Final Report

End-of-Programme Evaluation of the HIV Prevention Programme 2007-11

Report prepared by
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for
Concern Worldwide in Zimbabwe

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Basic Information Page

Project title: Community Empowerment and Services to Prevent HIV Transmission and Mitigate the Impact of HIV and AIDS

Agency Name: Concern Worldwide

CSCF Number: 431

Country: Zimbabwe

Local Partners:
Family AIDS Caring Trust (FACT), Nyanga
A Self-help Assistance Programme (ASAP), Nyanga
Bastsirai (VCT), Gokwe South
Kana Mission Hospital, Gokwe South
Avila Mission Hospital, Nyanga
Elim Mission Hospital, Nyanga
Chireya Mission Hospital, Gokwe North
Mutora Mission Hospital, Gokwe North

Name of person and company who compiled this evaluation report:
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Period Evaluation Undertaken:
The end line survey ran from 23 May to 31 July 2011, including field work from 23 May to 24 June 2011. Data analysis and report writing was from 24 June to 20 July 2011.
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Prepared for

CONCERN worldwide

Concern Worldwide in Zimbabwe

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All photos in this report were provided by Mr. Robin Weeks, robinweeks.images@yahoo.com unless otherwise identified
All maps are courtesy of Concern International in Zimbabwe unless otherwise identified

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Anti-retrovirals
ASAP	A Self Assistance Programme
BCC	Behavioural Change Communication
CBO	Community Based Organisation
DHS	Demographic and Health Survey
FACT	Family AIDS Caring Trust
FBO	Faith Based Organisation
FGD	Focus Group Discussion
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GRZ	Government of the Republic of Zimbabwe
HIV	Human Immunodeficiency Virus
IGA	Income Generating Activities
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MOHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NGO	Non-Governmental Organisation
OVC	Orphans and other Vulnerable Children
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
SIAPAC	Social Impact Assessment and Policy Analysis Corporation (Pty) Ltd.
STAR	Societies Tackling HIV/AIDS Through Rights
STI	Sexually Transmitted Infections
TOR	Terms of Reference
UNAIDS	United Nations Programme for HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WBCC	Ward Behaviour Change Committee
WHO	World Health Organisation
ZIMSTAT	Zimbabwe National Statistics Agency
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan

Map 1: Map of Zimbabwe Showing its Position in Africa

Map 2: Map of Zimbabwe Showing Districts

Source: UNICEF (2010). A Situational Analysis on the Status of Women's and Children's Rights in Zimbabwe, 2005-2010. A Call for Reducing Disparities and Improving Equity, UNICEF, Harare.

Summary Sheet

Issue Area	Findings and Conclusions
Overall	Effective direct reach with many aspects of the intervention. Important indirect impacts. Focus on capacity enhancement was positive, working with partners was a sound strategy, regardless of the difficulties encountered. Poorly guided and served by a logframe that undermined implementation and monitoring. Programme overly complex. Livelihoods support valued, but not clearly connected to risk reduction.
Impacts	Important impacts associated with direct reach. Important indirect impacts on HIV issues if directly reached by STAR or other peer education mechanism. Impact expectations on behaviours partially realistic for directly affected, including regarding changing social norms, but overly-optimistic on sexual behaviours and on the situation for indirectly reached.
Relevance	Effective participatory learning and action work up front, along with thereafter the information from the baseline and the context analysis, suggests that the Programme responded to important felt needs. Concern showed a flexibility in implementation in this regard, and its policy of community placement of officers to work largely with community volunteers and groups helped ensure that the Programme remained flexible. Nevertheless, there were some problems with over-definition of the problem, with particular regard to the set of traditional social norms defined as uniformly negative, but also with targeting. Pro-poor targeting appeared to have taken place, and policy alignment within Concern and with Government was attained. One important unexpected outcome, albeit noted in a 2010 context analysis, was the strengthening of social capital networks in areas where these had weakened due to a variety of factors.
Effectiveness	Those directly reached by the Programme in many respects benefitted from this engagement. Group-focused interventions and partnerships appeared to have been especially effective. There were some reports that young people were less engaged than should have been the case, especially out-of-school youth, and that young people in school did not play a sufficiently strong role in determining implementation priorities and actions. Further, evidence from the impact assessment component of the evaluation suggested that indirect reach through peer education channels allowed the Programme to expand reach considerable, and that this reach had important implications for knowledge, attitudes and practices (although important gaps remain). Effectiveness was largely undermined by overly-ambitious outcome objectives coupled with a confused logframe that did not guide implementation. While Programme personnel devoted attention to networking with Government and other agencies involved in the HIV&AIDS response, implementation was sporadic. In part this was due to the lack of effective avenues for such engagement, but as the situation is improving in Zimbabwe, this should be more relevant for future programming.
Efficiency	The flow of funds was constrained initially in terms of working with local partners, and this slowed implementation. Other findings suggest that funds moved as intended beyond this particular constrain. However, external factors were especially important in slowing implementation, which was not Programme related. The cost effectiveness of the intervention was heightened based on placement policies, but undermined by a focus on a relatively small number of persons directly reached. Too many Programme objectives were far too ambitious, and should not have been considered as short-term objectives.
Sustainability	Lack of sustainability represents an important challenge to the Programme, as any lasting legacy would largely apply to those directly reached, and even here further attention is required. The partnerships established with local actors proved to be especially valuable, but like many such organisations they need continued assistance, and should not be judged as sustainable or not simply based on a few years of support. This was also the case with local groups established or strengthened through the Programme. And while more attention could have been focused on linking with Government, this was not necessarily practical given conditions applying during most of the implementation period. The objectives, which were overly-ambitious, should have been scaled back earlier to be more realistic. Realistic benchmarks could have been established and means for sustaining these determined, even if this required other external support rather than leaving these institutions without other external support. In terms of Programme replication, many lessons were learned during implementation, driven by review procedures put into place by Concern. Notably useful were the participatory learning and action activities early in the implementation period when, along with the baselines, the Programme had time to reflect on its action. The context analysis, conducted in 2010, offered useful insights into what this Programme, and any future programme, would need to consider, notably issues around targeting and structured learning as an important implementation element.

Executive Summary

Overview of the Document

This End-of-Programme Evaluation Report presents findings from a two-stage assessment of the HIV Prevention Programme (hereinafter referred to as the Programme). The first stage comprised measuring impacts, employing both quantitative and qualitative approaches. This resulted in the submission of a draft Indicators Status Report that showed progress along Programme components. The second stage comprised a field visit by the evaluator where impact data were considered and, coupled with further information collection around Programme effectiveness, efficiency, relevance and sustainability, were used to prepare this evaluation report. This End-of-Programme Evaluation Report represents an integration of findings from both of these phases.

Main Findings

General

The evaluation has found that there have been a number of important, positive impacts that suggest progress along many of the objectives of the Programme. In the context of Zimbabwe at the time this is an important accomplishment. However, it is unlikely that the Programme approach and the way in which the Programme has been implemented will result in a wide range of long-term impacts in the Programme areas. While the impacts to date should not be undervalued, long-term impacts are less likely, and likely to only relate to a subset of activities. This is due to a combination of overly-ambitious objectives and constraints with implementation that did not include sufficient focus on sustainability. At the same time, in considering the situation in Zimbabwe it was unrealistic to anticipate sustained impacts in the first place.

Overall, the Programme did yield important (and demonstrable) impacts in the Programme area not just among those directly reached, but also among those further reached. The Programme provided services that were all but lacking in an area of great need, filling a major void at the time. And the Programme started a dialogue about longer-term cultural and economic changes that, while implemented with important defects, nevertheless sets the ground for further actions by other agencies, including a strengthened State.

Impact

The Terms of Reference noted that impact should consider the following issues:

1. What real difference has the programme made to beneficiaries?
2. What is the level of change in terms of the three key areas of work: behaviour change, access to services, and increased income and control by women from activities?
3. Where significant changed has occurred, how much of it can be attributed to Concern's interventions (fieldwork should include non-programme areas for comparison)?
4. How many people has the programme affected? Disaggregate the numbers.

The most important impact finding is that direct exposure to peer educators or other one-on-one channels seems to covary with improved knowledge and attitudes, greater compassion for those who were HIV

positive and more openness about HIV status, some improved gender norms, and changing attitudes about worst forms of gender-based violence. The survey findings repeatedly underlined the importance of this direct exposure. This is especially important when considered in light of the *lack* of covariation between exposure to secondary means of information on HIV&AIDS, gender-based violence, and other information and actual knowledge and attitudes.

Indicators by outcomes are summarised as follows:

Outcome 1: Improved knowledge, attitudes and practices

- Those exposed to peer educators or other direct means of exposure were more likely to have higher levels of knowledge and more progressive attitudes than those who were not.
- There were no clear differences in behaviours between those reached by the Programme and those who were not reached, regardless of levels of exposure, and there were no clear differences between treatment and control locations.
- There were important gaps in knowledge that helped explain a disconnect between levels of knowledge and risk behaviours, notably related to a lack of proper understanding of the actual risk of HIV infection and how risk can be properly assessed.
- Attitudes about those living with HIV tended to be compassionate, but were especially so for those directly exposed to Programme interventions.
- Attitudes about condoms remained ambivalent, and were generally negative across populations.
- International definitions of gender-based violence did not appear to be consistent with how violence was locally perceived. What was locally considered to be acceptable discipline is internationally considered to be violence. What did appear to have changed during the Programme was a perception that 'excessive' violence was less acceptable than in the past.

Outcome 2: Culture and tradition and sexual decision-making

- Direct exposure from the Programme covaried with more progressive attitudes about the female role in sexual decision-making. However, attitudes about female roles in sexual decision-making in marriage remain constrained.
- Qualitative findings suggest that directly reached persons did question the value of some traditional practices that might heighten risk, but that the extent to which this yielded behavioural change was felt to be extremely limited.
- HIV testing was high throughout the area and, although little is known about testing patterns (e.g., link to risk perception, repeated testing in cases of perceived risk), can be viewed as an important Programme impact. When linked to the roll-out of ARV provision, significant progress was made.

Outcome 3: Improved attitudes and practices around HIV and the drivers of the epidemic

- Programme intentions associated with key drivers of the epidemic were extraordinarily ambitious and largely unrealistic, associated with age of first sexual activity, age at marriage, forced sex, and age gaps between sexual partners. Qualitative findings do suggest that some attitudes are changing, but that little learning has taken place by Programme personnel in why these 'negative cultural practices' exist nor what their impacts are on HIV seroprevalence and risk.
- Data were not available on child sexual abuse, but qualitative findings suggest that it may be less common in the Programme area than in the past.

Outcome 4: VCT, PMTCT, STIs

- Attitudes about VCT had improved in the Programme area, in particular among those with direct exposure to the Programme. In Gokwe treatment area locations for females, VCT access expanded

as well. In other locations, these impacts were less positive, in Gokwe due to reported male resistance to direct testing, and in Nyanga due to previously high levels of testing because of broader availability of services.

- Data on STI services were not available.

Outcome 5: Livelihoods enhancement

- Qualitative respondents tended to agree that livelihoods support was central to risk behaviour reduction by young women, but that the Programme reach was insufficient to have much impact.
- Livelihoods support activities in Nyanga were reported to have been positive, but this was not the case in Gokwe.
- Impacts of livelihoods support activities on levels of transactional sex was felt to be negligible.

Overall conclusions on impacts are as follows:

- Available evidence suggests that knowledge and attitudes have improved, largely due to direct exposure to peer education interventions, with little impact due to overall reach with HIV information, even with exposure to multiple sources. Direct contact appears to make a difference.
    - However, for all groups important knowledge gaps remain around the depth of understanding of HIV, confusion about condoms, and means of transmission. And why many attitudes around HIV&AIDS were quite positive, there were particular concerns about attitudes about gender-based violence.
- While there was some evidence that some aspects of practices have changed, in most cases impacts on practices were limited. In large part this is due to high expectations about behavioural change, rather than focusing on bellwether indicators of the potential for behavioural change, in particular related to attitudes.
- In Gokwe the VCT activities have had an important impact on HIV testing reach, and has helped the mission hospitals to extend outreach and help meet demand. In part this appears to be due to having good local partners, although capacity enhancement was required. In Nyanga, it appears that testing services were more available, and in this respect the additive impacts of testing service availability is less clear. There were similar findings for PMTCT.
- The livelihoods support intervention did not work well in Gokwe, but did have success with those reached in Nyanga. In part this appears to have been due to the presence of a solid local partner organisation in Nyanga. Impacts on risk reduction associated with transactional sex work is not clear, and probably not very important, but the HIV activities themselves appear to have resulted in important changes in knowledge and attitudes that may well reduce risk behaviours, especially if livelihood options are available.
- In discussions with team members on the final stage of the evaluation, and based on comments from key informants and focus group discussions, it is evident that an important unintended impact of the Programme was the strengthening of social capital networks. This is doubly important given that a number of the Programme areas are partially comprised of resettled populations, and given the settlement and economic disruptions associated with Zimbabwe's economic decline and policy decisions.

<u>Relevance</u>

The Terms of Reference noted that relevance should consider the following issues:

5. Have the right things been done?
6. To what extent did the programme address the problems cited by communities and stakeholders during the problem analysis phase as documented in the Participatory Learning and Appraisal reports.
7. How was the targeting done and was it appropriate?
8. How were the poorest and most vulnerable included?

9. How much have target groups and stakeholders participated in different programme interventions?
10. Were the interventions consistent with Concern's policies and guidelines of equality, capacity-building, programme participant protection policy, and HIV policy?
11. Did the programme support the Zimbabwe National AIDS Strategic Plan?
12. Were there unexpected outcomes from the programme?

Findings are as follows:

- Findings suggest that, overall, the Programme addressed HIV&AIDS priorities, especially with regard to service provision. The PLA exercise that took place at start-up was felt to have provided important insights into perceived needs.
- Findings also suggest that community engagement continued throughout Programme implementation, supported by Concern's policy of placing extension officers in communities. There are concerns about the relative power between the extension officers and the communities which needs further consideration, and which would have benefitted from reflection as the Programme proceeded.
- Having said this, the extraordinarily difficult economic conditions at the time of Programme implementation meant that, beyond service provision, HIV&AIDS overall was not a priority concern, as livelihoods was even more central to people's lives than in the past.
- There were some aspects of the Programme that may have been over-defined, in particular the issue of 'negative cultural practices' that did not leave room for discussion and therefore were constrained in their analysis.
- Concerning targeting, the context analysis of Concern's work in the two Gokwe districts, covering all of their programmes, (Concern Worldwide Zimbabwe, 2010) referred to Concern's 2010 policy on targeting that mean that targeting of extreme poor itself was not always necessary, rather the focus should be on targeting in such a way that benefits accrue to the extreme poor. Such a focus on outcomes meant that reach could well exceed the ultra-poor during the process of implementation, and it also meant that levels of response could be individual, household, community or other level. The context analysis found that, despite high levels of poverty overall in the two Gokwe districts, there is economic differentiation in the Programme area. Referring to 2006 fieldwork conducted by Concern, the report noted that some 20% of the Programme area population was very poor, and an additional 40% were poor. It further noted an interesting dynamic where the targeting was actually effective in terms of poorer persons, but that this did not always reach poorer households that were locally felt to be most in need and deserving of priority support. Further, the targeting did not always match risk of HIV infection. Targeting at levels above individuals and households and additional attention to strengthening social capital and social networks would help overcome some of the problems and prevent some of the negative dynamics that resulted from the targeting that took place.
- The Programme was aligned with the Zimbabwe National AIDS Strategic Plan, in part because the Plan was broad in scope, but also in part because the priorities in the Plan and in the Programme were truly felt needs. Having said this, the deficiencies in the logframe and the resultant deficiencies in monitoring meant that the Programme could not properly contribute towards the Plan's M&E Framework.
- Findings suggest that there was policy alignment with Concern's policies, and there was particular appreciation of policies that encouraged community engagement. Nevertheless, for future programming, Concern may wish to consider whether the way in which these policies are implemented may constrain community engagement and local decision-making.
- One important and positive unintended consequence of the Programme was the strengthening of social capital networks that had been weakened by the difficult economic and political times. This was noted in the context analysis conducted in 2010 (Concern Worldwide Zimbabwe, 2010), and recommendations made to further strengthen this outcome.

