2-3 days a week
week
4. 4-5 days a week 5. Every day 6. Other

906. Have you heard or seen information about HIV and AIDS in the past month?

1. Yes 2. No

2→909

907. Where did you hear or see this information about HIV/AIDS?

1. Radio 2. Television 3. Workplace
4. Newspaper/ Magazine 5. Posters 6. Billboards
7. People from NGOs 8. Health Worker/Counsellor 9. Friends/ Relatives
10.Other (Specify)_____

908. What was the main message(s) that you picked about HIV/AIDS?

1. _____
2. _____
3. _____

909. Have you heard or seen information about Sexual Behavioural Change?

1. Yes
2. No

910. If yes, where did you hear or see this information?

- | | | |
|------------------------|-----------------------------|-----------------------|
| 1. Radio | 2. Television | 3. Workplace |
| 4. Newspaper/ Magazine | 5. Posters | 6. Billboards |
| 7. People from NGOs | 8. Health Worker/Counsellor | 9. Friends/ Relatives |

911. Do you know of any national political leaders who have spoken out on Sexual Behavioural Change?

1. Yes
2. No

912. Do you know of any national political leader who has disclosed that they are living with HIV or AIDS?

1. Yes
2. No

913. Do you know of any famous person who has spoken out on sexual behavioural change?

1. Yes
2. No

914. Do you know of any famous person who has disclosed that they are living with HIV or AIDS?

1. Yes
2. No

915. Do you think the Government is providing adequate information on HIV/AIDS through the media?

1. Yes
2. No

SECTION 10: MEASURE OF HEALTH MOTIVATION.

1000. I have changed my sexual behaviour because of AIDS?

- | | | |
|-------------------|----------------------|--------------|
| 1. Strongly Agree | 2. Agree | 3. Uncertain |
| 4. Disagree | 5. Strongly Disagree | |

1001. Knowing one's HIV is not helpful in the absence of treatment.

- | | | |
|-------------------|----------------------|--------------|
| 1. Strongly Agree | 2. Agree | 3. Uncertain |
| 4. Disagree | 5. Strongly Disagree | |

1002. If I engage in high-risk sexual behaviour, I will go for HIV tests as soon as possible.

- | | | |
|-------------------|----------|--------------|
| 1. Strongly Agree | 2. Agree | 3. Uncertain |
|-------------------|----------|--------------|

4. Disagree

5. Strongly Disagree

1003. What factors would motivate you to sexual behavioural change?

1. _____
—
2. _____
—
3. _____
—

SECTION 11: PERSONAL EXPERIENCES AND OPINIONS ABOUT HIV/AIDS

1100. Do you personally know someone who has HIV/AIDS?

1. Yes

2. No

2→1104

1101. How did you know about his/her HIV status? _____

1102. Do you have a family member who has HIV/AIDS?

1. Yes

2. No

1103. If yes, what is the relationship? (*multiple response possible*)

1. Mother

2. Father

3. Brother

4. Sister

5. Other _____

1104. Have you personally known someone who has died of AIDS?

1. Yes

2. No

2→1110

1105. How did you know about his/her HIV status? _____

1106. Do you have a family member(s) who died of AIDS?

1. Yes

2. No

1107. If yes, what was the relationship? (*multiple response possible*)

1. Mother

2. Father

3. Brother

4. Sister

5. Other _____

1108. Have you ever provided care for any relative/friend suffering from AIDS?

1. Yes

2. No

1109. Was he/she on Anti – Retroviral Therapy?

1. Yes

2. No

3. Don't Know

1110. Do you discuss any HIV and AIDS issues with:

Yes

No

1110a. Immediate Family Members?

1

2

1110b. Relatives?

1

2

1110c. Friends?

1

2

1111. How easy is it to discuss HIV and AIDS issues with:

	Very Easy	Easy	Difficult	Very
Difficult 1111a. Immediate Family Members?	1	2	3	
4				
1111b. Relatives?	1	2	3	
4				
1111c. Friends?	1	2	3	
4				

1112. DO you think HIV/AIDS will become easier to prevent if people become more open about it?

1. Yes

2. No

1113. What are your thoughts and worries about AIDS?

1114. What factors do you think are causing knowledge of HIV and AIDS not to translate to behavioural change in Harare?

THANK YOU FOR YOUR COOPERATION!

Dear Researcher

Please use this space to write any additional notes that you may feel will be useful
for this research.

APPENDIX 2: DATA ANALYSIS USING SPSS

Frequencies

(q100) Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	183	50.4	50.4	50.4
	Female	180	49.6	49.6	100.0
	Total	363	100.0	100.0	

(q102) Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	141	38.8	38.8	38.8
	Never Married	194	53.4	53.4	92.3
	Divorced	9	2.5	2.5	94.8
	Separated	12	3.3	3.3	98.1
	Widowed	7	1.9	1.9	100.0
	Total	363	100.0	100.0	

(q103) Serious Relationship

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	120	33.1	33.1	33.1
	No	124	34.2	34.2	67.2
	Not Applicable	119	32.8	32.8	100.0
	Total	363	100.0	100.0	

(q104) Highest Level of Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary	9	2.5	2.5	2.5
	Secondary	199	54.8	54.8	57.3
	'A' level	76	20.9	20.9	78.2
	First degree	54	14.9	14.9	93.1
	Masters	6	1.7	1.7	94.8
	Other	19	5.2	5.2	100.0
	Total	363	100.0	100.0	

(q105) Religion

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Christianity	323	89.0	89.0	89.0
	African Tradition	16	4.4	4.4	93.4
	Muslim	1	.3	.3	93.7
	None	20	5.5	5.5	99.2
	Other	3	.8	.8	100.0
	Total	363	100.0	100.0	

(q106) Occupation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Formally employed	181	49.9	49.9	49.9
	Informally employed	80	22.0	22.0	71.9
	Unemployed	15	4.1	4.1	76.0
	Student	87	24.0	24.0	100.0
	Total	363	100.0	100.0	

(q109.1) Grouped Residences

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	363	100.0	100.0	100.0

(q200) Sexual Intercourse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	264	72.7	72.7	72.7
	No	99	27.3	27.3	100.0
	Total	363	100.0	100.0	

(q201) Age at first sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	8	1	.3	.3	.3
	10	1	.3	.3	.6
	12	1	.3	.3	.8
	13	2	.6	.6	1.4
	14	6	1.7	1.7	3.0
	15	6	1.7	1.7	4.7
	16	26	7.2	7.2	11.9
	17	18	5.0	5.0	16.9
	18	28	7.7	7.7	24.6
	19	21	5.8	5.8	30.4
	20	46	12.7	12.7	43.1
	21	39	10.7	10.8	53.9
	22	16	4.4	4.4	58.3
	23	18	5.0	5.0	63.3
	24	10	2.8	2.8	66.0
	25	15	4.1	4.1	70.2
	26	4	1.1	1.1	71.3
	27	3	.8	.8	72.1
	29	1	.3	.3	72.4
	88	100	27.5	27.6	100.0
	Total	362	99.7	100.0	
Missing	System	1	.3		
Total		363	100.0		

(q202) Sexual Partners in last 12 months

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	26	7.2	7.2	7.2
	1	172	47.4	47.4	54.5
	2	30	8.3	8.3	62.8
	3	11	3.0	3.0	65.8
	4	6	1.7	1.7	67.5
	5	3	.8	.8	68.3
	6	3	.8	.8	69.1
	10	3	.8	.8	70.0
	13	1	.3	.3	70.2
	15	2	.6	.6	70.8
	20	2	.6	.6	71.3
	24	1	.3	.3	71.6
	27	1	.3	.3	71.9
	52	1	.3	.3	72.2
	88	101	27.8	27.8	100.0
	Total	363	100.0	100.0	

(q203) Relationship with last sexual partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Spouse	117	32.2	32.2	32.2
	Steady partner	101	27.8	27.8	60.1
	Casual partner	34	9.4	9.4	69.4
	Other	3	.8	.8	70.2
	88	108	29.8	29.8	100.0
	Total	363	100.0	100.0	

(q204) Sex with person other than spouse/steady partner in last 12 months

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	61	16.8	16.8	16.8
	No	195	53.7	53.7	70.5
	Dont Remember	4	1.1	1.1	71.6
	Not Applicable	103	28.4	28.4	100.0
	Total	363	100.0	100.0	

(q205) Increased or decreased sexual partners in past 12 months

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Increased	15	4.1	4.1	4.1
	Decreased	65	17.9	17.9	22.0
	Constant	180	49.6	49.6	71.6
	Not Applicable	103	28.4	28.4	100.0
	Total	363	100.0	100.0	

(q206) Is it normal to indulge in casual sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	79	21.8	21.8	21.8
	No	246	67.8	67.8	89.5
	Dont Know	12	3.3	3.3	92.8
	Not Applicable	26	7.2	7.2	100.0
	Total	363	100.0	100.0	