Effectiveness

The Terms of Reference noted that effectiveness should consider the following issues:

1. How effective was Concern's approach in terms of staffing, use of partners and community volunteers?
2. Were the methodologies used, especially Societies Tackling AIDS through Rights (STAR) appropriate and of sufficient quality to achieve impacts?
3. Were the methodologies used appropriate for all age groups and for both men and women?

Findings are as follows:

- Findings suggest that the design and implementation of the Programme has been extremely effective for those directly reached by the Programme. This includes Programme partners and the quality and quantity of what they were able to deliver through the Programme, and those end users reached in Programme area communities.
- With the partners, attention to capacity enhancement and a focus on joint planning and implementation meant that the activities carried out through these partners were evaluated as effective, as far the actions went.
- The placement of extension officers in Programme area wards to work with community volunteers, end users and intermediaries, served as an effective strategy.
- School-based activities were well designed and focused on working with young people in an effective manner.
- Two Programme design factors undermined effectiveness: 1) the small number of people reached directly in a substantive manner; and 2) overly-ambitious outcome objectives. Regarding the former, concerns were noted about the small number of people directly reached by Programme activities, affecting community-based interventions and school-based interventions. For the latter, overly-ambitious outcome objectives, this affected most aspects of the Programme and undermined what could have been a more effective focus on realistic objectives.
- While constrained, however, the impact assessment found Programme reach well beyond those directly involved in Programme activities. The vast majority of residents in the Programme area had been directly exposed to peer education activities, including discussions with STAR group members, and these contacts appear to have had important impacts in two important areas relevant to HIV&AIDS: improved knowledge and improved attitudes.
- Available evidence suggests that the Programme gave due consideration to different needs across socio-economic status, gender and age, and also directly involved those HIV positive.
- The impact assessment findings suggest that important progress was made towards challenging cultural norms, but that this was constrained by the approach, and the Programme's timeline. There were particular constraints around attitudes towards gender-based violence.
- The effectiveness of STAR was undermined by the small number of people reached.
- The out-of-school youth component did not gain traction, while in-school activities were well received.
- Income generating activities in Nyanga District were well received and were felt to be successful. There were also important spin off benefits in terms of building social support networks. Nevertheless, reach was limited, and the links between HIV risk and livelihoods support remains uncertain.

Efficiency

The Terms of Reference noted that efficiency should consider the following question: Does the programme cost justify the benefit bearing in mind the programme reach in the remote area (if possible compared to similar HIV programmes for useful observations and learning)?

Findings are as follows:

- Findings suggest that funds moved as intended, that cash flow did not hamper activities at any point during implementation, and the use of was reviewed through the system to ensure proper expenditures.
- Community-based operations was a cost effective way of proceeding. Nevertheless, as the ones with the resources, it is unclear how equal the relationship was between the two parties (communities and Concern), and what impacts this might have had on sustainability.
- Active listening, as displayed during the PLA exercises, and in considering the findings of the baselines, along with how the Programme was implemented on a day-to-day basis has proven cost effective. Nevertheless, there are grave doubts about the ability of the groups set up as part of Programme implementation to survive even into the near future. How this will affect the situation of individuals is uncertain as well, but is likely to be less effective than if the groups would survive.
- While a focus on behavioural change may have been too ambitious, impact assessment findings suggest changes particularly in attitudes that offers an important foundation for behavioural change. This proved to be a good use of resources, even if this is mid-directed.
- Too many Programme objectives were far too ambitious, and were not possible to respond to in the short-term. This would have been fine if attention had been devoted to how interventions could be sustained into the future that would tackle these over the long-term, but this was not the case for the Programme. The Programme's focus on these more intractable issues may therefore not have been a cost effective use of resources.

Sustainability

The Terms of Reference noted that sustainability should consider the following issues:

1. Is there evidence that initiatives begun under the programme will last and spread without ongoing support from Concern?
2. Are there comprehensive exit strategies in place?
3. Are there additional measures that Concern should do to improve sustainability?
4. Was there capacity building of partners and Concern?

Findings are as follows:

- Lack of sustainability is perhaps *the* most serious challenge to the Programme, as it is doubtful that the Programme will have yielded any lasting legacy beyond the individuals directly reached, and even for them the constraints they face in reducing risks and accessing services is of concern.
- However, it may have been unrealistic to expect that sustainable impacts could have emerged from the Programme. The implementation period coincided with the worst economic crisis seen in independent Zimbabwe, while political constraints also undermined Programme viability.
- Related to this, if other agencies (or Concern itself) are able to strengthen the HIV&AIDS response in the Programme area for a number of years into the future, and if these agencies continue to focus attention on institutional strengthening and working with local (state and non-state), this should be considered as part of a sustainable response. It is unrealistic to assume that a five year programme, implemented during one of the most difficult times in Zimbabwe's independence history, can be sustained into the future. Instead, a longer timeline should have been considered, coupled with a stronger focus on learning as the Programme proceeded.
- Despite this, the extent to which the Programme contributed towards sustainability is a fair question. For the HIV Programme, insufficient attention was focused on sustainability, and as a result this did

not form part of the review processes instituted during implementation. Systematic reflecting, along with a more strategic mid-term review, might have had important sustainability impacts on Programme implementation, supporting sustainability, as recommended in the 2010 context analysis (Concern Worldwide Zimbabwe, 2010).

- The survivability of groups, either community-based or school-based, is questionable in the absence of systematic and over-time support. With the exception of income groups in Nyanga District, it is difficult to see what will hold the remaining groups together as formal entities in the long-term. In such a situation, it might have been better to cover a significantly higher number of people with anticipated shorter-term impacts.
- Concerning services, secular trends in Zimbabwe suggest that access to public health services will continue to improve over the worst years (2007/9), and the work done by the Programme may yield a residual impact if partner agencies are involved.
- Virtually all of the key informants involved in the Programme, or knowledgeable about the Programme, felt that it was too complicated and difficult to implement, and poorly guided by a vague and confusing logframe.
- Early attention to an exit strategy may have helped focus greater attention on sustainability.

Recommendations

Recommendations are specifically focused on implications for future programming, based on a response to the question in the Terms of Reference: "How can things be done better in future?" The TOR included four specific queries in this regard:

1. How can programme best practices be captured and spread to encourage replication? Is this programme positively affecting other Concern programmes in Zimbabwe?
2. What new initiatives should be included in future programmes?
3. Is a multi-faceted programme approach the best HIV prevention strategy or what should Concern focus more on in future programmes?
4. Given Zimbabwe's contextual changes regarding the HIV epidemic, improvements in the health sector, the growing economy, together with increasing donor need for short-term results, what are the implications for the future of HIV programming in the operational areas in light of the evaluation findings?

- The careful attention to partner selection and capacity enhancement, while sometimes a slow and frustrating process, was an excellent idea. In any future programming, similar relationships would be important as well, but should be subject to more attention focused on sustainability matters. For non-state actors, sustainability should be more broadly viewed as building alliances that would help these agencies secure additional support in future. Given the changing situation in Zimbabwe, it is also more likely not to effectively engage with Government than it was during Programme implementation. It is recommended that partnerships and capacity enhancement remain central tenets of Concern's future programming in the HIV&AIDS arena.
- The participatory learning and action exercise, along with the extended baseline surveys, supported community buy-in of the intervention overall, expanded awareness of the Programme itself, and helped shape Programme implementation based on felt needs in the area. Granted that it still carried a great deal of previously identified 'baggage' (e.g., what was right and what was wrong), it nevertheless helped Concern better respond to felt needs. These and other efforts towards the implementation of a 'bottom up' approach are commendable, whatever the deficiencies. It is recommended that Concern include in any future programming a *specific* objective on learning from programme implementation, and that programme implementation be evaluated against achievement of this objective. It is also recommended that any future programme avoid over-definition of 'good' and 'bad', and that a culture of listening and learning be put into place that allows programmes to grow as implementation proceeds. Such an approach, that devotes equal attention to process and product, would strengthen over time.
- The placement of Concern personnel in communities full-time allowed these officers to better link to community volunteers, groups, school authorities, etc. during implementation. It also helped

strengthen bonds between these officers and community members. Again, whatever the deficiencies in actual implementation, such an approach is commendable, and certainly contributed to Programme implementation effectiveness. It is recommended that such an approach be used in future programming, but that additional measures be put into place to ensure that there are systems of proper reflection and learning from this model as programme implementation proceeds.

- The problems encountered in trying to operationalise the logframe highlight the importance of having clear, achievable objectives where progress can be measured. As Programme implementation proceeded there was growing recognition that the Programme itself was far too ambitious, and should have been rescaled and refocused on what could be achieved. A particular problem is viewing HIV&AIDS as separate from people's broader lives, and setting benchmarks that assume that an HIV&AIDS intervention itself doesn't need to consider these other factors. It is recommended that programme objectives and expected accomplishments be tailored to a better understanding of these factors. One excellent way of proceeding would be to conduct a context analysis that includes HIV&AIDS and livelihoods at programme start-up, and using this to consider benchmarks and ultimate objectives. Another would be to monitoring effectiveness by considering the results of the learning cycle noted above.
- Consideration needs to be given to a proper balance between Programme intensively and Programme reach. The Programme erred on the side of intensive impacts, which yielded a narrow reach. It should nevertheless be underlined that it was direct exposure to the interventions that had an important impact on outcomes, along with direct exposure to those reached by the Programme. For a programmatic focus on enhanced understanding and attitudinal change, it is recommended that this direct and onward reach approach be considered for future programming, and that target numbers be established based on this model.
- The Programme focused on a subset of wards in the three districts. While the needs of people beyond these wards are indeed worth consideration, it does not necessarily imply that Concern should respond to these issues, especially given the presence of other actors. It may instead be wise to consider focusing on wards where Concern has had a presence, and focus attention on how Concern could build on previous activities and previous partnerships. It is recommended that Concern consider, as possible, future programming in the same programme areas. This is especially the case if objectives are ambitious, including many of the aims in the Programme related to behavioural change and risk reduction.
- The context analysis highlights what is essentially already know from most other development interventions: people resent external actors defining who is most in need, who should be targeted, and how they should be targeted. Instead, it is recommended that this be an outcome of consultations taking place at start up, and considered throughout implementation.
- Programme sustainability needs to be properly cast in the context of what is possible to achieve in the time allowed and with the resources available in the locations and with the populations targeted. The Concern Programme had sustainability objectives that were removed from what could practically be accomplished and, when coupled with a logframe that did not guide implementation effectively, overwhelmed the Programme. As a result, even less ambitious objectives around sustainability are unlikely to be achieved. Beyond staying in targeted wards for longer periods of time across programmes to support sustainability, it is recommended that the programme clearly define what it intends to accomplish in terms of sustainability, and measure towards this as implementation proceeds. Objectives should be realistic in this regard.
- A programmatic focus strengthening local institutions and building effective social networks are both commendable, and in some respects these should be considered objectives unto themselves. However, it should be recognised that some of these local institutions will remain critically weak and that programme completion may result in institutional collapse. This holds in particular for structures such as anti-AIDS clubs and local anti-AIDS groups in communities. These groups collapse largely because they don't have the resources to see their activities through, but more importantly because they often don't have a clear reason to continue their work outside of a programmatic framework. Unless there are going to be other channels of support for these groups, it is difficult to see the long-term efficacy of institutional strengthening. Therefore, it is recommended that the context analysis conducted at programme start-up look at the potential for long-term support

for these institutions, and that these other actors be involved in implementation from early in the programme. This should be considered as part of an exit strategy.

- A stand-alone HIV programme may well be warranted in the Programme area. Available evidence from the evaluation suggests that in the current wards this is indeed the case. The number of actors involved in the HIV response in the Programme wards, and the breadth of their activities, remain limited, and will likely remain so for the foreseeable future. With this in mind, a well focused HIV programme with realistic objectives may be quite beneficial. However, it should focus specifically on HIV&AIDS and capacity enhancement. Of particular importance, before programme start-up it is recommended that attention be devoted to establishing the need for public health activities, or whether Concern's competitive edge falls outside of this arena. Even if there is a need for public health support, it remains to be seen whether Concern is the best agency to provide support, or whether it might consider teaming up with another agency that focuses specifically in this area. It is recommended that Concern consider these approaches. To the extent possible, it is recommended that Concern work with partner agencies (not as contractors, rather as strategic partners) also delivering services rather than trying to provide all these services itself. This often works best with both agencies work with the same local partners as possible.
- While a programmatic focus on livelihoods enhancement to reduce HIV risk is commendable, it is unlikely that it can be achieved if it is but one component among many falling under an HIV programme. If HIV risk reduction is an important factor, it is recommended that it should be considered as part of a livelihoods intervention, and the programme should be accountable to including, and measuring, HIV risk reduction knowledge, attitudes and (as possible) behaviours. This goes beyond HIV mainstreaming in a livelihoods initiative, and instead makes it a specific deliverable.
    - If it is concluded that a livelihoods and HIV reduction programme is the best way forward, Concern should consider whether the programme should focus only on this particular aspect of the HIV response. It is, simply put, an extremely difficult activity that would warrant full attention. Muddling this with other intended HIV programme activities may only serve to weaken the programme overall. It is therefore recommended that, should Concern decide to focus on HIV risk reduction and livelihoods, it focus specifically on this matter, and not include this as part of a broader initiative. Focus is central to making this work.
- Any future programme needs to have a clear logframe with achievable objectives and reasonable measures of success. It is recommended that attention be devoted at start-up to designing a workable logframe.
- The Programme learned from external activities, including from the baseline surveys, the participatory learning and action activities, the mid-term review, the context analysis and the evaluation. This is an important lesson learned, and it is recommended that this be a stated intent of any future programme.
- For the monitoring and evaluation framework for any future programme, monitoring should not be overly ambitious, and should be focused on measuring activities, inputs and outputs. A specific learning component can inform the framework more substantively, and can serve as 'soft' measures of intermediate outcomes as implementation proceeds. External evaluation activities can inform the measurement of impacts, which should not be a focus of monitoring activities. It is recommended that considered attention be devoted to the design of an M&E framework, linked to the logframe, that carefully considers how to measure activities, inputs and outputs associated with monitoring separate from an evaluation focus on outcomes and impacts.

1 Introduction

1.1 Introduction

This report presents findings from a End-of-Programme Evaluation, hereinafter referred to as the Evaluation, commissioned by Concern Worldwide in Zimbabwe of the "Community Empowerment and Services to Prevent HIV Transmission and Mitigate the Impact of HIV and AIDS" (hereinafter referred to as the Programme), financed by Concern Worldwide and implemented by their local office in Zimbabwe.

According to the Programme logframe, the **goal** of the Programme is "to reduce the prevalence and impact of HIV and AIDS through community empowerment (of women and girls, men and boys) in three districts". The Programme employs three main approaches to respond to HIV&AIDS: 1) working with groups and institutions to support behavioural change; 2) improving access to preventive health services; and 3) increasing financial capital and control over finances by women through an enhancement of income generating activities.

The **purpose** of the Programme is "to improve the behavioural practices related to the prevention of HIV and AIDS among women and girls, men and boys through increased awareness of sexual and equality rights by holders and duty bearers".

This report is organised as follows:

Executive Summary

***Chapter 1: Introduction** - background information on the initiative, approach, background information on Zimbabwe*
***Chapter 2: Programme Overview and Main Achievements** - discussion of programme progress, challenges, deficiencies, and strengths*
Chapter 3: Assessment of Impacts
Chapter 4: Assessment of Relevance, Effectiveness, Efficiency and Sustainability of the Initiative

Annexes
***Annex A:** Logframe Findings*
***Annex B:** Findings from the Quantitative Survey*
***Annex C:** Terms of Reference*
***Annex D:** Documents Consulted*

Four **outputs** are specified:

Output 1	Improved negotiation of safe and voluntary sexual encounters by women and girls, 10-49 years.
Output 2	Increased capacity of institutions to recognise and deal with incidences of male-dominated, negative, cultural practices fuelling the spread of HIV and AIDS.
Output 3	Increased availability, access and usage of key preventive services (PMTCT, C&T and STI treatment) for men and women, provided by local stakeholders through improved capacity.
Output 4	Improved access and control/ownership of appropriate, safe and sustainable livelihood activities by women and girls, 10-49 years.

According to the TOR, the **main objective** of the evaluation is to establish "if the targeting was appropriate and verify whether the three-pronged approach was relevant, effective, efficient and sustainable". Specific impact related objectives are as follows:

Objective 1	Assess the impact of the programme by reviewing and verifying the data on logframe indicators as presented in the HIV M&E matrix (the data of the baseline/mid-term/end-line will be available in advance as well as the questionnaires of the baseline) and the quality of M&E systems.
Objective 2	For indicators which were difficult to measure, assess the impact of the programme using appropriate research methods.
Objective 3	Demonstrate where the programme has used best practices for maximum impact.
Objective 4	Reflect and comment on any previous reviews or evaluations that are related to the programme, and report on the degree to which recommendations have been responded to and implemented.

Evaluation questions were noted in the TOR as follows, consistent with the evaluation criteria normally applied by the European Union:

Relevance – Have the right things been done?

(a) To what extent did the programme address the problems cited by communities and stakeholders during the problem analysis phase as documented in the PLA reports?
(b) How was the targeting done and was it appropriate? How eere the poorest and most vulnerable included? How much have target groups and stakeholders participated in different programme interventions?
(c) Were the interventions consistent with Concern's policies and guidelines of Equality, Capacity building, Programme Participant Protection Policy and HIV policy?
(d) Did the programme support the Zimbabwe National AIDS Strategic Plan?
(e) Were there unexpected outcomes from the programme?

Effectiveness and Efficiency – Have things been done right?

(a) How effective was Concern approach in terms of staffing, use of partners and community volunteers?
(b) Were the methodologies used, especially Societies Tackling AIDS through Rights (STAR) appropriate and of sufficient quality to achieve impact? Were they appropriate for all age groups and for both men and women?

Impacts - What is the impact of the programme?

(a) What real difference has the programme made to beneficiaries? What is the level of change in terms of the three key areas of work: behaviour change, access to services, and increased income and control by women from activities.
(b) Where significant change has occurred, how much of it can be attributed to Concern's interventions? Fieldwork should include non programme areas for comparison.
(c) How many people has the programme affected? Disaggregate the numbers.

Sustainability - Are the results sustainable?

(a) Is there evidence that initiatives begun under the programme will last and spread without ongoing support from Concern?
(b) Are there comprehensive exit strategies in place? Are there additional measures that Concern should do to improve sustainability?
(c) Was there capacity building of partners and Concern?

How can things be done better in future?

(a) How can programme best practices be captured and spread to encourage replication? Is this programme positively affecting other Concern programmes in Zimbabwe?
(b) What new initiatives should be included in future programmes?
(c) Is a multi faceted programme approach the best HIV prevention strategy or what should Concern focus more on in future programmes?
(d) Given Zimbabwe's contextual changes regarding the HIV epidemic, improvements in the health sector, the growing economy, together with increasing donor need for short term results, what are the implications for the future of HIV programming in the operational areas in light of the evaluation findings?

1.2 Methods and Approach

The evaluation was conducted by Social Impact Assessment and Policy Analysis Corporation (Pty) Ltd., a Namibian consultancy firm with extensive evaluation experience and specific HIV&AIDS experience, and evaluation experience in Zimbabwe. Fieldwork was conducted by Concern personnel, with a quality control officer provided by SIAPAC. Technical support was provided for Phase 1, comprising field instrument development to measure indicators, and quality control support for field data collection and data entry/validation, and following completion of fieldwork, analysis and write-up of quantitative and qualitative findings. Phase 2 efforts focused on gap filling, developing a coherent evaluation report, and conducting final fieldwork as part of the evaluation.

During Phase 1 four tools were employed to collect information for the evaluation:

1. Quantitative Questionnaire – a highly-structured medium-length instrument administered to 1320 randomly-selected households in project areas and neighbouring locations (treatment and control locations, respectively)
2. National, District and Local Level Key Informant Interview Guide – administered at various levels to those familiar with the programme, including Concern personnel at each level, partner organisations, Government, non-party non-governmental organisations, traditional leaders, and others at community level
3. Focus Group Discussion Instrument – comprising target groups reached by the Programme, including People Living with HIV/AIDS (PLHIV) support groups, income generation groups, ward-based committees known as Ward Behavioural Change Communication committees, community leaders, peer educator groups, Action AIDS Clubs, and community facilitators and volunteers.
4. Audit Tool – comprising a detailed listing of each indicator and how it was measured, with gaps filled by senior Concern personnel most familiar with the Programme.

Fieldwork was conducted across treatment and control locations, with treatment locations comprising the Programme Area and control locations comprising neighbouring districts that were identified as 'most

similar' to the treatment locations. A series of statistical tests were conducted to assess the validity of the assumption of similarity across treatment and control groups, and the two groups were found comparable based on these demographic findings. Qualitative data collection took place at national level and within the Programme locations. Field implementation was carried out by the Concern team, with quality control support provided by an officer from SIAPAC; a Training and Field Report was issued upon completion of this technical assistance.

Data entry and validation of quantitative data, and text compilation of qualitative data, took place at Concern. Final data cleaning took place using the Statistical Package for the Social Sciences, and was conducted by SIAPAC. This comprised searching for out-of-range values, as well as sorting questions by main question – sub-question and checking to ensure that skip and go-to prompts were followed. A series of other checks were also conducted, and the dataset final cleaned.

The evaluation was divided into two phases. Phase 1 comprised primary data collection to establish indicator values, with indicators being clarified as part of Phase 1 as well. At the end of Phase 1, and Indicators Status Report was issued. Findings from this report have been included as Annex A, covering the indicator values, and Annex B, presenting quantitative findings, to this evaluation report. The inclusion of this detailed information in annexes to this report allowed the main evaluation report to focus specifically on the evaluation criteria of relevance, effectiveness, efficiency, impacts, and sustainability.

For primary data, this is presented across one full control group and one partial control group, with findings presented for Gokwe (Gokwe South and Gokwe North combined) separate from Nyanga District. The 'full control' group is from purposefully selected control locations proximate to the treatment locations, while the 'partial control' group comes from a 'levels of exposure' measure for those in treatment locations. Quantitative findings are therefore presented as follows:

Nyanga

- Treatment
    - Exposure to programme activities
    - Non-exposure to programme activities
- Control

Gokwe (north and south combined)

- Treatment
    - Exposure to programme activities
    - Non-exposure to programme activities

- Control

Qualitative information informed a number of the indicators, and the evaluation findings. This included findings from detailed focus group discussions, national, district and local level one-on-one interviews, and an 'audit tool' that was used to fill information gaps and solicit opinions from those most closely involved with implementation.

In addition, key secondary documents were also assembled, and data included as relevant, this report.

1.3 Background Information on Zimbabwe

Zimbabwe is 390,757km^2 in size with a population of approximately 11.4 million people (2009 data, see USAID, 2009[1]), located in south central Africa. Zimbabwe's history since independence in 1980 can be categorised into three distinct stages: 1980-1990; 1991-1996; and 1997-2009. The first period, the 1980s, was dominated by rapid gains made on numerous social indicators and improved economic equality. However, macroeconomic imbalances worsened, and as a result the 1990s saw the implementation of a structural adjustment programme that undermined the social gains made in the 1980s.

Dissatisfaction with the structural adjustment programme led to its abandonment by 1997, followed by the implosion of the economy from 1998. Between 1998 and 2009, Zimbabwe's Gross Domestic Product declined by 37%, the local currency lost all of its valued due to hyperinflation, unemployment skyrocketed as industries came to a standstill and on-farm employment in the commercial farming sector collapsed, and millions of Zimbabweans left the country largely due to economic or political reasons (see Bloch, 2008). Many of these out-migrants were among Zimbabwe's most skilled, contributing towards the rapid decline in service delivery, including in the health sector.

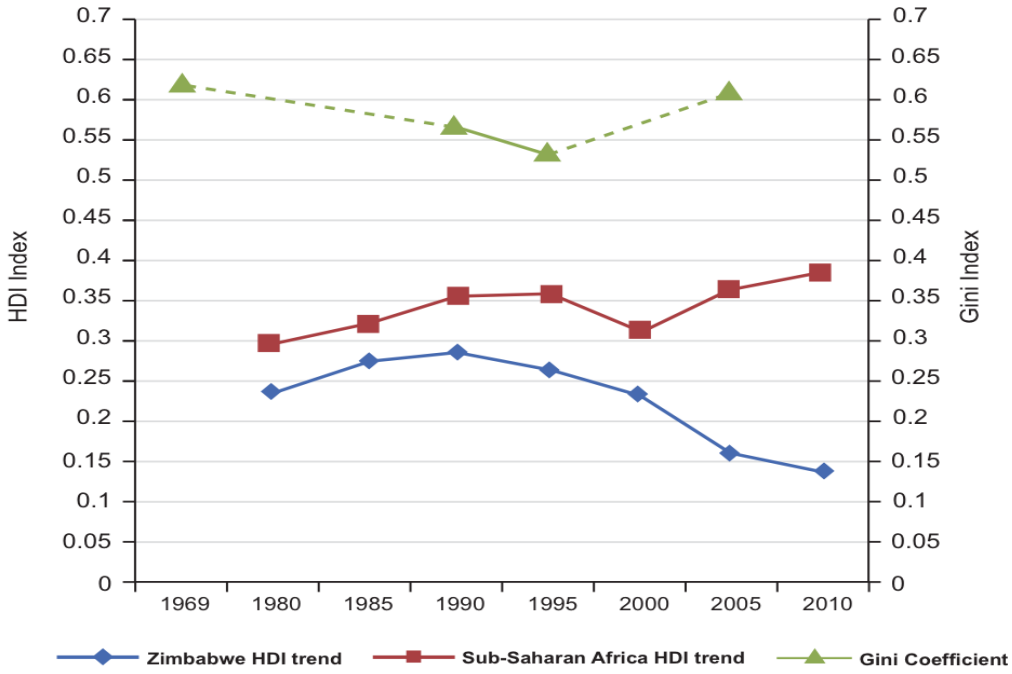
Map 3: Map of Zimbabwe Showing Its Position in Southern Africa

As of 2005, Zimbabwe ranked 151 out of 177 countries in the Human Development Index. The decline has coincided with a political standoff and politically-linked violence that has further undermined the recovery. This secular decline is captured by tracking trends in the Human Development Index for

[1] Population estimates given by various agencies yield dramatically different results, with estimates ranging from less than 11m to over 13m.

Zimbabwe (UNICEF, 2010), shown in the following figure. Extreme poverty remains high, at some 48% of the population. This figure would have been significantly higher had not significant numbers of Zimbabweans left the country and supported families in Zimbabwe through extensive remittances.

Figure 1: Trends in HDI and the Gini Coefficient of Income Inequality

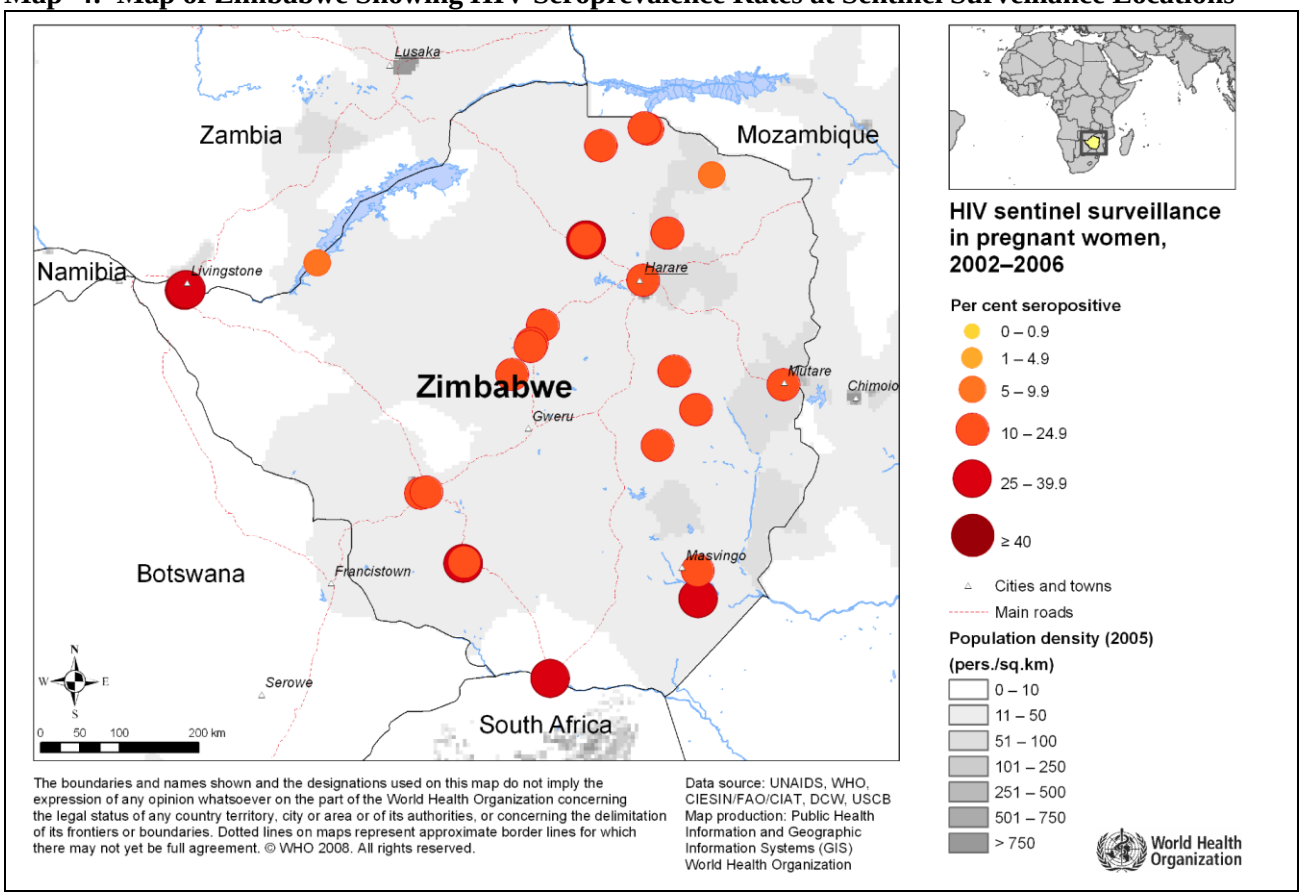


In 2009 Zimbabwe abandoned the Zimbabwean dollar, and now uses the US dollar and, to a lesser extent, the South African Rand. This helped to stabilise the economy, supported by an (albeit on-again off-again) political reconciliation following the signing of the Global Political Agreement in late 2008. In 2009, the economic grew by 5.7%, government's revenue situation also improved, and inflation is under control and estimated at 3.3% for 2010. Economic growth for 2010 is estimated at 8%, reflecting improved prices especially for gold and platinum and a rise in diamond exports. Economic policy is now guided by the Three Year Macro-Economic Policy and Budget Framework covering the period 2010-2012, and the Medium Term Plan covering the period 2010-2015. The former was intended to lay a sound macro-economic framework to stabilise the economy, while the latter was intended to set the groundwork for growth and development, and associated social development (UNICEF, 2010; see also UNDP, 2008).