(q207) Normal for a man or woman to have an extra marital relationship

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	108	29.8	29.8	29.8
	No	248	68.3	68.3	98.1
	Dont Know	5	1.4	1.4	99.4
	Not Applicable	2	.6	.6	100.0
	Total	363	100.0	100.0	

(q300.1) HIV is spread by - Sexual intercourse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	14	3.9	3.9	3.9
	Yes	349	96.1	96.1	100.0
	Total	363	100.0	100.0	

(q300.2) Sharp infected instruments

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	232	63.9	63.9	63.9
	Yes	131	36.1	36.1	100.0
	Total	363	100.0	100.0	

(q300.3) Blood contact

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	303	83.5	83.5	83.5
	Yes	60	16.5	16.5	100.0
	Total	363	100.0	100.0	

(q300.4) MTCT

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	320	88.2	88.2	88.2
	Yes	43	11.8	11.8	100.0
	Total	363	100.0	100.0	

(q300.5) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	354	97.5	97.5	97.5
	Yes	9	2.5	2.5	100.0
	Total	363	100.0	100.0	

(q301) Can you tell that someone is HIV positive

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	114	31.4	31.4	31.4
	No	231	63.6	63.6	95.0
	Not Sure	18	5.0	5.0	100.0
	Total	363	100.0	100.0	

(q302) Can HIV be prevented

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	330	90.9	90.9	90.9
	No	23	6.3	6.3	97.2
	Dont Know	10	2.8	2.8	100.0
	Total	363	100.0	100.0	

**(q303.1) Name all HIV and AIDS prevention methods you know -
Abstinence**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	149	41.0	41.0	41.0
	Yes	214	59.0	59.0	100.0
	Total	363	100.0	100.0	

(q303.2) Faithfulness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	162	44.6	44.6	44.6
	Yes	201	55.4	55.4	100.0
	Total	363	100.0	100.0	

(q303.3) Condom Use

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	127	35.0	35.0	35.0
	Yes	236	65.0	65.0	100.0
	Total	363	100.0	100.0	

(q303.4) Not Sharing sharp instruments

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	339	93.4	93.4	93.4
	Yes	24	6.6	6.6	100.0
	Total	363	100.0	100.0	

(q303.5) Preventing blood contact

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	359	98.9	98.9	98.9
	Yes	4	1.1	1.1	100.0
	Total	363	100.0	100.0	

(q303.6) ARVs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	361	99.4	99.4	99.4
	Yes	2	.6	.6	100.0
	Total	363	100.0	100.0	

(q303.7) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	344	94.8	94.8	94.8
	Yes	19	5.2	5.2	100.0
	Total	363	100.0	100.0	

(q304) Have you ever heard of National AIDS Council (NAC)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	274	75.5	75.5	75.5
	No	89	24.5	24.5	100.0
	Total	363	100.0	100.0	

(q400) Have you ever used a condom

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	187	51.5	51.5	51.5
	No	176	48.5	48.5	100.0
	Total	363	100.0	100.0	

(q401) How did you get the condom

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Bought	131	36.1	36.1	36.1
	Given For Free	33	9.1	9.1	45.2
	Partner had them	27	7.4	7.4	52.6
	88	172	47.4	47.4	100.0
	Total	363	100.0	100.0	

(q402.1) If no, why do you not use condom - Never had sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	74	20.4	20.4	20.4
	Yes	82	22.6	22.6	43.0
	Not Applicable	207	57.0	57.0	100.0
	Total	363	100.0	100.0	

(q402.2) Faithful and trust partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	113	31.1	31.1	31.1
	Yes	39	10.7	10.7	41.9
	Not Applicable	211	58.1	58.1	100.0
	Total	363	100.0	100.0	

(q402.3) Dont trust or like them

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	128	35.3	35.3	35.3
	Yes	23	6.3	6.3	41.6
	Not Applicable	212	58.4	58.4	100.0
	Total	363	100.0	100.0	

(q402.4) Married to one spouse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	136	37.5	37.5	37.5
	Yes	14	3.9	3.9	41.3
	Not Applicable	213	58.7	58.7	100.0
	Total	363	100.0	100.0	

(q403) Intend to use condoms in next 12 months

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	71	19.6	19.6	19.6
	Uncertain	34	9.4	9.4	28.9
	Disagree	138	38.0	38.0	66.9
	Not Applicable	120	33.1	33.1	100.0
	Total	363	100.0	100.0	

(q404) Do you know where to get condoms if you need them

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	339	93.4	93.4	93.4
	No	24	6.6	6.6	100.0
	Total	363	100.0	100.0	

(q405) How readily available are condoms

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Found everywhere	333	91.7	91.7	91.7
	Have to carry them	7	1.9	1.9	93.7
	Not available	16	4.4	4.4	98.1
	88	7	1.9	1.9	100.0
	Total	363	100.0	100.0	

(q406) How often do you use condoms during sexual intercourse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Always	69	19.0	19.0	19.0
	Sometimes	88	24.2	24.2	43.3
	Never	206	56.7	56.7	100.0
	Total	363	100.0	100.0	

(q407) Opportunity to have sex arises but you cannot access a condom

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Go ahead and have unprotected sex	79	21.8	21.8	21.8
	Let the opportunity pass till I can secure a condom	216	59.5	59.5	81.3
	I am not sure	68	18.7	18.7	100.0
	Total	363	100.0	100.0	

(q408) Condoms are only for men who have sex with casual sex workers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	69	19.0	19.0	19.0
	No	288	79.3	79.3	98.3
	Not Sure	5	1.4	1.4	99.7
	Not Applicable	1	.3	.3	100.0
	Total	363	100.0	100.0	

(q409) Is it acceptable for a woman to bring a condom in a sexual relationship

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	205	56.5	56.5	56.5
	No	131	36.1	36.1	92.6
	Dont Know	27	7.4	7.4	100.0
	Total	363	100.0	100.0	

(q410) Refuse to have sex if your partner did not want to use a condom

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	.3	.3	.3
	Yes	242	66.7	66.7	66.9
	No	106	29.2	29.2	96.1
	Not Applicable	14	3.9	3.9	100.0
	Total	363	100.0	100.0	

(q411) What would you do if partner suggests using a condom

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Discuss why a condom should be used	162	44.6	44.6	44.6
	Seriously think about breaking the relationship	22	6.1	6.1	50.7
	Accept use of condoms	158	43.5	43.5	94.2
	Don't Know	13	3.6	3.6	97.8
	Not Applicable	8	2.2	2.2	100.0
	Total	363	100.0	100.0	

(q502) Getting HIV is the worst thing I can imagine

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	231	63.6	63.6	63.6
	No	132	36.4	36.4	100.0
	Total	363	100.0	100.0	

(q503) HIV and AIDS a serious disease that warrants your attention

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	349	96.1	96.1	96.1
	No	14	3.9	3.9	100.0
	Total	363	100.0	100.0	

q504) Consequences of getting HIV and AIDS are significant enough to avoid

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	358	98.6	98.6	98.6
	No	5	1.4	1.4	100.0
	Total	363	100.0	100.0	

(q505) Is AIDS a serious problem in your community

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	273	75.2	75.2	75.2
	No	58	16.0	16.0	91.2
	Don't Know	32	8.8	8.8	100.0
	Total	363	100.0	100.0	

(q600) Tested for HIV

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	145	39.9	39.9	39.9
	No	218	60.1	60.1	100.0
	Total	363	100.0	100.0	

(q601.1) If yes, why - Just to know

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	53	14.6	14.6	14.6
	Yes	91	25.1	25.1	39.7
	Not Applicable	219	60.3	60.3	100.0
	Total	363	100.0	100.0	

(q601.2) Doctor requirement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	132	36.4	36.4	36.4
	Yes	13	3.6	3.6	39.9
	Not Applicable	218	60.1	60.1	100.0
	Total	363	100.0	100.0	

(q601.3) Partner initiated

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	125	34.4	34.4	34.4
	Yes	19	5.2	5.2	39.7
	Not Applicable	219	60.3	60.3	100.0
	Total	363	100.0	100.0	

(q601.4) Antenatal clinic requirement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	134	36.9	36.9	36.9
	Yes	10	2.8	2.8	39.7
	Not Applicable	219	60.3	60.3	100.0
	Total	363	100.0	100.0	

(q601.5) Work/College requirement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	132	36.4	36.4	36.4
	Yes	12	3.3	3.3	39.7
	Not Applicable	219	60.3	60.3	100.0
	Total	363	100.0	100.0	

(q602) If no, would you like to be tested

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	136	37.5	37.5	37.5
	No	63	17.4	17.4	54.8
	Not Decided	18	5.0	5.0	59.8
	88	146	40.2	40.2	100.0
	Total	363	100.0	100.0	

(q603.1) If no, why would you not want to be tested - Stressful

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	48	13.2	13.2	13.2
	Yes	38	10.5	10.5	23.7
	Not Applicable	277	76.3	76.3	100.0
	Total	363	100.0	100.0	

(q603.2) Knows is negative

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	75	20.7	20.7	20.7
	Yes	11	3.0	3.0	23.7
	Not Applicable	277	76.3	76.3	100.0
	Total	363	100.0	100.0	