1.4 HIV&AIDS In Zimbabwe

Zimbabwe has a generalised HIV epidemic largely driven through heterosexual sexual intercourse. Rates are similar across the country, however with higher rates in border areas, as shown in the following map:

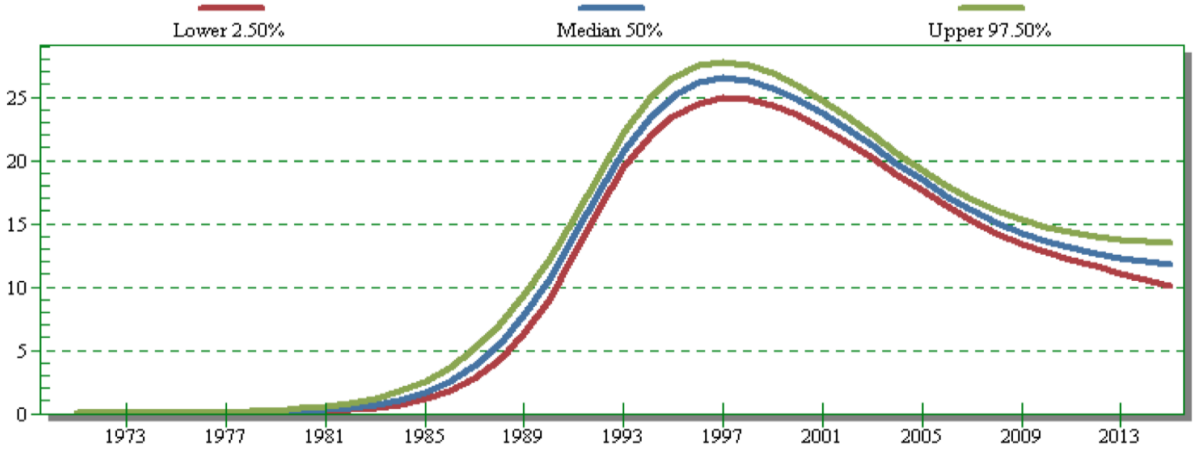
Map 4: Map of Zimbabwe Showing HIV Seroprevalence Rates at Sentinel Surveillance Locations



Source: WHO/UNAIDS/UNICEF, 2008, p. 9.

While still having one of the highest infection rates in the world, the HIV seroprevalence rate in Zimbabwe have declined steadily since it peaked in the mid-1990s. The rapid rise, and the eventual decline, are shown quite dramatically in the following figure (see UNGASS Report, NAC, 2010: 11):

Figure 2: Trends in Adult HIV Prevalence, Zimbabwe: 1907-2015



	1973	1977	1981	1985	1989	1993	1997	2001	2005	2009	2013
Lower 2.50%	0.00	0.02	0.18	1.11	6.24	19.42	24.96	22.57	17.59	13.38	11.09
Median 50%	0.01	0.05	0.29	1.62	7.69	20.70	26.48	23.71	18.43	14.26	12.31
Upper 97.50%	0.02	0.11	0.55	2.52	9.39	22.14	27.77	24.76	19.25	15.27	13.69

Adult (aged 15 and older) prevalence peaked in 1997, at 26.5%. The rate declined to 18.1% by 2006 for the same age group, and continued its decline to an estimated 14.3% for 2010. The decline was especially dramatic for women, although infection rates for younger women remained at twice the rate for males in the same age group (15-24) (2009 data). As of late 2009, an estimated 1.2 million Zimbabweans were living with HIV.

The decline is attributed to behavioural change, confirmed via a number of sexual behaviour survey results, mortality (the deaths of those who were HIV positive), and enhanced treatment (reducing the rate at which those living with HIV can infect others). A reduction in the number of casual sexual partners and increased condom use among those with multiple partners were noted as especially important (see Gregson et. al, 2010).

During implementation, the Concern Programme Zimbabwe's HIV&AIDS response was guided by the Zimbabwe National HIV and AIDS Strategic Plan (2006-2010) (NAC, 2006), which was itself guided by the 1999 National HIV and AIDS Policy. The Strategic Plan reflected high level political commitment to the HIV&AIDS response, and the expected heightened level of non-state actor involvement in the implementation of planned activities. The Strategic Plan also underlined the importance of strengthening the evidence-based response for programme design, and highlighted the lack of attention to this in the past (section 3.7).

The Strategic Plan highlighted four main strategies intended to support the overall **goal** of reducing "the spread of HIV, improve the quality of life of those infected and affected, and mitigate the socio-economic impact of the epidemic in Zimbabwe" (NAC, 2006: 16):

- "HIV prevention to reduce [the] number of new infections, with a focus on behavioural change promotion;
- Increase access and utilisation of treatment and care services;
- Improved support for individuals, families and communities, including orphans and other vulnerable children infected and affected by HIV and AIDS;
- Effective management and coordination of the national HIV and AIDS response (including resource mobilization)."

Targets were thereafter included comprising a drop in HIV seroprevalence for 15-24 year olds from 17% to 'single digits'[2], coverage of 75% of those with opportunistic infections and anti-retroviral therapy (ART), an increase in the percentage of persons tested and counselled rising from 15% to 75% for 15-49 year olds, and coverage of at least 50% of OVC and affected households with a basic package of support services.

A particular focus of the Strategic Plan was the prevention of new infections. The focus was on behavioural change in this regard, including consistent condom use among those who do not abstain, faithfulness in relationships, a supportive environment that encourages safer sexual practices, and a specific emphasis on women's empowerment in sexual relationships and a reduction in levels of gender-based violence. Also mentioned as supporting prevention were male circumcision, and expanded PMTCT and counselling and testing services. Shifting to treatment and care, severe constraints were noted in terms of health service provision and affordability of services by the population as well as Government, and constraints in supply and distribution unreliability. The needed rapid expansion in services to reach those in need under such difficult circumstances required a particular focus on partnerships and support for home-based care. Partnerships would be particularly strengthened through the strengthening of umbrella organisations and encouraging non-state actors to work together.

Priority research arenas included multiple concurrent partnerships, consistency of condom use, the impact of ART roll-out on sexual behaviours, the sexual practices of persons living with HIV (PLHIV), the acceptability and feasibility of large-scale male circumcision, risks for most at risk groups, and PMTCT.

Operationally, a country review conducted in 2008 (International Treatment Preparedness Coalition, 2008) highlighted the overwhelming problems facing health care infrastructure in Zimbabwe quite specifically, and the Zimbabwean economy's collapse on the other, which undermined the ability of Zimbabwe to meet Strategic Plan objectives. They noted sub-par budget allocations by Government, a disconnect between targets and resource planning, the need to incorporate HIV counselling and testing as part of routine health services as well as specifically with tuberculosis and sexually transmitted diseases prevention and treatment services, and development partner commitment to health services more generally and not just HIV. Adding to the problems, the Global Fund shifted from the NAC to UNDP to handle its funds in 2009 as the Central Bank diverted $7.3m in funds in 2008. Encouragingly, the health sector appears to be recovering quickly following the dollarization of the economy in 2009, and staff retention appears to be extremely high. However, this recovery is taking place in the context of unresolved political issues that have important

[2] This particular target is difficult to establish, as figures for HIV seroprevalence just one year after the 2006 Strategic Plan was published showed a seroprevalence rate of 7.7% for females and 2.9% for males, with even the high estimate at 11.7% for females and 4.4% for males. This is even more problematic when looking at 2005 figures showing that, for 15-24 year olds at htat time, the rate was 4.2% for males and 11% for females. It is unclear how the 17% estimate was arrived at. See WHO/UNAIDS/UNICEF, 2008.

impacts on the economy and social development. This means that the operating environment for businesses and non-governmental organisations remains uncertain.

2 Programme Overview

2.1 Background

Concern Worldwide began operations in Zimbabwe in 2002, after the economic collapse had begun. In the early years it focused on emergency feeding, working in collaboration with the World Food Programme (WFP). Concern thereafter expanded its operations in Zimbabwe by adding a food security programme. Growing recognition of the impacts of HIV&AIDS on food security led to the design, in 2006, of a multi-year HIV&AIDS initiative in three districts where Concern had a previous presence: Gokwe North, Gokwe South, and Nyanga. These three districts are shown in the following map:

The Project Area is comprised of 17 Wards across these three districts, as shown in the following table:

Table 1: List of Project Area Wards by District

District	Wards
Nyanga	Ward 1: Marowo Ward 2: Shungu Ward 3: Muntamwe Ward 5: Nyamasara Ward 6: Nyamahumba
Gokwe South	Ward 14: Njelele 3 Ward 25: Chisina 3 Ward 7: Huchu Ward 8: Masuka Ward 6: Sai 2 Ward 26: Mkoka
Gokwe North	Ward 10: Goredema Ward 6: Mashame Ward 8: Chireya 2 Ward 3: Madzivazvido 1 Ward 1: Simchembu 1 Ward 29: Nenyunga A
Total	17 wards

The specific wards were selected because, based on Concern's previous experience in the area, these were the poorest and least food secure locations in the three districts. The design of the Programme was preceded by a Participatory Learning and Action (PLA) exercise that involved household members, opinion leaders, and officials throughout the Programme area. The PLA found a weak response to HIV&AIDS on the ground, with severely limited Government involvement in co-ordination of the response and limited STI/PMTCT/VCT outreach confined to populations close to the district centre in Gokwe South and not even that in Gokwe North, NGO involvement in some wards in Gokwe North and Gokwe South districts, but not in any where Concern had been active and proposed Project implementation. For Nyanga, a number of

NGOs were found to be active in the HIV&AIDS arena, along with a number of mission hospitals with the capacity to provide STI/PMTCT/VCT services. The summary findings from the PLA fieldwork, included in the financing proposal, was as follows (Concern, 2006: 15):

> The PLA field assessments in all three districts painted a gloomy picture on gender inequalities at the grassroots, with little evidence to "redress harm". The negative attitudes and cultural practices that increase women and girls' vulnerability to HIV go on unchallenged due to a number of reasons. Firstly, there is little presence of civil society on the ground or at the grassroots to advocate for women and girls. Secondly, sound government policies have rarely been implemented. Thirdly the victims, women and girls, as well as the community at large, are powerless. Limited livelihood options push many women in particular to adopt risky coping behaviours in order to feed, clothe and school their dependents.
>
> While there have been some formal interventions through the schools HIV programme focusing on children, these are limited to those still attending school. And in circumstances where cases of rape or sexual abuse by school teachers and other community members were reported but nothing was done, the effectiveness of such interventions remains questionable.

The PLA exercise also helped identify local partners to support implementation, including FACT and ASAP for the economic empowerment component as well as mission hospitals to support health treatment aspects of the Programme.

Gokwe South District is located in the Midlands Province, south west of Harare, the capital. Gokwe South is divided into 30 wards, and has an estimated population of 293,620, although these data are quite old (2002 data). The District is subject to erratic rainfall patterns and periodic drought. Cotton is the District's predominant cash crop, followed by some distance by livestock tending (Concern, 2006). In Gokwe, seasonal agricultural work in the cotton sector is felt to be an important driver of the epidemic in the broader Programme area. Transactional and commercial sex work is noted to be common at this time, and has not felt to have changed over time, according to key informants. Gender relations overall remain highly unequal, and are felt to contribute significantly to new infections (key informant interview findings).

Gokwe North District is located in the Midlands Province, to the north of Gokwe South District. The population is estimated at 214,359, although these data are quite old (2002 data). The District is divided into thirty wards. Unlike Gokwe South, which is relatively well connected to other locations via good infrastructure, Gokwe North District is remote and, particularly during the rainy season, is sometimes inaccessible (Concern, 2006).

Nyanga District is located in Manicaland Province. It is divided into thirty-one wards, with an estimated population of 119,370 (2002 data). It is an ecologically diverse district spread across plains to highland areas. The Concern Project area, near the Mozambican border, is remote with less predictable rainfall patterns and, as a result, more diversified livelihoods. Activities include horticulture, tea plantations, forestry plantations, timber processing, irrigated agriculture, gold panning and cross-border trade (Concern, 2006).

2.2 Purpose, Outputs, Objective

As noted in Chapter 1, the **purpose** of the Programme is "To improve the behavioural practices related to the prevention of HIV and AIDS among women and girls, men and boys through increased awareness of sexual and equality rights by holders and duty bearers".

Four **outputs** are specified:

Output 1	Improved negotiation of safe and voluntary sexual encounters by women and girls, 10-49 years.
Output 2	Increased capacity of institutions to recognise and deal with incidences of male-dominated, negative, cultural practices fuelling the spread of HIV and AIDS.
Output 3	Increased availability, access and usage of key preventive services (PMTCT, C&T and STI treatment) for men and women, provided by local stakeholders through improved capacity.
Output 4	Improved access and control/ownership of appropriate, safe and sustainable livelihood activities by women and girls, 10-49 years.

Programme components are summarised as follows, by output:

Output 1.1: Improved behavioural practices related to HIV&AIDS among women and girls, men and boys in targeted wards

- Community training to enhance behavioural change – community-based and peer group approach using a modification of the Stepping Stones methodology known as Society Tackling AIDS through Rights (STAR).
- Life skills and AIDS education programmes in schools – HIV&AIDS schools-based interventions at 67 schools focused on anti-AIDS clubs, school competitions, teacher training and onward training.
- Peer education for out-of-school youth – school-based peer educations to conduct peer group sessions with out-of-school youth. Would also include annual sports competitions, music events, drama, dance, etc.
- Condom promotion – including condom distribution and messaging around safer sex.
- HIV&AIDS 'hot spot' campaign – Focus on gold panning areas in Gokwe South (Mkoka area) and Nyanga (wards 3 and 6).

Output 1.2: Decreased incidence of male-dominated, negative, cultural practices fuelling the spread of HIV&AIDS

- Behavioural change communication (BCC) – Focused on addressing the underlying causes of the AIDS epidemic, including gender equity, widow inheritance, gender-based violence, and child sex abuse. The activity operates through community facilitators, working with faith/traditional healers, church leaders, child protection committees and traditional courts.
- Legal- and rights-based capacity building – Training of officials and opinion leaders on the issues raised under BCC.

Output 2.1: Increased availability, access and usage of key preventive services such as PMTCT, VCT/PITC (Provider Initiated Treatment and Counselling), and STI treatment for both men and women, implemented by stakeholders through improved capacity

- VCT/PITC services - Collaboration with Population Services International (PSI) and Population Services Zimbabwe to support condom distribution services in the twelve wards of Gokwe North and Gokwe South where Concern operates. In Gokwe, Concern partnered with mission hospitals in the two Gokwe districts. In Nyanga, Concern partnered with two mission hospitals to provide VCT/PITC outreach services in five wards. Concern also partnered with an NGO, Btsirai, to offer mobile VCT services.
- PMTCT services – Collaboration with five mission hospitals, two in Nyanga covering five wards, one in Gokwe South covering one ward (Kana Mission Hospital), and two in Gokwe North covering three wards (Chireya and Mutora mission hospitals).
- STI management services – Training of mission hospitals by Ministry of Health personnel, and public awareness campaigns and outreach by mission hospital staff and Concern personnel.

Output 3.1: Improved access and control/ownership of appropriate, safe and sustainable livelihood activities by women and girls aged 10-49

- Support to income generation activities (IGA) – Targets vulnerable women and girls who are engaged in, or at risk of engaging in, risky behaviours.

The summary of direct and indirect beneficiaries (Concern, 2006: 26) is included in the following table, provided following Programme completion:

Table 2: Beneficiaries by Activity (indirect beneficiaries are estimates)

Activities	Direct Beneficiaries			Indirect Beneficiaries
	Girls/Women	Boys/Men	Total	
Training to enhance behaviour change (STAR circles)	5340	2008	7348	44088
Life skills and AIDS education programmes in schools	1924	1036	2960	35520
Peer education for out-of-school youth	2304	1536	3840	23040
Social marketing of condoms	488	488	976	9760
Community training to address negative cultural practices	3600	3600	7200	na
Legal and rights-based capacity building	1658	1657	3315	82875
Counselling and testing (HIV)	15170	5851	21021	21021
PMTCT services	3116	na	3116	6232
STI management services	636	557	1193	na
Training of beneficiaries in income generating activities (IGAs)	2986	na	2986	17916
TOTAL	37222	16733	53855	240452
Proportion of males/females in direct	69.1%	30.9%	100%	
Proportion of direct to indirect			22.4%	77.6%

* According to Concern, direct beneficiaries (10-49 sexually active age group) are defined as those who are principally targeted for the intervention. For example, STAR circle members or AIDS Action Committee students who attend the discussions. Indirect beneficiaries refer to those who receive information form the principal recipients, for example STAR circle attendees after their circle sessions they discussed with members of their families or communities what transpired. Given the average household size in Zimbabwe,

The Programme reached almost 300,000 persons directly and indirectly, of which just over one-fifth were direct beneficiaries. Almost 55,000 were directly reached, of which some 70% were women/girls. Total estimates of direct and indirect beneficiaries were not available from the proposal, as VCT, PMTCT and STI estimates were not available. For the remaining interventions, targets totalled around 60,000, just over the actual levels reached. Indirect beneficiaries were only established for HIV prevention and traditional social

norms, with totals estimated at 160,000 indirectly reached, well below the numbers indicated in the previous table.

Direct implementation partners were also noted in the proposal (Concern, 2006: 27):

Table 3: Direct Implementing Partners

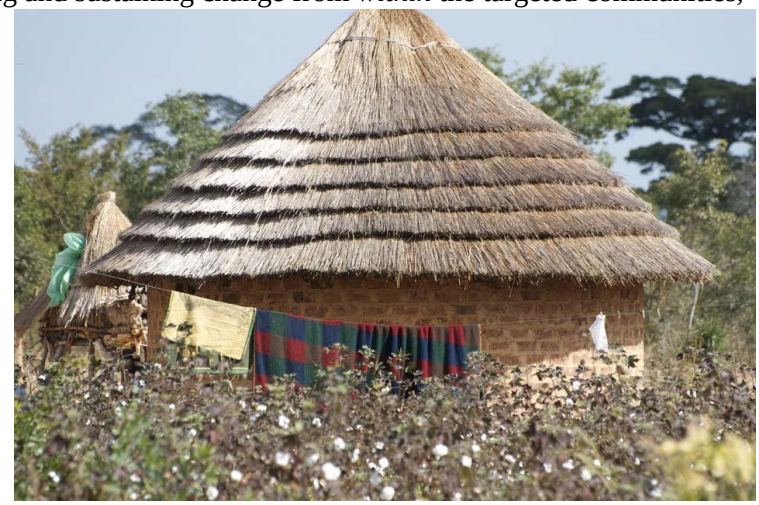
	District		
Objective	**Nyanga**	**Gokwe South**	**Gokwe North**
1. a) To improve successful negotiation of safe and voluntary sexual encounters by women and girls, 10 - 49 years b) To decrease incidence of male-dominated, negative, cultural practices fuelling the spread of HIV&AIDS	FACT	N/A (Concern)	N/A (Concern)
2. To increase rural communities' access to and uptake of VCT, PMTCT and STI management services, in a stigma-reduced environment, through strengthening strategic links and building the capacity of at least two existing / potential service providers in each district	Avila Mission Hospital Elim Mission Hospital	Kana Mission Hospital Bastsirai (VCT)	Chireya Mission Hospital Mutora Mission Hospital
3. To reduce the negative impact of HIV & AIDS on women and girls of age 10 - 49 through improved, increased, safe and appropriate livelihood activities.	ASAP	N/A (implemented by Concern)	N/A (implemented by Concern)

Programme impact sustainability was included as follows in the proposal (Concern, 2006: 30):

> "Broadly, the implementation methodology involves working with existing and emerging community groups which will remain in the community all the time.
>
> Through 'twinning' or the formation of clusters (for example, clusters of income generating groups or post test clubs / peer support groups), Concern will mobilize and strengthen grassroots efforts in a sustainable manner and create relationships that will last beyond the current project[3]. Clusters will be formed voluntarily and informally, with sustainable partnership between two or more clusters within the same ward which share the same activities. Through exchange visits and joint training, ongoing communication, information sharing and support amongst themselves will be encouraged.
>
> Village or ward level committees, along the lines of child protection committees, may be formed around HIV&AIDS prevention, care and support, and it will be important for Concern to foster these as instruments of programme outcome sustainability.

[3] According to USAID (www.twinningagainstaids.org) twinning is a voluntary, formal, sustainable partnership between two or more similar organizations that provides human and organizational capacity development in HIV prevention, care, and treatment through exchange visits, training, and ongoing communications and information support.

For objective one, proven and effective participatory methodologies such as Stepping Stones and REFLECT, are aimed at stimulating and sustaining change from *within* the targeted communities, with particular emphasis on empowering marginalized groups such as women and the illiterate.



Objective two focuses on local structures, working in collaboration with Rural Development Councils, District AIDS Action Committees, Ward AIDS Action Committees, as well as building the capacity of local service providers. Promoting sustainability and institutional development of local actors and service providers will be key, to build potential for fund raising and sound project design and management, and to better enable these actors to access funds and manage projects independently.

The promotion of safe and appropriate income generating activities under objective three has a dual role. Firstly, in the long run IGAs are aimed at mitigating the impact of the epidemic on vulnerable women, girls and infected/affected households. Secondly, households targeted will be trained in the management of IGAs. The knowledge, skills and self-confidence acquired through the entire duration of the programme will enable beneficiaries to manage other projects with or for their families or community after completion of the intervention."

The 'exit strategy' was noted in the proposal as follows (Concern, 2006: 31):

"Upon a) the achievement of significant progress against the programme's major outcome indicators, which will be measured through a baseline follow-up survey, and b) demonstrated capacity for continuing support for the interventions and services established under the programme by implementing partners, Concern will fully hand over the various programme elements to such strategic partners. These may include but may not be limited to: village/ward clinics; schools; churches; traditional courts; the Zimbabwe Traditional Healers Association; FACT; mission hospitals; district authorities.

It is envisaged that there will be a second phase of this programme beyond the 3 year initial timeframe. Such continuation will depend on progress towards stated objectives necessitating an additional timeframe, or expansion of the initiative to other areas."

It should be noted that the exit strategy was in part mixed into some of the comments on sustainability. For this reason, some aspects of sustainability are also considered below in discussing the exit strategy.

3 Assessment of Impacts, Relevance, Effectiveness, Efficiency and Sustainability of the Initiative

3.1 Background and Overview

In this chapter, the Programme is considered in terms of relevance, effectiveness, efficiency and sustainability, taking into consideration impacts as noted in Section 3. 'Best practices' are also considered in Section 5.

3.1.1 Context

At the outset it is important to note that implementation of the HIV&AIDS Programme took place at perhaps the most difficult time in Zimbabwe's recent history. The collapse of the local currency through hyperinflation, with 2007/8 the height of economic difficulties, overlapped the Programme start-up phase, and confidence in the economy and economic opportunities were at an all time low. This coincided with severe fuel shortages, food shortages, and human resource shortfalls, while political factors associated with a pending election also made operations difficult. This is mentioned at the outset as this effectively shortened the implementation period for the Programme to 3.5 years.

While there are a number of challenges still facing operations in Zimbabwe, it is difficult to compare the situation today with the situation facing the country in 2007/8. Direct implementation was halted, with Concern unable to operate in the field in a direct capacity, fuel and spare parts were in extremely short supply meaning that partners were constrained in their ability to operate, and hyperinflation and dramatic input shortages made it very difficult to support livelihoods improvement. VCT services were extremely limited and, even if available, could not be linked to PMTCT and ARV outreach because of shortages in medical personnel and the availability of drugs. One key informant in Gokwe South summarised the situation succinctly. When asked about the Programme's duration in light of the situation in the country at the time, he noted that 'again, it [the Programme timeline] is too prompt [short], the hardships could have affected the programme at organisational level and community level. At the organisation level, it faced human and financial constraints that affect the actual execution of the programme activities. At community level people were facing a difficult time financially and physically, they were insecure so you find that if people are in a difficult time they will be concerned with looking for food and handouts and

anything that will ensure that they will survive. They will be preoccupied with trying to find food and money basically people were not really involved in HIV programmes … [the] NGO stoppage created a gap in terms of information that people got from STAR circles that all of a sudden then stopped'.

With the abandonment of the Zimbabwean dollar in 2009 and the signing of the political accords, the situation in Zimbabwe has changed for the better. While tensions remain (and indeed may worsen), the economy continues to grow, access to goods and services are nowhere near as severe as in the recent past, and the health and education sectors are stronger now than they were just a few years ago. It is nevertheless difficult to establish how well the national recovery has extended to the Programme area. The Programme area was selected due to high levels of poverty, poverty which existed before the economic collapse, and which worsened during the worst years. There are no trend data available to establish whether these areas are recovering along with the national economy. The impacts of the economic collapse on population movement out of the Programme area are also uncertain, so the loss of productive adults is also unknown (census data are almost ten years old). What is certain is that livelihood challenges remain severe, and services remain strained and underfinanced, including in terms of expenditures on HIV&AIDS.

The encouraging news is that the downward trends in HIV seroprevalence continued even during the worst years. Various studies, referred to earlier in this report, attributed these trends to positive behavioural change associated with the number of concurrent sexual partners, HIV testing, and the use of ARVs, along with high mortality rates in the mid-1990s of those who were HIV positive. The survey conducted as part of the impact assessment suggests that these behavioural changes noted nationwide are consistent with what is going on in the Programme area. Nevertheless, the HIV response infrastructure remains fragile, with a dearth of actors involved in the response particularly in the two Gokwe districts. Local partners remain weak, despite best efforts to enhance implementation capacity, holding for both the two Gokwe districts as well as Nyanga.

In key informant interviews at the national level and in the Programme districts, respondents noted a shortage of actors supporting the HIV response, and the lack of financing offered by Government. Field findings suggest that, at this juncture, partnerships with NGOs are welcome, particularly if they work with local actors and build local capacity as part of implementation. The same problem stated above, where alignment with the national Plan was felt to be straightforward because the Plan included a broad range of priorities, would likely remain a problem, and it is likely that state capacity to better manage partnerships in this regard will remain in the Programme area. Levels of external support to Zimbabwe's HIV&AIDS response continues to grow, and the number of actors involved continue to diversify. There are an increased number of actions dealing with issues such as ARV provision and support for drug compliance, supplementary feeding support for HIV positive persons, PMTCT testing services and drug support, and other public health aspects of an HIV response, but for the interim these will remain insufficient and are expected to remain insufficient for the foreseeable future. In terms of behavioural change, there is only one

major new initiative underway in the two Gokwe districts, implemented by the Midlands AIDS Support Organisation (MASO), and it appears to be focused on expanding knowledge, which may not be the main problem in the area. With regard to HIV and livelihoods, no major initiatives appear to be in place in the two Gokwe districts, while in Nyanga it is reported that Concern's partner is continuing work in the HIV and livelihoods arena, but its scale remains small. The Programme area will, in short, lose some external support following completion of the Programme that may not be covered in the next few years by other actors, particularly in Gokwe.

3.2 Impacts

In this section Programme impacts are considered. The findings in this section are based on the following information sources:

- Quantitative survey of 1320 households across the three districts, including treatment and control wards.
- Focus group discussions across the three districts.
- Key informant interviews at national, district, ward and local levels.
- Secondary materials review, including Programme materials.

Detailed findings are included in Annex A. Readers who are interested in the detailed findings should review this annex, if possible before considering the summary findings noted below.

3.3 Approach and Limitations

The Programme logframe had a number of limitations that required that, for the evaluation, an *evaluation logframe* be developed. This allowed a specific focus on outcomes, drawn from various sections of the logframe, and clarification of outcome indicators associated with these intended outcomes. This Evaluation Logframe is included as Annex B to this report. It should be noted that values are not attached to the indicators (e.g., knowledge moved from *x* to *y*), as this was not usually established in the Programme Logframe. Instead, values are given for treatment and control locations to establish differences between locations reached and locations not reached.

Given the difficulties in establishing a proper control group, a second measure was made comparing 'high exposure' and 'low/no exposure' populations in the treatment locations. High exposure was classified as being reached by three or more direct or indirect interventions. A separate measure was used to assess differences across key variables for those reached by STAR or by peer educators directly. Both measures are discussed in Annex A, and presented in the tables in Annex C. As STAR exposure in control locations occurred at a very low level (as the control and treatment wards bordered each other, some 'spill over' was expected, but proved to be minor), but peer education did occur, these same measures were considered in the control location as well.

Annex C also includes presentation of data from secondary sources, such as the demographic and health survey (DHS, 2005/6). At the time of the evaluation the full report from the 2010/11 DHS were not available, and therefore cannot be included herein. Secondary sources also included the two baseline surveys conducted by Concern in the Programme area. The data are not statistically comparable with the end-of-programme evaluation survey due to the sampling approach employed for the baseline, and due to the issues covered in the endline versus the baseline survey.

3.3.1 Findings

Findings from the quantitative survey, qualitative fieldwork (focus group discussions, key informant interviews), and field visits and team consultations by the Consultant, suggest that there have been a number of positive Programme impacts. Key impacts are as follows:

- Available evidence suggests that knowledge and attitudes have improved, largely due to direct exposure to peer education interventions of any type, with little impact due to overall reach with HIV information, even with exposure to multiple sources. Direct contact appears to make a difference.
    - However, for all groups important knowledge gaps remain around the depth of understanding of HIV, confusion about condoms, and means of transmission. And while many attitudes around HIV&AIDS were quite positive, there were particular concerns about attitudes about gender-based violence.
- While there was some evidence that some aspects of practices have changed, in most cases impacts on practices were limited. In large part this is due to overly high expectations about behavioural change, rather than a measurement focus on responsive indicators of the potential for behavioural change, in particular related to attitudes.
- In Gokwe the VCT activities have had an important impact on HIV testing reach particularly for females, and has helped the mission hospitals to extend outreach and help meet demand. In part this appears to be due to having good local partners, although considerable capacity enhancement was required. In Nyanga, it appears that testing services were more readily available, and in this respect the additive impacts of testing service availability is less clear. There were similar findings for PMTCT.
- The livelihoods support intervention did not work as well as it could have in Gokwe, but did have success with those reached in Nyanga. In part this appears to have been due to the presence of a solid local partner organisation in Nyanga. Impacts on risk reduction associated with transactional sex work is not clear, and probably not very strong, but the HIV activities themselves appear to have resulted in important changes in knowledge and attitudes that may well reduce risk behaviours, especially if livelihood options are available.
- In discussions with team members on the final stage of the evaluation, and based on comments from key informants and focus group discussions, it is evident that an important unintended impact of the Programme was the strengthening of social capital networks. This is doubly important given that a number of the Programme areas are partially comprised of resettled populations, and given the settlement and economic disruptions associated with Zimbabwe's economic decline and policy decisions.

3.4 Relevance

As per the TOR, relevance asks 'have the right things been done?'. Sub-questions under relevance are as follows:

(a) To what extent did the programme address the problems cited by communities and stakeholders during the problem analysis phase as documented in the PLA reports?
(b) How was the targeting done and was it appropriate? How were the poorest and most vulnerable included?
(c) How much have target groups and stakeholders participated in different programme interventions?
(d) Were the interventions consistent with Concern's policies and guidelines of Equality, Capacity building, Programme Participant Protection Policy and HIV policy?
(e) Did the programme support the Zimbabwe National AIDS Strategic Plan?
(f) Were there unexpected outcomes from the programme?

It should be noted at the outset that the discussion here under Relevance does *not* mean that the approach or activities were necessarily effective or had the desired impacts. This is rather discussed at the end of this section, when the various aspects of Programme evaluation are discussed together.