(q603.3) Not interested

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	52	14.3	14.3	14.3
	Yes	34	9.4	9.4	23.7
	Not Applicable	277	76.3	76.3	100.0
	Total	363	100.0	100.0	

(q604) Do you think you are at risk of infecting others

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	66	18.2	18.2	18.2
	No	138	38.0	38.0	56.2
	Don't Know	25	6.9	6.9	63.1
	88	134	36.9	36.9	100.0
	Total	363	100.0	100.0	

(q605) How often do you worry that you might get HIV

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Often	70	19.3	19.3	19.3
	Sometimes	121	33.3	33.3	52.6
	Never	172	47.4	47.4	100.0
	Total	363	100.0	100.0	

(q606) How likely is it that you will get HIV in the next five years

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	.3	.3	.3
	Very Likely	12	3.3	3.3	3.6
	Likely	55	15.2	15.2	18.7
	Unlikely	95	26.2	26.2	44.9
	Very Unlikely	200	55.1	55.1	100.0
	Total	363	100.0	100.0	

(q607) How likely do you think it is that you already are HIV positive?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	.3	.3	.3
Very Likely	6	1.7	1.7	1.9
Likely	45	12.4	12.4	14.3
Unlikely	67	18.5	18.5	32.8
Very Unlikely	244	67.2	67.2	100.0
Total	363	100.0	100.0	

(q608) Get HIV and AIDS if you engage in high risk sexual behaviour

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly Agree	217	59.8	59.8	59.8
Agree	123	33.9	33.9	93.7
Uncertain	6	1.7	1.7	95.3
Disagree	9	2.5	2.5	97.8
Strongly Disagree	8	2.2	2.2	100.0
Total	363	100.0	100.0	

(q609) Do you think there are high risk groups in your area

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	298	82.1	82.1	82.1
No	44	12.1	12.1	94.2
Don't Know	21	5.8	5.8	100.0
Total	363	100.0	100.0	

(q610.1) If yes, what are the groups - Commercial sex workers

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No	106	29.2	29.2	29.2
Yes	197	54.3	54.3	83.5
Not Applicable	60	16.5	16.5	100.0
Total	363	100.0	100.0	

(q610.2) Truck Drivers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	272	74.9	74.9	74.9
	Yes	31	8.5	8.5	83.5
	Not Applicable	60	16.5	16.5	100.0
	Total	363	100.0	100.0	

(q610.3) Cross border traders

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	271	74.7	74.7	74.7
	Yes	32	8.8	8.8	83.5
	Not Applicable	60	16.5	16.5	100.0
	Total	363	100.0	100.0	

(q610.4) Peers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	281	77.4	77.4	77.4
	Yes	22	6.1	6.1	83.5
	Not Applicable	60	16.5	16.5	100.0
	Total	363	100.0	100.0	

(q610.5) Rich people

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	294	81.0	81.0	81.0
	Yes	9	2.5	2.5	83.5
	Not Applicable	60	16.5	16.5	100.0
	Total	363	100.0	100.0	

(q610.6) Young people

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	208	57.3	57.3	57.3
	Yes	95	26.2	26.2	83.5
	Not Applicable	60	16.5	16.5	100.0
	Total	363	100.0	100.0	

(q610.7) Single mothers and Night Clubbers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	244	67.2	67.2	67.2
	Yes	59	16.3	16.3	83.5
	Not Applicable	60	16.5	16.5	100.0
	Total	363	100.0	100.0	

(q610.8) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	276	76.0	76.0	76.0
	Yes	27	7.4	7.4	83.5
	Not Applicable	60	16.5	16.5	100.0
	Total	363	100.0	100.0	

(q611) Socio-economic class is more vulnerable to contract HIV

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Rich	99	27.3	27.3	27.3
	Poor	70	19.3	19.3	46.6
	Both	193	53.2	53.2	99.7
	88	1	.3	.3	100.0
	Total	363	100.0	100.0	

(q612) Present standard of life make you vulnerable

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	.3	.3	.3
	Yes	96	26.4	26.4	26.7
	No	263	72.5	72.5	99.2
	3	3	.8	.8	100.0
	Total	363	100.0	100.0	

(q613.1) Give an explanation for answer - ABC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	189	52.1	52.1	52.1
	Yes	174	47.9	47.9	100.0
	Total	363	100.0	100.0	

(q613.2) Work commitment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	352	97.0	97.0	97.0
	Yes	11	3.0	3.0	100.0
	Total	363	100.0	100.0	

(q613.3) Have the knowledge

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	346	95.3	95.3	95.3
	Yes	17	4.7	4.7	100.0
	Total	363	100.0	100.0	

(q613.4) Careful

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	300	82.6	82.6	82.6
	Yes	63	17.4	17.4	100.0
	Total	363	100.0	100.0	

(q613.5) Peer Pressure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	334	92.0	92.0	92.0
	Yes	29	8.0	8.0	100.0
	Total	363	100.0	100.0	

(q613.6) Economic conditions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	318	87.6	87.6	87.6
	Yes	45	12.4	12.4	100.0
	Total	363	100.0	100.0	

(q613.7) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	336	92.6	92.6	92.6
	Yes	27	7.4	7.4	100.0
	Total	363	100.0	100.0	

(q700) It is (was) easy to abstain from sex until marriage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	221	60.9	60.9	60.9
	Uncertain	15	4.1	4.1	65.0
	Disagree	127	35.0	35.0	100.0
	Total	363	100.0	100.0	

q701) Sexual Abstinence best method of preventing HIV and AIDS and STIs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	292	80.4	80.4	80.4
	Uncertain	15	4.1	4.1	84.6
	Disagree	56	15.4	15.4	100.0
	Total	363	100.0	100.0	

(q702) Is it difficult nowadays to be faithful to one partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	136	37.5	37.5	37.5
	Uncertain	25	6.9	6.9	44.4
	Disagree	202	55.6	55.6	100.0
	Total	363	100.0	100.0	

(q703) Zimbabwean man of today can be faithful

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	.3	.3	.3
	Agree	74	20.4	20.4	20.7
	Uncertain	47	12.9	12.9	33.6
	Disagree	241	66.4	66.4	100.0
	Total	363	100.0	100.0	

(q704) Zimbabwean woman of today can be faithful

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	101	27.8	27.8	27.8
	Uncertain	53	14.6	14.6	42.4
	Disagree	209	57.6	57.6	100.0
	Total	363	100.0	100.0	

(q705) Can you prevent HIV and AIDS through faithfulness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	302	83.2	83.2	83.2
	Uncertain	23	6.3	6.3	89.5
	Disagree	38	10.5	10.5	100.0
	Total	363	100.0	100.0	

(q706.1) If no, why not - Promiscuous

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	8	2.2	2.2	2.2
	Yes	25	6.9	6.9	9.1
	Not Applicable	330	90.9	90.9	100.0
	Total	363	100.0	100.0	

(q706.2) Mother to Child transmission

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	24	6.6	6.6	6.6
	Yes	9	2.5	2.5	9.1
	Not Applicable	330	90.9	90.9	100.0
	Total	363	100.0	100.0	

(q707) Is it natural for man to have multiple sexual partners

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	106	29.2	29.2	29.2
	Uncertain	26	7.2	7.2	36.4
	Disagree	231	63.6	63.6	100.0
	Total	363	100.0	100.0	

(q708) Condoms can effectively prevent HIV/AIDS and other STIs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	149	41.0	41.0	41.0
	Uncertain	68	18.7	18.7	59.8
	Disagree	146	40.2	40.2	100.0
	Total	363	100.0	100.0	

(q709) Mind being seen carrying condoms with partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	214	59.0	59.0	59.0
	Uncertain	31	8.5	8.5	67.5
	Disagree	118	32.5	32.5	100.0
	Total	363	100.0	100.0	

(q710) Do you think ABC approach is being effective in Zimbabwe

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	155	42.7	42.7	42.7
	No	83	22.9	22.9	65.6
	Somehow	100	27.5	27.5	93.1
	Don't Know	25	6.9	6.9	100.0
	Total	363	100.0	100.0	

(q711) Do you see indications of sexual behavioural change in Harare

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	141	38.8	38.8	38.8
	No	222	61.2	61.2	100.0
	Total	363	100.0	100.0	

(q712) Economic conditions in Harare provide an environment for sexual behavioural change

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	104	28.7	28.7	28.7
	No	259	71.3	71.3	100.0
	Total	363	100.0	100.0	

(q713) Harare provide an environment in which people are not scared of talking about their HIV and AIDS status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	.3	.3	.3
	Yes	156	43.0	43.0	43.3
	No	206	56.7	56.7	100.0
	Total	363	100.0	100.0	

(q800) Do you inquire sexual history of new partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	260	71.6	71.6	71.6
	No	103	28.4	28.4	100.0
	Total	363	100.0	100.0	

(q801) Would it seem rude to ask anew partner about their sexual life

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	103	28.4	28.4	28.4
	No	220	60.6	60.6	89.0
	Depends	40	11.0	11.0	100.0
	Total	363	100.0	100.0	

(q802) Would you feel guilty if you use a condom

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	72	19.8	19.8	19.8
	No	237	65.3	65.3	85.1
	Not Sure	54	14.9	14.9	100.0
	Total	363	100.0	100.0	

(q803) Condom would feel uncomfortable or too tight

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	94	25.9	25.9	25.9
	No	159	43.8	43.8	69.7
	Not Sure	110	30.3	30.3	100.0
	Total	363	100.0	100.0	

(q804) Condom might break

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	239	65.8	65.8	65.8
	No	55	15.2	15.2	81.0
	Not Sure	69	19.0	19.0	100.0
	Total	363	100.0	100.0	

(q805) Would you worry less about getting HIV if you use condoms

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	181	49.9	49.9	49.9
	No	109	30.0	30.0	79.9
	Indifferent	73	20.1	20.1	100.0
	Total	363	100.0	100.0	

q806) Would a steady partner think you had sex with someone else if you insisted on condom use

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	154	42.4	42.4	42.4
	No	141	38.8	38.8	81.3
	Not sure	68	18.7	18.7	100.0
	Total	363	100.0	100.0	

(q807) Would a steady partner be angry if you insisted on condom use

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	151	41.6	41.6	41.6
	No	146	40.2	40.2	81.8
	Not Sure	66	18.2	18.2	100.0
	Total	363	100.0	100.0	

(q808) A steady partner would refuse to have sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	141	38.8	38.8	38.8
	No	160	44.1	44.1	82.9
	Don't Know	62	17.1	17.1	100.0
	Total	363	100.0	100.0	

(q809) Would you be angry if a casual partner insisted on condom use

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	56	15.4	15.4	15.4
	No	255	70.2	70.2	85.7
	Not Sure	52	14.3	14.3	100.0
	Total	363	100.0	100.0	

(q810) Would friends think bad of you if you carried condoms in pocket

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	204	56.2	56.2	56.2
No	135	37.2	37.2	93.4
Don't Know	24	6.6	6.6	100.0
Total	363	100.0	100.0	

(q900) Listen to radio

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	306	84.3	84.3	84.3
No	57	15.7	15.7	100.0
Total	363	100.0	100.0	

(q901) Frequency of radio listenig

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	.3	.3	.3
Less than once a week	8	2.2	2.2	2.5
About once a week	34	9.4	9.4	11.8
2-3 days a week	56	15.4	15.4	27.3
4-5 days a week	16	4.4	4.4	31.7
Every day	193	53.2	53.2	84.8
Occasionally	3	.8	.8	85.7
88	52	14.3	14.3	100.0
Total	363	100.0	100.0	

(q902) TV watching

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	321	88.4	88.4	88.4
No	42	11.6	11.6	100.0
Total	363	100.0	100.0	

(q903) Frequency of TV watching

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	.6	.6	.6
Less than once a week	4	1.1	1.1	1.7
About once a week	19	5.2	5.2	6.9
2-3 days a week	36	9.9	9.9	16.8
4-5 days a week	17	4.7	4.7	21.5
Every day	242	66.7	66.7	88.2
Occasionally	4	1.1	1.1	89.3
88	39	10.7	10.7	100.0
Total	363	100.0	100.0	

(q904) Read newspapers

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	300	82.6	82.6	82.6
No	63	17.4	17.4	100.0
Total	363	100.0	100.0	

(q905) Frequency of newspaper reading

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Less than once a week	12	3.3	3.3	3.3
About once a week	68	18.7	18.7	22.0
2-3 days a week	70	19.3	19.3	41.3
4-5 days a week	14	3.9	3.9	45.2
Every day	125	34.4	34.4	79.6
Occasionally	12	3.3	3.3	82.9
88	62	17.1	17.1	100.0
Total	363	100.0	100.0	

(q906) Heard or seen information about HIV and AIDS in past month

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	252	69.4	69.4	69.4
No	108	29.8	29.8	99.2
88	3	.8	.8	100.0
Total	363	100.0	100.0	

(q907.1) Where did you see or hear this information - Radio

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	136	37.5	37.5	37.5
	Yes	119	32.8	32.8	70.2
	Not Applicable	108	29.8	29.8	100.0
	Total	363	100.0	100.0	

(q907.2) Television

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	71	19.6	19.6	19.6
	Yes	183	50.4	50.4	70.0
	Not Applicable	109	30.0	30.0	100.0
	Total	363	100.0	100.0	

(q907.3) Workplace

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	218	60.1	60.1	60.1
	Yes	36	9.9	9.9	70.0
	Not Applicable	109	30.0	30.0	100.0
	Total	363	100.0	100.0	

(q907.4) Newspaper/Magazine

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	147	40.5	40.5	40.5
	Yes	107	29.5	29.5	70.0
	Not Applicable	109	30.0	30.0	100.0
	Total	363	100.0	100.0	

(q907.5) Posters

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	198	54.5	54.5	54.5
	Yes	56	15.4	15.4	70.0
	Not Applicable	109	30.0	30.0	100.0
	Total	363	100.0	100.0	

(q907.6) Billboards

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	226	62.3	62.3	62.3
	Yes	28	7.7	7.7	70.0
	Not Applicable	109	30.0	30.0	100.0
	Total	363	100.0	100.0	

(q907.7) People from NGOs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	225	62.0	62.0	62.0
	Yes	29	8.0	8.0	70.0
	Not Applicable	109	30.0	30.0	100.0
	Total	363	100.0	100.0	

(q907.8) Health worker/ Counsellor

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	232	63.9	63.9	63.9
	Yes	22	6.1	6.1	70.0
	Not Applicable	109	30.0	30.0	100.0
	Total	363	100.0	100.0	

(q907.9) Friends/Relatives

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	214	59.0	59.0	59.0
	Yes	40	11.0	11.0	70.0
	Not Applicable	109	30.0	30.0	100.0
	Total	363	100.0	100.0	

(q907.10) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	.3	.3	.3
	No	238	65.6	65.6	65.8
	Yes	15	4.1	4.1	70.0
	Not Applicable	109	30.0	30.0	100.0
	Total	363	100.0	100.0	

(q908.1) Main messages picked about HIV/AIDS - ABC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	108	29.8	29.8	29.8
	Yes	148	40.8	40.8	70.5
	Not Applicable	107	29.5	29.5	100.0
	Total	363	100.0	100.0	

(q908.2) Positive Living/Disclosure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	181	49.9	49.9	49.9
	Yes	75	20.7	20.7	70.5
	Not Applicable	107	29.5	29.5	100.0
	Total	363	100.0	100.0	

(q908.3) Knowing Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	221	60.9	60.9	60.9
	Yes	35	9.6	9.6	70.5
	Not Applicable	107	29.5	29.5	100.0
	Total	363	100.0	100.0	

(q908.4) HIV does not discriminate

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	236	65.0	65.0	65.0
	Yes	20	5.5	5.5	70.5
	Not Applicable	107	29.5	29.5	100.0
	Total	363	100.0	100.0	

(q908.5) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	241	66.4	66.4	66.4
	Yes	15	4.1	4.1	70.5
	Not Applicable	107	29.5	29.5	100.0
	Total	363	100.0	100.0	

(q909) Heard or seen information about sexual behavioural change

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	230	63.4	63.4	63.4
No	133	36.6	36.6	100.0
Total	363	100.0	100.0	

(q910.1) If yes where did you hear or see this information - Radio

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No	125	34.4	34.4	34.4
Yes	105	28.9	28.9	63.4
Not Applicable	133	36.6	36.6	100.0
Total	363	100.0	100.0	

(q910.2) Television

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No	103	28.4	28.4	28.4
Yes	127	35.0	35.0	63.4
Not Applicable	133	36.6	36.6	100.0
Total	363	100.0	100.0	

(q910.3) Workplace

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No	197	54.3	54.3	54.3
Yes	33	9.1	9.1	63.4
Not Applicable	133	36.6	36.6	100.0
Total	363	100.0	100.0	

(q910.4) Newspaper/Magazine

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No	172	47.4	47.4	47.4
Yes	58	16.0	16.0	63.4
Not Applicable	133	36.6	36.6	100.0
Total	363	100.0	100.0	

(q910.5) Posters

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	206	56.7	56.7	56.7
	Yes	24	6.6	6.6	63.4
	Not Applicable	133	36.6	36.6	100.0
	Total	363	100.0	100.0	

(q910.6) Billboards

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	220	60.6	60.6	60.6
	Yes	10	2.8	2.8	63.4
	Not Applicable	133	36.6	36.6	100.0
	Total	363	100.0	100.0	

(q910.7) People from NGOs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	211	58.1	58.1	58.1
	Yes	19	5.2	5.2	63.4
	Not Applicable	133	36.6	36.6	100.0
	Total	363	100.0	100.0	