3.4.1 Findings

Overall findings suggest that the various Programme activities were relevant for the lives of those reached by the Programme. Programme activities were 'felt needs' expressed in discussions with Programme area residents during the PLA exercises (albeit constrained by PLA conclusions that focused on gaps that the Programme could deliver). This was confirmed by a number of key informants as well as focus group discussion participants. Yet while the Programme itself was broadly relevant to the needs of the Programme area population, and while it was well linked to the PLA exercise, some problems arose about the *practicality* of achieving Programme objectives, and the packaging of the response. Questions also arise about the relevance of implementation *approaches* and some aspects of the Programme's focus. The strengths and challenges arising in this regard are elaborated below.

3.4.1.1 Consultation and Relevance

The Programme's activities appear to have responded effectively to the priorities elaborated in the PLA reports, derived from a broad range of consultations including institutional mapping, stakeholder analysis, gender analysis, group discussions, and other consultations. There have also been lessons learned from the baseline surveys that were considered by the teams during implementation. A number of key informants suggested that, without the PLA exercise, the Programme would not have been such a good match. These same key informants at district and sub-district level noted their direct engagement in the PLA activities, and their satisfaction with doing so. Gender-based violence, the need for behavioural change to reduce risk, and socio-cultural practices that could impact on risk took on an importance in the programme arising from the

consultations. Consultations also led to a focus on strengthening the local response, both in communities and in schools.

In discussions with the Gokwe field officers, some of whom had been with the Programme from the start, it was evident that the officers were generally aware of the results of the PLA, as well as the baseline surveys, and that they had taken these findings 'on board' in their work. The team seemed to have a good understanding of how communities and households 'worked' in their areas.

Having said this, one concern that arose was that, precisely because the PLA led to a better understanding of the many and serious needs of people in the Programme area, the problems that Concern tried to tackle were rather intractable (from behavioural change to reducing transactional sex). This led Concern to be overly-ambitious in what it could accomplish, especially under such difficult circumstances and with limited partnership opportunities. Had the PLA exercise focused more attention on what was possible to achieve within the constraints facing the Programme (the implementation environment, with few actors on the ground at that time), this might have helped. In this respect, Concern was responsive to expressed needs, and these were relevant to the problems facing community members, but in some aspects this appears to have been unrealistic.

3.4.1.2 Targeting and Relevance

Targeting took place at one level in terms of the districts selected for Programme focus. The districts were initially targeted for this Programme by Concern because of their previous experience in the areas in supporting emergency food distribution from 2002, and because Concern was implementing a Food Security and Livelihoods Recovery Programme in these districts from 2005. For HIV&AIDS, the districts were much the same as most other rural districts in Zimbabwe (excluding border areas) in terms of seroprevalence, as well as in terms of a constrained response especially during the most difficult years around 2007/8. And they were clearly areas in need of support, with few actors involved in the HIV&AIDS response, particularly in the two Gokwe districts. Within the districts, ward identification followed a similar logic as at the district level, with an existing Concern presence on the ground. These wards were selected by the livelihoods programme to reflect a focus on what were perceived to be the poorest parts of the districts, based on knowledge of the areas from the food distribution programme. In this respect, targeting of especially poor areas would hold for the HIV Programme as well, assuming that the original assumptions were valid.

Within the wards themselves, some Programme components yielded varied targeting decisions. In some cases these arose from practical matters, such as where partner organisations could be found (the partner NGO in Nyanga, the partner hospitals in Gokwe), where outreach was possible, and where building the public health component was possible (e.g., where it was possible to either link people to existing PMTCT, VCT, and STI services, or where these could be provided). In other cases the problems were widespread,

and likely affected households and individuals in wards reached and unreached by the Programme (e.g., risk profile, gender relations, negative coping, and service needs).

While Concern's mandate is to work with the very poor, in a situation such as rural Zimbabwe over the past few years, it is difficult to know whether additional targeting based on socio-economic status would have been the best use of available resources. The Programme targeted women and girls who were felt to be at particular risk of engaging in negative coping strategies, given that risk was present both inside and outside marriage (the former of which eventually became a key concern of the Programme), and considering the particular economic limitations facing women, such targeting would reach those who would seem to need particular attention. Further, persons affected by HIV were also included in community-based activities.

The behavioural change interventions (school-based youth who were old enough to be sexually active, out-of-school youth, STAR groups) were also focused on groups that did indeed face risks associated with HIV infection. However, the same can be said about most members of society. While relevant to these groups, this could also have been said about many other groups. There were also patterns of particular vulnerability that might have been given additional attention, including migrant workers and women in in-migration populations in cotton production areas and transit points, but as a targeting criteria it is not clear whether this would have worked with what was essentially a community-based programme, even with the Hot Spot campaign. In light of these other considerations, and given the overwhelming nature of the problems in the Programme areas, groups reached by the Programme are likely to have included many of those in need.

3.4.1.3 Unexpected Outcomes

For those directly reached by the STAR intervention, one very positive unintended consequence of the intervention was the strengthening of social capital networks. In field discussions and in the focus group discussions, STAR group members and income group members reported strong bonds that did not exist beforehand. Given the many economic and social challenges communities face in rural Zimbabwe, this is a major accomplishment, and likely has important impacts in livelihoods protection and social support for the long term. Unfortunately this was not tracked, nor was it measured, so the actual impacts are uncertain but were likely to be significant, albeit limited to those directly reached over fairly long periods of time.

While partner capacity enhancement was an anticipated impact, one possibly unexpected outcome was a commitment to outreach among at least some of the partner hospitals. It is uncertain whether this commitment will continue in the face of the end of funding support, but even then this would suggest that the organisations would have both the skills of relevance to a more integrated outreach approach and the intention to do more in the future if the opportunity arises.

3.4.1.4 Relevance to the National Response

The Programme was designed to align with the HIV&AIDS Policy, which is quite broad in content, as well as the 2006-2010 Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) (NAC, 2006). The Plan included four strategic aims: 1) prevention, focused on the reduction in the number of new infections with an emphasis on behavioural change; 2) increased access and utilisation of care and treatment services; 3) improved support for those affected by and living with HIV; and 4) effective management and co-ordination of the national response. In reviewing the activities and intentions under each of these, an alignment is clear between the Concern Programme and the National Plan. This holds with specific regard to behavioural change approaches, stigma reduction, PMTCT, ARV access, and livelihoods enhancement. In part this is due to the inclusiveness of the Plan, but also because the Plan correctly noted key areas of deficiency in the national response. Having said this, with a confused and vague logframe and resultant difficulties in monitoring, it is perhaps not surprising that the Programme could not contribute well towards the monitoring of activities to contribute to the national M&E framework's monitoring of progress nationwide.

3.4.1.5 Programme Engagement and Relevance

One clear advantage of Concern's community-based approach is the ability to engage community members and leaders throughout the implementation process. This is distinct from the more common approach across a number of agencies where consultations were common at start-up, but fell away as programme implementation proceeded. In this particular Programme, there was also a second advantage: Concern was already known in the Programme area, and was offering livelihoods support in the same areas as the HIV Programme was being implemented. Both of these yielded a higher profile for Concern in Programme area communities and among local leaders in this regard.

Programme documentation included a discussion of problems encountered, in the early years of implementation, vis-à-vis engagement with Government. From a ban on NGO activities in the first year of implementation, to severe human resources shortages at local government level, to engagement at the national level, efforts to engage with state actors were constrained by factors generally outside of Concern's control. Efforts to engage were nevertheless relevant, and early successes (e.g., with the education sector) highlighted the relevance of continued efforts to engage with state actors.

3.4.1.6 Concern's Policies

Regarding alignment with Concern's policies and guidelines of Equality, Capacity Building, Programme Participant Protection, and HIV, in interviews with Concern personnel as well as partner organisations, alignment with Concern's policies were noted as consistent during Programme design and implementation, as well as the evaluation itself (in terms of Participant Protection). For Capacity Building, this was with partners in terms of NGOs in Nyanga and the hospitals in Gokwe. Systematic assessments were conducted of partner organisations and gaps considered for capacity enhancement, with particular attention to strengthening financial management systems. In the early years of the Programme, capacity enhancement was felt to be a particular focus of the Programme.

Concerning HIV, despite this being an HIV Programme, discussions with Concern personnel suggest that mainstreaming was only limited to some internal mainstreaming activities, while there was little consideration of external mainstreaming following discussion of HIV impacts during the PLA fieldwork. There were some concerns about the risks associated with field officer placement in communities, but this does not seem to have been translated into risk-reduction actions. One matter that did not come up in the early risk assessment was the risk associated with public or private hire transport for field officers to district headquarters and from the districts to Harare, where a number of officers travelled on weekends.

Regarding equality, this was one area where Concern personnel felt that Programme design and implementation were quite successful, from hiring procedures, to management approaches to team management, to Programme focus.

Child Protection

In addition to Concern's policy on participant protection, additional measures were taken to ensure the protection of children. The project worked with children in AIDS Action Clubs, and out of school youth and trained staff and partners on how to best support these clubs and groups. A specific Junior STAR approach has been developed, where staff and partners were trained on supporting child-led discussions and how to motivate children. With partners. Concern has set up a Community Complaints Mechanism with some suggestion boxes being placed in schools. Some of these complaints are around child abuse and these are referred to the relevant authorities. Concern's future HIV prevention programme will focus specifically on young people

3.5 Effectiveness and Efficiency

As per the TOR, effectiveness refers to whether the Programme was implemented in an effective and useful manner, while efficiency was a related issue regarding whether the Programme was implemented in a cost effective manner. Sub-questions under effectiveness and efficiency are as follows:

(a) How effective was Concern's approach in terms of staffing, use of partners and community volunteers?
(b) Were the methodologies used, especially Societies Tackling AIDS through Rights (STAR) appropriate and of sufficient quality to achieve impact? Were they appropriate for all age groups and for both men and women?
(c) Does the Programme cost justify the benefits, bearing in mind the Programme reach in the remote area? If possible, compare to similar HIV programmes for useful observations and learning.

It should be highlighted that this sub-section does not assess the sustainability of the Programme, despite the links between sustainability and effectiveness and efficiency. Instead, these links are discussed at the end of the section as a whole.

3.5.1 Effectiveness

Overall findings suggest that the design and implementation of the Programme has been extremely effective for those directly reached by the Programme. This includes Programme partners and the quality and quantity of what they were able to deliver through the Programme, and those end users reached in Programme area communities. With the partners, attention to capacity enhancement and a focus on joint planning and implementation meant that the activities carried out through these partners were evaluated as effective, as far as these actions went. With direct implementation in the field in the Gokwe districts, the placement of extension officers in Programme area wards to work with community volunteers, end users and intermediaries was felt to be an effective strategy. Further, school-based activities were well designed and focused on working with young people in an effective manner, although as the mid-term review noted, the clubs were strongly driven by teachers rather than students themselves, at least in the early days.

There were two main constraints that undermined effectiveness, both arising from Programme design: 1) the small number of people directly reached by the Programme in a substantive manner; and 2) overly-ambitious outcome objectives. For the former, key informants and Programme personnel raised concerns about the small number of people directly reached by Programme activities, affecting community-based interventions (both STAR groups as well as income-generating groups) and school-based interventions (anti-AIDS clubs, teachers). As one key informant put it, 'implementation has been extremely effective, but the challenge is that the reach is too small'. This problem is magnified given the levels of need in these communities, in particular in the income-generation arena, that far exceed Programme reach. For the latter, overly-ambitious objectives, Concern's responsiveness to the PLA and other inputs yielded objectives that were in essence too difficult to fully achieve in such a short period of time.

Having said this, the impact assessment found Programme reach well beyond those directly involved in Programme activities. The vast majority of residents in the Programme area had been directly exposed to peer education activities, including discussions with STAR group members, and these contacts appear to have had important impacts in two important areas relevant to HIV&AIDS: improved knowledge and improved attitudes. And available evidence suggests that the Programme gave due consideration of different needs across socio-economic status, gender and age, and also directly involved those HIV positive. The creativity displayed in how community-based and schools-based interventions were implemented is commendable, and likely had important impacts on Programme effectiveness.

Further, the impact assessment findings suggest that important progress has been made *towards* these outcome objectives. This is reflected in changes in knowledge and attitudes among those directly reached by someone involved with the Programme (including community volunteers), but it is also reflected in people beginning to challenge long-held beliefs about cultural norms (gender relations, sexual conduct including within marriage, discussion of sexual issues). Serious gaps remain in each of these areas (indeed, there were problems in terms of knowledge for both reached and unreached populations), but this does not negate the progress made. The situation regarding condoms is similar, and an emergent focus on condom use within marriage is likely to have been well too ambitious, or perhaps misdirected given other risk reduction options available within marriage (e.g., reduction in STIs and effective STI treatment, expanded male clinic attendance for STIs, ARVs, etc.). Condoms were also reported as not being seen as a method of family planning but rather as a means of HIV prevention, making it even more difficult to introduce into a marriage.

Another effectiveness concern was with regard to 'male-dominated, negative, cultural practices fuelling the spread of HIV&AIDS'. The characterisation of these practices at the outset as solely negative closed avenues to consider positive cultural norms that could be the focus of enhancement activities. Unfortunately, in the HIV&AIDS arena these characterisations are not uncommon, but even in comparison with others it is difficult to find one that is cast in such negative terms. The risks associated with wife inheritance, for example, may indeed be a concern for HIV infection, but there may well be important positive livelihood impacts. By casting wife inheritance solely in terms of HIV risk and solely in negative terms, it is difficult to see how learning could occur during Programme implementation.

Even things as potentially harmful as early marriage may still be valued in rural Zimbabwe for livelihoods protection, so the issue is rather not one of 'early marriage' *per se*, but rather establishing local definitions of what early marriage is, and responding to this concern. But by characterising early marriage as entirely negative, no room was left for the dialogue necessary to establishing what the problem was and what should be done about it. There is nevertheless some ambivalence in communities around the casting of a number of cultural practices as solely negative, as one focus group put it, 'things are difficult now, it is the time of AIDS'. Even with this ambivalence, more attention could have been focused on *listening* to STAR group members, as an example, rather than starting from the point that these practices were indeed negative and

dangerous. The approach to cultural issues is especially disappointing, as the context analysis conducted in 2010 highlighted the many avenues of cultural dynamics that needed further consideration, in particular how these dynamics might affect levels of risk (see Concern Worldwide Zimbabwe, 2010: 43-44).

There are similar problems associated with gender-based violence. In discussions in the field and with the team, it became evident that there were differences of opinion on what violence comprised compared to acceptable discipline. Yet by employing external definitions of violence and treating all aspects of violence, including those that might be considered reasonable discipline from a cultural point of view, as problematic, little room was left for dialogue in how to (for example) shift perceptions of physical discipline so that it might be less acceptable. Again, it is difficult to see how learning could take place that would help improve Programme effectiveness if a decision is made at the outset as to what is definitively right and wrong.

This does not mean that progress hasn't been made in responding to gender-based violence. Key informants and focus group discussion participants noted that what had changed for the better was a reported reduction in severe abuse that was defined culturally as violence, with husbands reported to be less likely to severely abuse their wives, and the husband's excessive behaviour more likely to be dealt with through traditional channels.

Those involved with STAR largely held positive views about the effectiveness of the component. Difficult issues associated with linking people across socio-economic status (and giving a voice to poorer persons), gender relations, cultural norms, and sexual behaviours overall were considered and dealt with in an increasingly open manner and things progressed. It was recognised that things of this nature take some time to take effect, and that challenges remained, with particular challenges facing risk reduction within marriage. A positive by-product of the STAR groups was the strengthening of social capital networks, and linking these groups to community leaders in a way in which it was unlikely to occur without the sustained support to STAR. A second positive outcome of STAR, in this case an intended one, was outreach by STAR group members to others in the community. A series of tests of knowledge and attitudes around HIV&AIDS found that direct exposure to STAR, or to a peer education through an anti-AIDS Club or through community volunteers, covaried with increased knowledge and improved attitudes.

In these respects the STAR approach was effective as far as it went. However, virtually all key informants and focus group discussion participants familiar with STAR raised concerns about the number of people directly reached via STAR, and whether effectiveness could have been enhanced if additional STAR groups could have been formed and supported during Programme implementation.

The Programme focus on out-of-school youth, originally intended to complement in-school activities, was roundly felt to be ineffective by those involved in implementation. The single most commonly stated problem was that the component failed to gain traction because there was nothing that kept the groups together.

One important aspect of the effectiveness of Programme *implementation modalities* was the placement of extension officers in Programme area wards, allowing them to work with community volunteers, groups, and implementing partners on a regular basis. The effect seems to have been a better grounding of the Programme in affected communities, and this likely also supported recognition of both Concern's work in the area and the Programme's work specifically (indeed, virtually 100% of the respondents had heard of Concern, and the majority of Programme area residents had been directly reached by someone involved in the Programme).

Having said this, questions arise concerning possible social distance that remain between Concern extension personnel and community members, given that Concern has something to provide that are valued resources. For the one field visit with the evaluator in the second phase of the evaluation, the team arrived two hours late to a meeting with a STAR group and a local AIDS committee due to organisational deficiencies. While conclusions cannot be drawn from this single incident, follow-up discussions suggest that this may not be uncommon, and needs further reflection within the organisation. While its impacts are most important in terms of sustainability, it also affects Programme effectiveness.

The review of the income generating activities in Nyanga District (Hamadziripi, 2011), along with findings from the key informant interviews and a focus group discussion, all highlight the success of this particular intervention in improving income status. This is consistent with numerous HIV&AIDS national plans that value livelihoods support as an important means of reducing engagement in high risk behaviours. This is also consistent with Zimbabwe's National Strategic Plan's impact mitigation strategy. The Consultant for this evaluation has conducted a number of previous assessments of HIV impact mitigation projects that focus on livelihoods recovery and enhancement, including one implemented by Africare in Zimbabwe, and the findings have been consistently positive, and highly valued by those reached. There were also important spin-off benefits in building social support networks.

It is less certain whether this in itself changes risk behaviours. Even those involved in this particular aspect of Programme implementation had concerns about its efficacy for married women. Beyond the initial resentment caused by the way in which targeting occurred, serious doubts remain that economic empowerment has a direct role on sexual negotiations that could reduce the risk of infection with HIV. It was felt to have resulted in better risk reduction opportunities for single women, but even here there were concerns that the magnitude of the economic crisis and the weakness of household economies did not yield intended impacts. As one key informant put it, 'I think the way it is stated is relevant theoretically but according to my own observations practically, I am not convinced that it was effective'.

However, consistent with the other consultancies conducted in Mozambique, Zimbabwe, Rwanda and Tanzania, the unit costs of these interventions are high and the number of people reached relatively small. This does not negate the accomplishments, but it does raise the question of whether adding in such a

component to an already complex Programme would allow it to reach a sufficient scale, and whether those with the public health and community mobilisation skills are the same ones to support an income and savings programme component. The failure of the goat programme in the Gokwe districts highlights the challenges facing the mixing of income generation with public health and outreach activities. Focusing a specific programme on HIV and livelihoods in future may be a wiser use of funds, rather than trying this as part of a complex set of interventions. While it would essentially be a livelihoods initiative, instead of mainstreaming HIV, HIV would be a central focus under a livelihood banner. Expanded access to finance, skills development, and economic diversification would all be supportive of HIV risk reduction if well thought through.

3.5.2 Efficiency

The benefits of the Programme in relation to Programme costs is difficult to establish, as outcomes overlap across Programme components, cost sharing exists across a number of Programmes, and expenditures are not itemised in a manner that allows an assessment of such a breakdown (personal communications and a review of accounts). Key informants involved with financial management did note that they felt that funds moved as intended, the flow of money in the Programme did not hamper activities at any point during implementation, and the use of funds was reviewed by district offices as well as headquarters in Harare. The only problems reported were in the early days in terms of the efficiency of systems to provide funds to local partners, where repeated delays were encountered.

Despite these apparent implementation strengths, this report is not intended as a financial audit of the Programme. Instead, for the purposes of an impact assessment, the focus should rather be on the *cost effectiveness* of activities, as this allows consideration of impacts in relation to expenditures on the Programme in light of possible alternative uses of the funds. Efficiency in this report is therefore measured as it relates to cost effectiveness.

Key positive findings related to Programme impacts and efficiency are as follows:

- Basing the extension officers in Programme area wards has had an important, positive impact on Programme operations, serving as an effective means to provide services.
- The selection of partners appears to have been quite sound and, despite the various challenges especially in the early days, the selection of partners with an existing presence in the Programme areas was a wise move.
- The school-based activities were felt to be especially cost effective, as simple things such as peer competitions reached a considerable number of young people.
- Knowledge and attitudinal changes can be attributed to direct exposure to peer educators. Funds spent that yield these direct outcomes are therefore well spent, whatever the broader Programme context. (The specific expenditures associated with direct outreach are unknown.)
- Access to testing services and PMTCT and ARV services have had important impacts, especially within the context of a dearth of actors in the two Gokwe districts. Impact assessment findings suggest that expanded uptake of HIV testing services is due in part to expanded outreach services, coupled with the eventual improved available of ARVs.
- The capacity of partner organisations has improved, in terms of implementation capacity and skills development, financial management, and outreach.
- Working via groups has had an unexpected positive impact on the strengthening of social capital networks. This is especially important in rural Zimbabwe, where dramatic economic and social changes have undermined these very networks.
- Issues that just a few years ago would have been extremely difficult to discuss openly are now being openly considered, including early marriage, sexual violence, child abuse, and living openly with HIV.

The main challenges to Programme efficiency are as follows:

- With the exception of the income groups in Nyanga District, it is difficult to see what would hold many of the groups together. Anti-AIDS Clubs are formed and re-formed on a regular basis in countries across the world, with little evidence that these structures can sustain themselves without external assistance. It is equally difficult to see what will formally hold the STAR groups together, as the actors diligently involved in keeping them together are removed from the field, even when community facilities are on the ground. This also holds for the Ward AIDS Action Committees, as without support and without a clear purpose, it is difficult to see what would keep them operating. This again is a problem facing committees of a similar nature around the world. Having said this, it should nevertheless be noted that the social networks that were strengthened under the Programme may possibly keep these groups together, even if they morph partially into entities that have a different purpose (e.g., income groups, women's association, trading groups, etc.). Further, the Wards AIDS Action Committee are logical entities to receive additional support from other actors who may work in the area. This need for external support should not necessarily be seen as a weakness, as technical support to the HIV&AIDS response is a long-term matter.
- Hospital outreach and service provision will also be challenged with the removal of financial and technical support. It is doubtful that these service providers will be able to continue to offer this level of service following Concern's departure.
- Some Programme components did not appear to be the best use of funds, given either the misdirected nature of implementation (the focus on cultural change with existing practices viewed entirely as negative), the magnitude of the problem (the need for income generation), or the intractability of the problems themselves (condom use within marriage).
- In other cases, its not clear whether Concern had a competitive edge over other actors who specialise in certain fields (condom distribution, PMTCT, STI treatment) or where a more sustained focus would be required (male circumcision). In these situations, the rationale for Concern's involvement is unclear, save that these were identified as important during the PLAs and Concern (quite understandably) tried to respond to these needs.
- And in other cases it is not clear whether Concern's actions can yield desired outcomes (nor measure these outcomes) without a long-term plan (child sex abuse, gender-based violence practices, age at first sexual encounter, as well as many other measures) that would extend well beyond the Programme period.
- The many problems with the Programme's logframe and the complexity of the Programme both meant that considerable resources needed to be devoted to monitoring Programme activities, inputs and outputs, but this very complexity and difficulties in establishing what the Programme was intended to do meant that it was difficult to draw links between outputs and outcomes, and as a result the role of monitoring in implementation was undermined.
- Some partners raised concerns about budget inflexibility, where good ideas were felt to not have received attention because they did not confirm to pre-defined expenditure categories.
- Programme objectives were overly ambitious, in part due to the understandable desire to meet the needs as outlined by people during the PLA exercise, but also because insufficient attention was given to the extent to which desired outcomes could be achieved.
- Consider funds were spent on baseline assessments of the Programme areas. While the intent of the baselines was commendable, and while Programme officers learned a great deal from the baselines, flaws in design and implementation meant that it was not possible to statistically compare the baseline data with the impact assessment data. Planning the baseline with the endline in mind, with proper attention to the rules around quantitative data collection, would have yielded useful information.

Cost effectiveness findings can be summarised as follows:

- Community-based operations was a cost effective way of proceeding. Nevertheless, as the ones with the resources, it is unclear how equal the relationship was between the two parties (communities and CONCERN), and what impacts this might have had on sustainability.

- Active listening, as displayed during the PLA exercises, and in considering the findings of the baselines, along with how the Programme was implemented on a day-to-day basis has proven cost effective. Nevertheless, there are grave doubts about the ability of the groups set up as part of Programme implementation to survive even into the near future. How this will affect the situation of individuals is uncertain as well, but is likely to be less effective than if the groups would survive.
- While a focus on behavioural change may have been too ambitious, impact assessment findings suggest changes particularly in attitudes that offers an important foundation for behavioural change. This proved to be a good use of resources, even if this is mid-directed.
- Too many Programme objectives were far too ambitious, and were not possible to respond to in the short-term. This would have been fine if attention had been devoted to how interventions could be sustained into the future that would tackle these over the long-term, but this was not the case for the Programme. The Programme's focus on these more intractable issues may therefore not have been a cost effective use of resources.

3.6 Sustainability

As per the TOR, sustainability is the extent to which impacts will last following the end of the Programme and, more broadly, the extent to which lessons learned from the Programme can affect future programming, within and outside Concern.

(a) Is there evidence that initiatives begun under the Programme will last and spread without ongoing support from Concern?
(b) Are there comprehensive exit strategies in place? Are there additional measures Concern should do to improve sustainability?
(c) Was there capacity building of partners and Concern?

3.6.1 Lasting Impacts

This is perhaps *the* most serious challenge to the Programme, as it is doubtful that the Programme will have yielded any lasting legacy beyond the individuals directly reached (including, it should be added, those reached by public health outreach services, itself very important), and even for them the constraints they face in reducing risks and accessing services is of concern. This holds for even its most successful activities.

In part, however, this may be the wrong question to ask when considering sustainability. In the current situation in Zimbabwe, where rural livelihoods are severely challenged, where the political situation remains uncertain, and where civil society has been weakened, the question should not be whether impacts will last over time, but rather whether local organisations have been strengthened in a manner that will allow activities to continue that will yield desired impacts. Related to this, if other agencies (or even Concern itself) are able to strengthen the HIV&AIDS response in the Programme area for a number of years into the future, and if these agencies continue to focus attention on institutional strengthening and working with local (state and non-state), this should be considered as part of a sustainable response. Simply put, it is unrealistic to assume that a programme that only lasted essentially three and a half years, implemented during one of the most difficult times in Zimbabwean history since the country's independence in 1980, can be sustained into the future. Instead, a longer timeline should have been considered, as is the case (for example) by World Vision, coupled with a stronger focus on learning as the Programme proceeded.

Having said this, the extent to which Programme activities *contribute* towards sustainability is a fair question. For the HIV Programme, insufficient attention was devoted to a consideration of sustainability, and as a result this did not form part of reviews during implementation. Systematic reflection (along with a more strategic mid-term review) might have had important sustainability impacts on Programme implementation, supporting sustainability, but this was not common; this was also highlighted in the 2010 context analysis (Concern Worldwide Zimbabwe, 2010).

The survivability of groups, either community-based or school-based, is of concern in the absence of systematic and over-time support, or without an economic (e.g., STAR groups) or administrative (e.g., WBCCs) purpose. With the exception of the income generation groups in Nyanga District, it is difficult to see what will hold the remaining groups together as formal entities in the long-run. In such a situation, it might have been better to cover a significantly higher number of people with anticipated shorter-term impacts. There is also growing recognition that volunteers cannot work for free for years, but no provision has been made for this. The magnitude of the problem of sustaining activities cannot be underestimated. In asking various district and local level key informants and focus groups about sustainability, the entire list of Programme components were raised as unlikely to be sustained.

Regarding services, secular trends suggesting increased access to public health services around Zimbabwe, and hopefully in the Programme areas, may well result in continued high levels of access to services, and this may be one residual impact of the Programme. There is also the direct, and important, impact the Programme had at the time of implementation on those reached with key public health services. In Nyanga, the partner hospital already had important reach in the service provision areas, and this may well continue. However, for the other partner hospitals, it is difficult to see how they can continue to operate at current levels, and this means less outreach. The mission hospitals in Gokwe remain committed to continuing outreach and service provision around sexual and reproductive health, but key informants suggest that services may need to be scaled down, including outreach. It would have been useful to look at strengthening links to Ministry of Health facilities.

The multifaceted nature of the Programme itself offers challenges for sustainability as well, despite in some cases the logical connections between the different components. Key informants involved in Programme implementation virtually all felt that the Programme was too complicated and difficult to implement, and poorly guided by a vague and confusing logframe. This was felt to have weakened each component, undermining sustainability.

Given all that people have been through in recent years in Zimbabwe, and given the nature of the political environment in Zimbabwe, where top-down approaches are not uncommon, it is perhaps not surprising that community-focused initiatives have faced considerable challenges. In a sensitive political environment, it is also not surprising that initiative may be lacking, at least at the outset. This had a particularly problematic impact on the Programme because of the politicisation of local authority, and mutual suspicions in this

regard during the early stages of consultation and implementation. While it is by no means certain that dialogue would have yielded a positive working relationship between Concern and these local leaders, the absence of dialogue has been felt to have heightened mistrust. The political circumstances have not changed significantly, but improvements have been noted anyway, albeit quite late in the programme.

3.6.2 Exit Strategies

The Programme proposal (Concern, 2006: 31) includes the following exit strategy:

> Upon a) the achievement of significant progress against the programme's major outcome indicators, which will be measured through a baseline [and a] follow-up survey, and b) demonstrated capacity for continuing support for the interventions and services established under the programme by implementing partners, Concern will fully hand over the various programme elements to such strategic partners. These may include but may not be limited to: village/ward clinics; schools; churches; traditional courts; ZINATHA; FACT; mission hospitals; district authorities.

Concern made provision for operationalising an exit strategy, and from 2010 worked with its partners to do so. In a review workshop of progress in this regard in February 2011 (an HIV/AIDS Review and Planning Workshop), the following were noted:

- STAR – work with Ward Behavioural Change Committees so that they can help strengthen the local response, and support the STAR groups;
- Considering with Community Facilitators how they can continue their work following Programme completion;
- STAR groups to help create additional STAR groups;
- Technical training for Theatre for Development groups;
- Continued exchange visits between these theatre groups and others;
- Provision of relevant equipment for these theatre groups;
- Linking Anti-AIDS clubs to STAR activities, looking at linking the two;
- Linking mission hospitals with community committee structures;
- Needs assessment survey of out-of-school youth;
- Additional training of STAR group members;
- Additional training of Condom Distributors, and improving their links with suppliers;
- In Nyanga, handover of income generating activities to livestock committees;
- Training at village and health facility level;
- Working with STAR groups, discuss HIV with the broader community;
- Obtain and use HIV&AIDS materials;
- Other activities.

In reviewing the activities, there was an emphasis on capacity enhancement, but in some cases activities seemed well late in the Programme to be considered as sustainability actions, from ideas about school newsletters to school competitions. These seemed instead to be ongoing interventions, rather than sustainability measures.

In part such an assessment is unfair, as a check of the mid-term review highlights that many of these actions are direct outcomes of the review. In these respects they were simply actions taken to try and follow-up on the recommendations of the review, a responsive and responsible action. However, the fact remains that they are not exit strategy actions. A stronger mid-term review focus on exit strategy matters might have assisted in this regard.