(q910.8) Health worker/ Counsellor

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	212	58.4	58.4	58.4
	Yes	18	5.0	5.0	63.4
	Not Applicable	133	36.6	36.6	100.0
	Total	363	100.0	100.0	

(q910.9) Friends/Relatives

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	191	52.6	52.6	52.6
	Yes	39	10.7	10.7	63.4
	Not Applicable	133	36.6	36.6	100.0
	Total	363	100.0	100.0	

(q910.10) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	217	59.8	59.8	59.8
	Yes	13	3.6	3.6	63.4
	Not Applicable	133	36.6	36.6	100.0
	Total	363	100.0	100.0	

(q911) Any political leaders who have spoken out on sexual behaviour change

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	191	52.6	52.6	52.6
	No	172	47.4	47.4	100.0
	Total	363	100.0	100.0	

(q912) Any political leaders who have disclosed they are living with HIV/AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	63	17.4	17.4	17.4
	No	300	82.6	82.6	100.0
	Total	363	100.0	100.0	

(q913) Any famous person who has spoken out on sexual behavioural change

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	208	57.3	57.3	57.3
	No	155	42.7	42.7	100.0
	Total	363	100.0	100.0	

(q914) Any famous person who has disclosed they are living with HIV/AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	193	53.2	53.2	53.2
	No	170	46.8	46.8	100.0
	Total	363	100.0	100.0	

(q915) Govt providing adequate inform about HIV/AIDS through media

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	210	57.9	57.9	57.9
No	153	42.1	42.1	100.0
Total	363	100.0	100.0	

(q1000) Changed sexual behaviour because of AIDS

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly agree	156	43.0	43.0	43.0
Agree	103	28.4	28.4	71.3
Uncertain	18	5.0	5.0	76.3
Disagree	37	10.2	10.2	86.5
Strongly disagree	49	13.5	13.5	100.0
Total	363	100.0	100.0	

(q1001) Knowing one's HIV status not helpful in absence of treatment

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly Agree	170	46.8	46.8	46.8
Agree	54	14.9	14.9	61.7
Uncertain	12	3.3	3.3	65.0
Disagree	69	19.0	19.0	84.0
Strongly Disagree	58	16.0	16.0	100.0
Total	363	100.0	100.0	

q1002) If engage in high risk behaviour, will go for HIV tests as soon as possible

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly Agree	167	46.0	46.0	46.0
Agree	102	28.1	28.1	74.1
Uncertain	23	6.3	6.3	80.4
Disagree	27	7.4	7.4	87.9
Strongly Disagree	44	12.1	12.1	100.0
Total	363	100.0	100.0	

(q1003.1) Motivation to sexual behavioural change - Fear HIV/AIDS and STIs

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	.3	.3	.3
No	131	36.1	36.1	36.4
Yes	230	63.4	63.4	99.7
4	1	.3	.3	100.0
Total	363	100.0	100.0	

(q1003.2) Religion

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	.3	.3	.3
No	311	85.7	85.7	86.0
Yes	51	14.0	14.0	100.0
Total	363	100.0	100.0	

(q1003.3) Background/Upbringing

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	.3	.3	.3
No	317	87.3	87.3	87.6
Yes	45	12.4	12.4	100.0
Total	363	100.0	100.0	

(q1003.4) Faithfulness

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	.3	.3	.3
No	347	95.6	95.6	95.9
Yes	15	4.1	4.1	100.0
Total	363	100.0	100.0	

(q1003.5) Experienced HIV/AIDS deaths

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	.3	.3	.3
No	343	94.5	94.5	94.8
Yes	19	5.2	5.2	100.0
Total	363	100.0	100.0	

(q1003.6) Other

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	.3	.3	.3
No	331	91.2	91.2	91.5
Yes	31	8.5	8.5	100.0
Total	363	100.0	100.0	

(q1100) Personally know someone who has HIV and AIDS

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0	2	.6	.6	.6
Yes	231	63.6	63.6	64.2
No	130	35.8	35.8	100.0
Total	363	100.0	100.0	

(q1101.1) How did you know about his/her HIV status - Disclosure

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No	95	26.2	26.2	26.2
Yes	138	38.0	38.0	64.2
Not Applicable	130	35.8	35.8	100.0
Total	363	100.0	100.0	

(q1101.2) Health Observation

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No	186	51.2	51.2	51.2
Yes	46	12.7	12.7	63.9
2	1	.3	.3	64.2
Not Applicable	130	35.8	35.8	100.0
Total	363	100.0	100.0	

(q1101.3) Rumours

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	.3	.3	.3
No	204	56.2	56.2	56.5
Yes	28	7.7	7.7	64.2
Not Applicable	130	35.8	35.8	100.0
Total	363	100.0	100.0	

(q1101.4) Medical Reports

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	211	58.1	58.1	58.1
	Yes	23	6.3	6.3	64.5
	Not Applicable	129	35.5	35.5	100.0
	Total	363	100.0	100.0	

(q1101.5) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	233	64.2	64.2	64.2
	Yes	1	.3	.3	64.5
	Not Applicable	129	35.5	35.5	100.0
	Total	363	100.0	100.0	

(q1102) A family member who has HIV/AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	116	32.0	32.0	32.0
	No	141	38.8	38.8	70.8
	88	106	29.2	29.2	100.0
	Total	363	100.0	100.0	

(q1103) If yes, what is the relationship

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Mother	13	3.6	3.6	3.6
	Father	5	1.4	1.4	5.0
	Brother	12	3.3	3.3	8.3
	Sister	20	5.5	5.5	13.8
	Uncle/Aunt	25	6.9	6.9	20.7
	Cousin/Nephews	25	6.9	6.9	27.5
	Child/Niece	6	1.7	1.7	29.2
	Other relatives	10	2.8	2.8	32.0
	88	247	68.0	68.0	100.0
	Total	363	100.0	100.0	

(q1104) Personally know someone who has died of AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	.3	.3	.3
	Yes	307	84.6	84.6	84.8
	No	53	14.6	14.6	99.4
	88	2	.6	.6	100.0
	Total	363	100.0	100.0	

(q1105.1) How did you know about his/her HIV status - Disclosure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	191	52.6	52.6	52.6
	Yes	119	32.8	32.8	85.4
	Not Applicable	53	14.6	14.6	100.0
	Total	363	100.0	100.0	

(q1105.2) Health Observation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	233	64.2	64.2	64.2
	Yes	77	21.2	21.2	85.4
	Not Applicable	53	14.6	14.6	100.0
	Total	363	100.0	100.0	

(q1105.3) Rumours

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	253	69.7	69.7	69.7
	Yes	57	15.7	15.7	85.4
	Not Applicable	53	14.6	14.6	100.0
	Total	363	100.0	100.0	

(q1105.4) Medical Reports

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	249	68.6	68.6	68.6
	Yes	60	16.5	16.5	85.1
	4	1	.3	.3	85.4
	Not Applicable	53	14.6	14.6	100.0
	Total	363	100.0	100.0	

(q1105.5) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	305	84.0	84.0	84.0
	Yes	5	1.4	1.4	85.4
	Not Applicable	53	14.6	14.6	100.0
	Total	363	100.0	100.0	

(q1106) Do you have a family member who has died of AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	.3	.3	.3
	Yes	245	67.5	67.5	67.8
	no	70	19.3	19.3	87.1
	88	47	12.9	12.9	100.0
	Total	363	100.0	100.0	

(q1107) If yes, what was the relationship

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Mother	22	6.1	6.1	6.1
	Father	4	1.1	1.1	7.2
	Brother	33	9.1	9.1	16.3
	Sister	33	9.1	9.1	25.3
	Uncle/Aunt	96	26.4	26.4	51.8
	Cousin/Nephews	37	10.2	10.2	62.0
	Child/Niece	9	2.5	2.5	64.5
	Other relatives	13	3.6	3.6	68.0
	88	116	32.0	32.0	100.0
	Total	363	100.0	100.0	

(q1108) Ever provided care for any relative or friend suffering from AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	141	38.8	38.8	38.8
	No	176	48.5	48.5	87.3
	88	46	12.7	12.7	100.0
	Total	363	100.0	100.0	

(q1109) Was he/she on ART?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	65	17.9	17.9	17.9
	No	80	22.0	22.0	39.9
	Dont Know	22	6.1	6.1	46.0
	88	196	54.0	54.0	100.0
	Total	363	100.0	100.0	

(q1110a) Do you discuss HIV and AIDS issues with immediate family members

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	288	79.3	79.3	79.3
	No	75	20.7	20.7	100.0
	Total	363	100.0	100.0	

(q1110b) Do you discuss HIV and AIDS issues with relatives

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	257	70.8	70.8	70.8
	No	106	29.2	29.2	100.0
	Total	363	100.0	100.0	

(q1110c) Do you discuss HIV and AIDS issues with friends

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	.3	.3	.3
	Yes	331	91.2	91.2	91.5
	No	31	8.5	8.5	100.0
	Total	363	100.0	100.0	

(q1111a) How easy is it to talk about HIV and AIDS with immediate family members

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Easy	156	43.0	43.0	43.0
	easy	122	33.6	33.6	76.6
	Difficult	49	13.5	13.5	90.1
	Very Difficult	36	9.9	9.9	100.0
	Total	363	100.0	100.0	

(q1111b) How easy is it to talk about HIV and AIDS with relatives

		Frequency	Percent	Valid Percent	Cumulativ e Percent
Valid	Very Easy	119	32.8	32.8	32.8
	Easy	140	38.6	38.6	71.3
	Diff icult	65	17.9	17.9	89.3
	Very Difficult	39	10.7	10.7	100.0
	Total	363	100.0	100.0	

(q1111c) How easy is it to talk about HIV and AIDS with friends

		Frequency	Percent	Valid Percent	Cumulativ e Percent
Valid	0	1	.3	.3	.3
	Very Easy	286	78.8	78.8	79.1
	Easy	56	15.4	15.4	94.5
	Diff icult	7	1.9	1.9	96.4
	Very Difficult	13	3.6	3.6	100.0
	Total	363	100.0	100.0	

(q1112) HIV and AIDS will become easier to prevent if people become more open

		Frequency	Percent	Valid Percent	Cumulativ e Percent
Valid	Yes	317	87.3	87.3	87.3
	No	46	12.7	12.7	100.0
	Total	363	100.0	100.0	

(q1113.1) Thoughts and worries about AIDS

		Frequency	Percent	Valid Percent	Cumulativ e Percent
Valid	No	133	36.6	36.6	36.6
	Yes	230	63.4	63.4	100.0
	Total	363	100.0	100.0	

(q1113.2) Orphan Crisis

		Frequency	Percent	Valid Percent	Cumulativ e Percent
Valid	No	323	89.0	89.0	89.0
	Yes	40	11.0	11.0	100.0
	Total	363	100.0	100.0	

(q1113.3) Effects on development (Household and National)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	323	89.0	89.0	89.0
	Yes	40	11.0	11.0	100.0
	Total	363	100.0	100.0	

(q1113.4) Stigma and discrimination

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	333	91.7	91.7	91.7
	Yes	30	8.3	8.3	100.0
	Total	363	100.0	100.0	

(q1113.5) Not worried

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	339	93.4	93.4	93.4
	Yes	24	6.6	6.6	100.0
	Total	363	100.0	100.0	

(q1113.6) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	352	97.0	97.0	97.0
	Yes	11	3.0	3.0	100.0
	Total	363	100.0	100.0	

(q1114.1) Why knowledge of HIV and AIDS is not translating to sexual behavioural change - Natural Promiscuity/Lust

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	243	66.9	66.9	66.9
	Yes	119	32.8	32.8	99.7
	2	1	.3	.3	100.0
	Total	363	100.0	100.0	

(q1114.2) Cultural or Religious Beliefs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	344	94.8	94.8	94.8
	Yes	19	5.2	5.2	100.0
	Total	363	100.0	100.0	

(q1114.3) Economic conditions and Poverty

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	210	57.9	57.9	57.9
	Yes	153	42.1	42.1	100.0
	Total	363	100.0	100.0	

(q1114.4) Communication barriers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	277	76.3	76.3	76.3
	Yes	86	23.7	23.7	100.0
	Total	363	100.0	100.0	

(q1114.5) Drugs and Alcohol consumption

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	354	97.5	97.5	97.5
	Yes	9	2.5	2.5	100.0
	Total	363	100.0	100.0	

(q1114.6) Over exposure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	350	96.4	96.4	96.4
	Yes	13	3.6	3.6	100.0
	Total	363	100.0	100.0	

(q1114.7) Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	356	98.1	98.1	98.1
	Yes	7	1.9	1.9	100.0
	Total	363	100.0	100.0	

q101.1 Grouped Ages

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-24	4	1.1	1.1	1.1
	25-29	80	22.0	22.0	23.1
	30-34	132	36.4	36.4	59.5
	40-44	65	17.9	17.9	77.4
	45-49	82	22.6	22.6	100.0
	Total	363	100.0	100.0	

q201.1 Age at First Sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		1	.3	.3	.3
	1	2	.6	.6	.8
	2	15	4.1	4.1	5.0
	3	139	38.3	38.3	43.3
	4	98	27.0	27.0	70.2
	6	8	2.2	2.2	72.5
	7	100	27.5	27.5	100.0
	Total	363	100.0	100.0	

q501.1 Grouped HIV/AIDS Deaths

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	192	52.9	54.9	54.9
	2	28	7.7	8.0	62.9
	3	33	9.1	9.4	72.3
	4	12	3.3	3.4	75.7
	5	11	3.0	3.1	78.9
	6	74	20.4	21.1	100.0
	Total	350	96.4	100.0	
Missing	System	13	3.6		
Total		363	100.0		

(q100) Gender * (q104) Highest Level of Education Crosstabulation

Count

		(q104) Highest Level of Education						Total
		Primary	Secondary	'A' level	First degree	Masters	Other	
(q100) Gender	Male	7	104	37	23	4	8	
	Female	2	95	39	31	2	11	
Total		9	199	76	54	6	19	

(q100) Gender * (q104) Highest Level of Education Crosstabulation

Count		(q104) Highest Level of Education						
		Primary	Secondary	'A' level	First degree	Masters	Other	Total
(q100) Gender	Male	7	104	37	23	4	8	163
	Female	2	95	39	31	2	11	170
Total		9	199	76	54	6	19	333

(q100) Gender * (q205) Increased or decreased sexual partners in past 12 months Crosstabulation

Count		8	10	12	13	14	15	16
(q100) Gender	Male	1	1	1	2	4	5	14
	Female	0	0	0	0	2	1	3
Total		1	1	1	2	6	6	17

(q100) Gender * (q205) Increased or decreased sexual partners in past 12 months Crosstabulation

Count		(q205) Increased or decreased sexual partners in past 12 months				Total
		Increased	Decreased	Constant	Not Applicable	
(q100) Gender	Male	14	45	89	35	183
	Female	1	20	91	68	180
Total		15	65	180	103	363

(q100) Gender * (q304) Have you ever heard of National AIDS Council (NAC) Crosstabulation

Count		(q304) Have you ever heard of National AIDS Council (NAC)		Total
		Yes	No	
(q100) Gender	Male	139	44	183
	Female	135	45	180
Total		274	89	363

Crosstabs

q100) Gender * (q410) Refuse to have sex if your partner did not want to use a condom * (q503) HIV and AIDS a serious disease that warrants your attention Crosstabulation

Count

(q503) HIV and AIDS a serious disease that warrants your attention			(q410) Ref use to have sex if your partner did not want to use a condom				Total
			Yes	No	Not Applicable		
Yes	(q100) Gender	Male	119	51	5	1	
		Female	113	51	9	0	
	Total		232	102	14	1	
No	(q100) Gender	Male	5	2			
		Female	5	2			
	Total		10	4			

q100) Gender * (q410) Refuse to have sex if your partner did not want to use a condom * (q600) Tested for HIV Crosstabulation

Count

(q600) Tested for HIV			(q410) Refuse to have sex if your partner did not want to use a condom				Total
			Yes	No	Not Applicable		
Yes	(q100) Gender	Male	45	14	3		
		Female	60	18	5		
	Total		105	32	8		
No	(q100) Gender	Male	79	39	2	1	
		Female	58	35	4	0	
	Total		137	74	6	1	

100) Gender * (q409) Is it acceptable for a woman to bring a condom in a sexual relationship * (q503) HIV and AIDS a serious disease that warrants your attention Crosstabulation

Count

(q503) HIV and AIDS a serious disease that warrants your attention			(q409) Is it acceptable for a woman to bring a condom in a sexual relationship			Total
			Yes	No	Dont Know	
Yes	(q100) Gender	Male	95	69	12	176
		Female	102	56	15	173
	Total		197	125	27	349
No	(q100) Gender	Male	4	3		7
		Female	4	3		7
	Total		8	6		14

**(q100) Gender * (q409) Is it acceptable for a woman to bring a condom in a sexual relationship *
(q600) Tested for HIV Crosstabulation**

Count

			(q409) Is it acceptable for a woman to bring a condom in a sexual relationship			Total
(q600) Tested for HIV			Yes	No	Dont Know	
Yes	(q100) Gender	Male	34	23	5	62
		Female	57	23	3	83
	Total		91	46	8	145
No	(q100) Gender	Male	65	49	7	121
		Female	49	36	12	97
	Total		114	85	19	218

(q100) Gender * (q104) Highest Level of Education Cross tabulation

		(q104) Highest Level of Education						Total
		Primary	Secondary	'A' level	First degree	Masters	Other	
(q100) Gender	Male	7	104	37	23	4	8	173
	Female	2	95	39	31	2	11	180
Total		9	199	76	54	6	19	353

(q100) Gender * (q203) Relationship with last sexual partner Crosstabulation

Count

		(q203) Relationship with last sexual partner					Total
		Spouse	Steady partner	Casual partner	Other	88	
(q100) Gender	Male	59	58	25	3	38	183
	Female	58	43	9		70	180
Total		117	101	34	3	108	363

(q100) Gender * (q206) Is it normal to indulge in casual sex Crosstabulation

Count

		(q206) Is it normal to indulge in casual sex				Total
		Yes	No	Dont Know	Not Applicable	
(q100) Gender	Male	49	122	5	7	183
	Female	30	124	7	19	180
Total		79	246	12	26	363

(q100) Gender * (q204) Sex with person other than spouse/steady partner in last 12 months Crosstabulation

Count

		(q204) Sex with person other than spouse/steady partner in last 12 months				Total
		Yes	No	Dont Remember	Not Applicable	
(q100) Gender	Male	48	96	2	37	183
	Female	13	99	2	66	180
Total		61	195	4	103	363

(q100) Gender * (q205) Increased or decreased sexual partners in past 12 months Crosstabulation

Count

		(q205) Increased or decreased sexual partners in past 12 months				Total
		Increased	Decreased	Constant	Not Applicable	
(q100) Gender	Male	14	45	89	35	183
	Female	1	20	91	68	180
Total		15	65	180	103	363

**(q100) Gender * (q300.1) HIV is spread by - Sexual intercourse
Crosstabulation**

Count

		(q300.1) HIV is spread by - Sexual intercourse		Total
		No	Yes	
(q100) Gender	Male	8	175	183
	Female	6	174	180
Total		14	349	363

(q100) Gender * (q302) Can HIV be prevented Crosstabulation

Count

		(q302) Can HIV be prevented			Total
		Yes	No	Dont Know	
(q100) Gender	Male	163	13	7	183
	Female	167	10	3	180
Total		330	23	10	363

(q100) Gender * (q206) Is it normal to indulge in casual sex Crosstabulation

Count

		(q206) Is it normal to indulge in casual sex				Total
		Yes	No	Dont Know	Not Applicable	
(q100) Gender	Male	49	122	5	7	183
	Female	30	124	7	19	180
Total		79	246	12	26	363

(q100) Gender * (q303.1) Name all HIV and AIDS prevention methods you know - Abstinence Crosstabulation

Count

		(q303.1) Name all HIV and AIDS prevention methods you know - Abstinence		Total
		No	Yes	
(q100) Gender	Male	81	102	183
	Female	68	112	180
Total		149	214	363

(q100) Gender * (q304) Have you ever heard of National AIDS Council (NAC) Crosstabulation

Count

		(q304) Have you ever heard of National AIDS Council (NAC)		Total
		Yes	No	
(q100) Gender	Male	139	44	183
	Female	135	45	180
Total		274	89	363

(q100) Gender * (q400) Have you ever used a condom Crosstabulation

Count

		(q400) Have you ever used a condom		Total
		Yes	No	
(q100) Gender	Male	117	66	183
	Female	70	110	180
Total		187	176	363

(q100) Gender * (q401) How did you get the condom Crosstabulation

Count

		(q401) How did you get the condom				Total
		Bought	Given For Free	Partner had them	88	
(q100) Gender	Male	95	20	4	64	183
	Female	36	13	23	108	180
Total		131	33	27	172	363

(q100) Gender * (q404) Do you know where to get condoms if you need them Crosstabulation

Count

		(q404) Do you know where to get condoms if you need them		Total
		Yes	No	
(q100) Gender	Male	173	10	183
	Female	166	14	180
Total		339	24	363

(q100) Gender * (q406) How often do you use condoms during sexual intercourse Crosstabulation

Count

		(q406) How often do you use condoms during sexual intercourse			Total
		Always	Sometimes	Never	
(q100) Gender	Male	40	55	88	183
	Female	29	33	118	180
Total		69	88	206	363

(q100) Gender * (q407) Opportunity to have sex arises but you cannot access a condom Crosstabulation

Count

		(q407) Opportunity to have sex arises but you cannot access a condom			Total
		Go ahead and have unprotected sex	Let the opportunity pass till I can secure a condom	I am not sure	
(q100) Gender	Male	40	117	26	183
	Female	39	99	42	180
Total		79	216	68	363

(q100) Gender * (q500) Do all people who get HIV develop AIDS Crosstabulation

Count

		(q500) Do all people who get HIV develop AIDS			Total
		Yes	No	Don't Know	
(q100) Gender	Male	91	67	25	183
	Female	81	69	30	180
Total		172	136	55	363

(q100) Gender * (q502) Getting HIV is the worst thing I can imagine Crosstabulation

Count

		(q502) Getting HIV is the worst thing I can imagine		Total
		Yes	No	
(q100) Gender	Male	110	73	183
	Female	121	59	180
Total		231	132	363

(q100) Gender * (q600) Tested for HIV Crosstabulation

Count

		(q600) Tested for HIV		Total
		Yes	No	
(q100) Gender	Male	62	121	183
	Female	83	97	180
Total		145	218	363

(q100) Gender * (q606) How likely is it that you will get HIV in the next five years Crosstabulation

Count

		(q606) How likely is it that you will get HIV in the next five years					Total
		Very Likely	Likely	Unlikely	Very Unlikely		
(q100) Gender	Male	2	32	47	102		183
	Female	10	23	48	98	1	180
Total		12	55	95	200	1	363

(q100) Gender * (q611) Socio-economic class is more vulnerable to contract HIV Crosstabulation

Count

		(q611) Socio-economic class is more vulnerable to contract HIV				Total
		Rich	Poor	Both	88	
(q100) Gender	Male	55	39	89		183
	Female	44	31	104	1	180
Total		99	70	193	1	363

(q100) Gender * (q612) Present standard of life make you vulnerable Crosstabulation

Count

		(q612) Present standard of life make you vulnerable				Total
		Yes	No	0	3	
(q100) Gender	Male	61	121		1	183
	Female	35	142	1	2	180
Total		96	263	1	3	363

**(q100) Gender * (q700) It is (was) easy to abstain from sex until marriage
Crosstabulation**

Count

		(q700) It is (was) easy to abstain from sex until marriage			Total
		Agree	Uncertain	Disagree	
(q100) Gender	Male	90	7	86	183
	Female	131	8	41	180
Total		221	15	127	363

**(q100) Gender * (q702) Is it difficult nowadays to be faithful to one partner
Crosstabulation**

Count

		(q702) Is it difficult nowadays to be faithful to one partner			Total
		Agree	Uncertain	Disagree	
(q100) Gender	Male	75	10	98	183
	Female	61	15	104	180
Total		136	25	202	363

**(q100) Gender * (q710) Do you think ABC approach is being effective in Zimbabwe
Crosstabulation**

Count

		(q710) Do you think ABC approach is being effective in Zimbabwe				Total
		Yes	No	Somehow	Don't Know	
(q100) Gender	Male	84	32	55	12	183
	Female	71	51	45	13	180
Total		155	83	100	25	363

**(q100) Gender * (q800) Do you inquire sexual history of new
partner Crosstabulation**

Count

		(q800) Do you inquire sexual history of new partner		Total
		Yes	No	
(q100) Gender	Male	129	54	183
	Female	131	49	180
Total		260	103	363

(q100) Gender * (q912) Any political leaders who have disclosed they are living with HIV/AIDS Crosstabulation

Count

		(q912) Any political leaders who have disclosed they are living with HIV/AIDS		Total
		Yes	No	
(q100) Gender	Male	31	152	183
	Female	32	148	180
Total		63	300	363

(q100) Gender * (q915) Gvt providing adequate inform about HIV/AIDS through media Crosstabulation

Count

		(q915) Gvt providing adequate inform about HIV/AIDS through media		Total
		Yes	No	
(q100) Gender	Male	97	86	183
	Female	113	67	180
Total		210	153	363

(q100) Gender * (q1000) Changed sexual behaviour because of AIDS Crosstabulation

Count

		(q1000) Changed sexual behaviour because of AIDS					Total
		Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
(q100) Gender	Male	87	48	11	16	21	183
	Female	69	55	7	21	28	180
Total		156	103	18	37	49	363

The average ages of respondents by sex and the standard deviations

(q100) Gender	Mean	N	Std. Deviation
Male	26.96	183	7.56
Female	25.07	180	7.48
Total	26.02	363	7.57

The average ages of the respondents by marital status and the standard deviations

(q101) Age

(q102) Marital Status	Mean	N	Std. Deviation
Married	31.01	141	7.36
Never Married	21.38	194	3.40
Divorced	32.11	9	8.49
Separated	29.67	12	6.73
Widowed	40.14	7	6.52
Total	26.02	363	7.57

APPENDIX 3: SAMPLES OF IN-DEPTH INTERVIEW QUESTIONS

HIV/AIDS PREVENTION PROGRAMMES AND BEHAVIOURAL CHANGE, PROBLEMS AND PROSPECTS: A CASE OF HARARE RESIDENTS

An Interview Guides with Mai Chisamba

(I am not sure if Mai Chisamba would rather have an interview in Shona or not, but if she does, you will have to translate the questions making sure the interpretation stay the same)

- Hello Mai Chisamba. How are you?
- My name is _____ and it is a great pleasure meeting you and an honour for allowing me to interview you. Thank you so much for your time, I really appreciate it. My research is on HIV and AIDS, prevention programmes and behavioural change in Harare.

Ask Mai Chisamba's background.

Questions

1. May you tell me your job title and what is involves?
2. What age groups and sex groups comprise your audience mostly?
3. You have been the mouth piece to so many people regarding different social issues some of which are regarded as taboo topics, have you ever received much opposition to what you do?
4. As I said before, I am here to talk to you about HIV and AIDS, how have you seen it in Harare? What are your comments regarding this epidemic in this city and in Zimbabwe as a whole?
5. Is it such an important issue for you to discuss on your shows. Have you ever had HIV and AIDS discussions and if yes, what did you discuss about?

6. Do you find people participating freely regarding to HIV/AIDS issues than any other domestic issues?
7. Do you think your Behavioural change communication programmes (BCC) strategies are working? There have been so many critics regarding currently running adverts on the T.V, that they actually promote people to have AIDS and not to preventing it. They say message given is you can still live your life even when positive so why worry? What is your comment?
8. The Government and N.G.Os are not producing shocking adverts, with people with full blown AIDS, dying of AIDS, at grave sites, the effects it is having on the country and the families. Do you not think this could be more effective with adverts showing the statistics? From the research we conducted, we noted that many people do not know how many people are dying of AIDS each week in Zimbabwe, and when we told them at the end of the interview, we could see the shock on their faces? Do you not think if people were to be told such horrific figures, they would change their behaviour?
9. With the economic situation in Zimbabwe at present, why would someone bother to getting tested knowing how the health system is at the moment with no drugs and facilities, and knowing that they will not afford any healthy foods to sustain their life, what is really the point of getting tested knowing there is nothing that they can do about it?
10. Do you agree or believe in the Abstinence, Be Faithful and Condom Use (ABC) Approach? Do you think the strategies are working (*Ask each approach individually*).
11. Do you think the availability of ARVs is promoting more promiscuity?
12. Some people may argue there is still a huge silence in communities regarding HIV and AIDS, what is your comment regarding this.
13. If you say there is, what can be done about it? What have you been doing to try and break this silence especially within families?
14. The National AIDS Council (NAC) published a report that the declining of HIV prevalence rates in Zimbabwe was due to behavioural change. However there have been a lot of theories disagreeing with this claim. Some argue it is only a political gimmick and others claim it is due to very high death rates and low birth rates and as well as nearly 3 million people who have left Zimbabwe

for the Diaspora. What is your comment on this? Do you first of all really believe the rates are declining from your own experience working in this field and do you give credit to behavioural change?

15. With the current economic situation in Harare, do you think the people are changing their sexual behaviour or they are getting much worst?
16. From your experience, do you think one's economic status makes you vulnerable to infections or that both the rich and the poor are equally vulnerable?
17. Do you think the general public is interested in coverage of HIV and AIDS issues?
18. From the research that we carried out, most people said they are so much fed up, '*vakufinbwa*' with hearing about AIDS and to them it does not mean anything anymore. What is your comment on this?
19. There has been a lot of people with funds now resorting to satellite dishes and foreign TV programmes as they say the ZBC is now unbearable. Do you share the same view? Have you witnessed a significant reduction in the number of viewers and listeners in your show?
20. What have you done to rectify this problem and to make sure people still have access to information and the programmes you air?
21. To what extent do you think the Government is interested in HIV and AIDS?
22. Do you think they are doing enough on its media coverage? What reasons can you think of that hinder knowledge about HIV and AIDS translating into behavioural change?
23. If you were to head the HIV and AIDS prevention strategy in Zimbabwe, what will be your solution to the HIV and AIDS pandemic?

Thank you so much for your time Mai Chisamba!

HIV/AIDS PREVENTION PROGRAMMES AND BEHAVIOURAL CHANGE, PROBLEMS AND PROSPECTS: A CASE OF HARARE RESIDENTS

An Interview Guide with the Zimbabwe Broadcasting Corporation (ZBC)

- Good Morning / Afternoon Sir. How are you?
- My name is _____ and it is a great pleasure meeting you and an honour for allowing me to interview you. Thank you so much for your time, I really appreciate it. My research is on HIV and AIDS, prevention programmes and behavioural change in Harare.

Questions

1. May you tell me your job title and what it involves?
2. How many t.v stations do you currently run and what are the contents?
3. How many radio stations do you run and what are the specific contents in each station? What makes one different from the other?
4. Where do you get your funding to run ZBC?
5. What are the percentages in terms of your media coverage? Do you have statistics and figures showing what programmes you aired both on television and radio? I will be grateful if you have statistics over a period of time showing trends in the last 10 years for example. (*Ask for the hard copies*).
6. Do you have a department or team that is responsible for health issues coverage?
7. In the midst of all the political and economic issues currently covering the headlines everyday, in your view, is HIV and AIDS newsworthy at all at the ZBC. To what extent has the coverage of HIV and AIDS given any importance in the midst of all the political and economic stories being reported on?
8. Do you have any statistics showing the extent to which HIV and AIDS issues are reported both through T.V and radio? Have you seen any changes in the coverage of HIV and AIDS since it was declared as a state of emergency? Do you have any statistics of the trends in media coverage of HIV and AIDS? (*Please get a copy if they have one*)
9. What specific issues on HIV and AIDS are mostly reported on?

10. Do you think the general public is interested in coverage of HIV and AIDS issues?
11. From the research that we carried out, most people said they are so much fed up, '*vakufinbwa*' with hearing about AIDS and to them it does not mean anything anymore. What is your comment on this?
12. How has the current economic situation impacted on general access to media including access to T.Vs and radios.
13. Do you have a system that monitors the number of viewers and listeners you currently have at any given time?
14. If so, which programmes attract the highest numbers and which ones attract the least numbers?
15. In what way has the economic situation affected the number of viewers and listeners you get?
16. As there is frequent power cuts in different areas at different times, are you making any effort to ensure that your viewers do not miss on any programmes. What strategies are you putting in place in regards to the frequent power cuts?
17. There has been a lot of people with funds now resorting to satellite dishes and foreign TV programmes as they say the ZBC is now unbearable. Do you share the same view? Have you witnessed a significant reduction in the number of viewers and listeners?
18. Don't you think it's a result of fear of stiffer penalties and effective policing on your part?
19. Most families are now resorting to satellite dishes for their source of entertainment such as S.A.B.C and some no longer have access to T.V and radio coverage due to power cuts. What have journalists and those responsible for coverage done to rectify this problem and to make sure people still have access to information. This is such an importance hindrance for information dissemination.
20. To what extent does the Government have control over this corporation? Some people are now calling it Zanu P.F Broadcasting Corporation, what is your comment regarding to this matter?
21. Do you think Behavioural change communication programmes (BCC) strategies are working? There have been so many critics regarding currently

running adverts on the T.V. that they actually promote people to have AIDS and not to preventing it. They say the message given is you can still live your life even when positive so why worry? What is your comment?

22. Do you not think it will be more effective if the Government tells its own people what to do regarding HIV and AIDS issues than international organisations such as adverts from PSI, or do you think the people in Harare have lost confidence in its Government that they will not be listened to anything they say?
23. Why is it that shocking adverts are not produced, showing people with full blown AIDS, dying of AIDS, at grave sites, the effects it is having on the country and the families. Why is it that there are no real life documentaries about people with AIDS, telling it like it is. Do you not think this could be more effective with adverts showing the statistics? From the research we conducted, we noted that many people do not know how many people are dying of AIDS each week in Zimbabwe, and when we told them at the end of the interview, we could see the shock on their faces? Do you not think if people were to be told such horrific figures, they would change their behaviour?
24. To what extent do you think the Government is interested in HIV and AIDS?
25. Do you think they are doing enough on its media coverage?
26. The National AIDS Council (NAC) published that the decline in prevalence rates was due to behavioural change? What is your comment on this?
27. Do you think the availability of ARVs, adverts on condoms and living positively is promoting more promiscuity?
28. Some people may argue there is still a huge silence in communities regarding HIV and AIDS, what is your comment regarding this.
29. If you say there is, what can be done about it?
30. With the current economic situation in Harare, do you think the people are changing their sexual behaviour or they are getting much worst?
31. From your experience, do you think one's economic status and access to information makes you vulnerable to infection or that both the rich and the poor are equally vulnerable?
32. What strengths do you the media have in the fight against HIV and AIDS?
33. What about the weaknesses?

34. In your organisation, do you believe there are some of your work colleagues, who are so knowledgeable about the disease yet may be promiscuous and some who do not even use the condoms that they write about?
35. What reasons can you think of that hinder knowledge about HIV and AIDS translating into behavioural change?
36. If you were to head the HIV and AIDS prevention strategy in Zimbabwe, what will be your solution to the HIV and AIDS pandemic?

Thank you so much for your time.