As the exit strategy highlights, capacity enhancement and partnerships are central to the Programme's exit strategy. Programme investment in partnerships, and in the capacity enhancement of key actors, was high, although there were particular challenges in working with state authorities due to factors outside of Concern's control.

Findings from the follow-up survey suggest that the Programme's direct impacts on the objectives around aspects of Objective 1 (improve successful negotiation of safe and voluntary sexual encounters; decrease in male-dominated, negative, cultural practices fuelling the spread of HIV) and Objective 2 (enhanced service access and use) have actually be quite successful when consider direct impacts on end users. Findings included in the impact assessment section of this report highlight the fact that direct exposure to peer education channels covaries with improvements across a number of measures for both these objectives. However, this has *not* necessarily proven to lead to (b) on capacity. No strategic assessment was conducted that considered the extent to which partner agencies were able to (or desired to) continue Programme activities. There was some evidence that the public health aspects of the Programme were of continued interest to partner hospitals, while income generating support activities appeared to have moved on to new locations based on the priorities of a new financing agency. State authorities generally came late into the process, and are largely not in a position to support implementation. The exception has been the Ministry of Education, but even here it is not clear what direct support can be offered to severely overworked and under-resourced education authorities to support anti-AIDS Clubs.

3.6.3 Capacity Enhancement

The Programme proposal notes that sustainability will be supported most directly by "working with existing and emerging community groups which will remain in the community all the time" (Concern, 2006: 30). Field findings suggest that the partner hospitals have stronger management systems in place due to the Programme, and this has important implications for the sustainability of their follow-on activities. The Programme proposal also notes the importance of strengthening ward committees, and these structures have indeed be capacitated. However, as noted above it is not clear whether this will support the longevity of these institutions.

Also mentioned under sustainability in the Programme proposal is the income generating activities, with the IGA groups provided with a range of skills key to being successful in business. The intended outcome is that "the knowledge, skills and self-confidence acquired through the entire duration of the programme will enable

beneficiaries to manage other projects with or for their families or community after completion of the intervention". The assessment conducted in early 2011 of the IGA activities in Nyanga District suggests that this was an apparent outcome of the IGA activities (Hamadziripi, 2011). From an impact mitigation point of view, this was an important outcome. However, it is less clear what impacts this had on risk reduction behaviours.

Institutional capacity enhancement was also noted as important, focused on formal institutions and partner agencies, including state actors. In the two Gokwe districts one of the most serious problems was the absence of effective community-based organisations with which to partner, save the hospitals for the public health interventions under Objective 2 on service provision. Unfortunately the broader context in the health arena made this especially difficult. As one key informant in Gokwe South put it, the shortages in the medical sector 'took away a large chunk of the complimentary interventions you would normally have expected. As an agency, Concern has therefore been implementing its programme with relatively fragile institutions. Even in a case where substantial support has been offered and capacity building successful, the absence of broader support for primary health care interventions meant that the HIV response did not take place in a wider environment where broad-based primary health care interventions dominated.

For Nyanga, both state institutions and non-state partners were stronger than in Gokwe. The Family AIDS Action Trust (FACT) had previous experience in the HIV&AIDS arena as well as HIV&AIDS and livelihoods support, while the Africa Self Help Assistance Programme (ASAP) had particular expertise in community-based income, savings and loan groups. Further, public health service delivery systems were stronger than in Gokwe.

4 Conclusions

4.1 Introduction

Conclusions are drawn based on findings from the impact assessment and the evaluation associated with effectiveness, efficiency, relevance and sustainability. The **purpose** of the Programme was "to improve the behavioural practices related to the prevention of HIV and AIDS among women and girls, men and boys through increased awareness of sexual and equality rights by holders and duty bearers".

Four **outputs** are specified:

Output 1	Improved negotiation of safe and voluntary sexual encounters by women and girls, 10-49 years.
Output 2	Increased capacity of institutions to recognise and deal with incidences of male-dominated, negative, cultural practices fuelling the spread of HIV and AIDS.
Output 3	Increased availability, access and usage of key preventive services (PMTCT, C&T and STI treatment) for men and women, provided by local stakeholders through improved capacity.
Output 4	Improved access and control/ownership of appropriate, safe and sustainable livelihood activities by women and girls, 10-49 years.

4.2 Discussion

Findings suggest that there has been some progress towards meeting the overall purpose of the Programme, and towards the four outputs. However, this must be seen in light of the overly ambitious nature of the outputs themselves. Recast as progress made in terms of knowledge and attitudes and service availability, considered within the context of a dearth of outreach in the Programme areas, and when evaluated in the context of what is realistically possible to accomplish in the timeframe and at this particular time in Zimbabwe, there are notable achievements. These can be divided into operational achievements associated with Programme intent and operations, and impacts on populations reached.

In terms of operational achievements, many respects the Programme was implemented in a progressive fashion. It had a number of characteristics to commend it, including the participatory learning and action exercise at start-up, a sustained focus on identifying competent partners and building capacity, community-based placement, careful consideration of multiple populations at risk, and intentions to respond to the plethora of problems facing Programme area populations. The Programme was implemented without major financing and cash flow constraints, all efforts were made to keep the Programme proceeding as well as possible under difficult circumstances (when it was allowed to do so), problem solving was generally efficient, and team members worked hard. Implementation also tended to favour poorer households,

recognising perhaps not a differential risk of HIV infection (there rarely is), but rather a differential ability to manage the consequences of infection (see Concern Worldwide Zimbabwe, 2010: 45).

Impacts on implementing partners were generally quite positive, with capacity enhancement a persistent concern, while impacts on Programme area communities, in particular those directly reached by the Programme, tended to be positive. Section 3 of this report highlights a number of areas where progress has been made in having desired impacts. There was commitment to implementation of a bottom-up approach, not always easy in such a politicised environment and one where top-down approaches were common.

Despite these best efforts, the Programme was poorly served by an overly-ambitious agenda, poorly guided by an unworkable logframe, and caught in some of its own strongly-defined notions of what was 'right and wrong', 'good and bad'. The difficulties facing Programme implementation cannot be overstated. One national level key informant put it best: 'the intent was good but the level of disempowerment in Zimbabwe was underestimated. This has not only to do with the political situation but also with the culture and hierarchy at different levels including male dominance at household level'. And the particular problems facing especially the two Gokwe districts cannot be underestimated. It was a remarkably difficult time in Zimbabwe, where factors that would already have made implementation difficult were dramatically worsened by the economic collapse and political difficulties.

Further, as the routine of implementation set in, these problems meant that different Programme components tended to proceed without reference to others, despite innovations within each. This tended to widen the gap between Programme components, and reinforced a focus on operational issues rather than strategic ones. The mid-term review, which commendable in its breadth and attention to Programme detail, tended to be weak in identifying these strategic issues, meaning that mid-course corrections that might have strengthened the Programme (or at least focus it better) did not take place.

The overall picture is one where proper Programme preparation, hard work, innovation and effective management of expenditures made it possible to reach some communities and community members and provide important services in an area that was in serious need of such support, and where few other actors were present. Yet it is also a picture where the sustainability of the Programme is brought into question. This lack of sustainability is in part due to unrealistic expectations around what could be accomplished, especially in light of seriously over-ambitious objectives, but it is also due to a lack of careful thought about how Programme activities might have longer-term impacts.

4.2.1 Lessons Learned for Future Programming

Lessons learned come from what are sometimes referred to as 'best practices', but they also come from due consideration of what did *not* work well. Lessons learned from both what worked and what did not are summarised below:

- The careful attention to partner selection and capacity enhancement, while sometimes a slow and frustrating process, was an excellent idea. In any future programming, similar relationships would be important as well, but should be subject to more attention focused on sustainability matters.
- The participatory learning and action exercise, along with the extended baseline surveys, helped community buy-in of the intervention overall, expanded awareness of the Programme itself, and helped shape Programme implementation based on felt needs in the area. Granted that it still carried a great deal of previously identified 'baggage' (e.g., what was right and what was wrong), it nevertheless helped Concern better respond to felt needs. These and other efforts towards the implementation of a 'bottom up' approach are commendable, whatever the deficiencies.
- Having said this, the 2010 context analysis provided a wealth of information and insights that would have been better to have had earlier in Programme implementation. Much of the information in the report had important implications for Programme implementation (see Concern Worldwide Zimbabwe, 2010). There is nevertheless a risk that the wealth of information contained in this context analysis would have yielded an even more complex programme. 'Translating' such an analysis into action points is therefore a difficult, but important, step in using this information in a meaningful manner.
- The placement of Concern personnel in communities full-time allowed these officers to better link to community volunteers, groups, school authorities, etc. during implementation. It also helped strengthen bonds between these officers and community members. Again, whatever the deficiencies in actual implementation, such an approach is commendable, and certainly contributed to Programme implementation effectiveness.
- The problems encountered in trying to operationalise the logframe highlight the importance of having clear, achievable objectives where progress can be measured. As Programme implementation proceeded there was growing recognition that the Programme itself was far too ambitious, and should have been rescaled and refocused on what could be achieved. A particular problem is viewing HIV&AIDS as separate from people's broader lives, and setting benchmarks that assume that an HIV&AIDS intervention itself doesn't need to consider these other factors.
- Consideration needs to be given to a proper balance between Programme intensity and Programme reach. The Programme erred on the side of intensive impacts, which yielded a narrow reach. If more attention would have been devoted to sustainability, this would be expected to yield especially beneficial, long-term impacts.
- Programme sustainability needs to be properly cast in the context of what is possible to achieve in the time allowed and with the resources available in the locations and with the populations targeted. The Concern Programme had sustainability objectives that were far removed from what could practically be accomplished and, when coupled with a logframe that did not guide implementation effectively, overwhelmed the Programme. As a result, even less ambitious objectives around sustainability are unlikely to be achieved.

The mid-term review recommended a series of actions intended to guide implementation in the final year and a half of implementation. The document included a number of useful actions, based on findings from the review itself that reflected implementation problems. However, the review focused very much at an operational level only, itself needed, but not sufficient -- it did not tackle some of the more strategic matters.

4.2.2 Summary of Lessons Learned and how they will be shared

The 3 most important lessons learned are:

(a) Not uncomonly in the HIV & AIDS arena, cultural practices such as early marriage and widow inheritance are often characterised as negative and decisions are made at the onset of a project as to what is definitively right and wrong. This can close avenues for working with positive cultural norms and leaves no room for the dialogue necessay to establish what the problems was and what should be done about it. This is also an issue for gender-based violence, where what is considered to be violence internationally is often perceived to be 'appropriate discipline'. By condemning it at the outset, rather than listening and gaining a better understanding of the relevant dynamics, the effectiveness of responses to GBV are undermined.

(b) Improving knowledge on HIV & AIDS, GBV and increasing uptake of VCT leads to a demand for referral systems for GBV and ART treatment and other HIV & AIDS services which are extremely limited and not functioning well in underserved and remote areas. This can undermine long term behavioural change, as people are discouraged from seeking testing services or reporting problems.

(c) A important spin off benefits was the building of social support networks. This is a major accomplishment, and likely has important impacts in livelihoods protection and social support for the long term. However, the impact of livelihood support on risk reduction associated with transactional sex work is not clear and the depth of poverty is such that the projects type of livelihoods support would have little immediate impacts on transactional sex.

These lessons will be disseminated in the following way:

Concern has the opportunity to disseminate lessons learned through various internal and external channels.

Internally, at country office level, lessons learned will be shared at the 6-weekly National Coordination meeting, through email and when designing new programmes. Recently, Concern Zimbabwe initiated internal discussion fora through Facebook, which enables all staff to contribute and this approach could be used for the findings of the EOP evaluation. At global level, lessons learned can be shared through the global HIV & AIDS advisor, who is in touch with the 25 country offices around the world. A yearly HIV & AIDS technical meeting, that brings together the programme managers of the countries that implement HIV & AIDS programmes, serves as an opportunity to share and discuss best practices and lessons learned. The EOP evaluation report will be published at Concern's intranet.

Externally, when funds permit, the lessons learned should be shared with the communities and WBCCs that coordinate BCC activities at ward level through role play with Theatre for Development groups. At district level, Concern can share the lessons learnt at the yearly district stakeholder meeting and the monthly HIV&AIDS coordination group, chaired by the DAC. These activities will be coordinated by the recently recruited Communications Officer who coordinates the implementation of the Humanitarian Accountability Partnership. At national level, experiences should be shared at the UNFPA facilitated national behavior change forum, the NAC M&E working group and the ISAL Working Group. Partners took part in various stages of the EOP evaluation and can disseminate these lessons through their various networks.

Crucially, the lessons learned from the evaluation, and other reviews are being used for the preparation and design of a new HIV&AIDS programme which will begin in late 2011. This preparation includes two assessments (health systems and youth) and workshops with the same communities and many of the same stakeholders Concern has been working with over the last three years. The lessons learned are an essential part of this process.

Annex A: Detailed Findings on Impacts

Introduction

In this chapter Programme impacts are considered. The findings in this chapter are based on the following information sources:

- Quantitative survey of 1320 households across the three districts, including treatment and control wards.
- Focus group discussions across the three districts.
- Key informant interviews at national, district, ward and local levels.
- Secondary materials review, including Programme materials.

Approach and Limitations

The Programme logframe had a number of limitations that required that, for the evaluation, an *evaluation logframe* be developed. This allowed a specific focus on outcomes, drawn from various sections of the logframe, and clarification of outcome indicators associated with these intended outcomes. This Evaluation Logframe is included as Annex B to this report. It should be noted that values are not attached to the indicators (e.g., knowledge moved from *x* to *y*), as this was not usually established in the Programme Logframe. Instead, values are given for treatment and control locations to establish differences between locations reached and locations not reached.

Given the difficulties in establishing a proper control group, a second measure was made comparing 'high exposure' and 'low/no exposure' populations in the treatment locations. High exposure was classified as being reached by three or more direct or indirect interventions. A separate measure was used to assess differences across key variables for those reached by STAR or by peer educators directly. Both measures are presented in this section of the report. As STAR exposure in control locations occurred at a very low level (as the control and treatment wards bordered each other, some 'spill over' was expected, but proved to be minor), but peer education did occur, these same measures were considered in the control location as well.

This section also includes presentation of data from secondary sources, such as the demographic and health survey (DHS, 2005/6). At the time of the evaluation the full report from the 2010/11 DHS were not available, and therefore cannot be included herein. Secondary sources also included the two baseline surveys conducted by Concern in the Programme area. The data are not statistically comparable with the end-of-programme evaluation survey due to the sampling approach employed for the baseline, and due to the issues covered in the endline versus the baseline survey.

Outcome 1: Improved Knowledge, Attitudes and Practices

The Evaluation Logframe repackaged outcomes from the original logframe, taking care to ensure that outcomes in the logframe were considered in this evaluation. Outcome 1 was "increased levels of knowledge, improved attitudes, and improved practices about HIV among those reached by the Programme relative to those not reached by the Programme".

Outcome Indicator 1.1: Level of Knowledge of Males and Females About HIV Across the Programme Area

Outcome Indicator 1.1 was broken down into four sub-indicators:

- 1.1.1 – Basic knowledge of HIV&AIDS
- 1.1.2 - Understanding of how HIV is spread and not spread
- 1.1.3 – Knowledge of ways to reduce the risk of HIV infection
- 1.1.4 – Knowledge of STIs

Basic Knowledge of HIV&AIDS

Virtually all respondents had heard of HIV&AIDS. Those who had heard of HIV&AIDS were asked to specify the relationship between HIV and AIDS. Most respondents, across location, could not correctly state the relationship between the two (HIV causes AIDS), with half of the females in the two Gokwe districts indicating that they did not know the relationship between the two. To further test the depth of understanding of HIV&AIDS, the respondents who could correctly specify the relationship between HIV and AIDS were asked how long the asymptomatic period was from HIV infection to the 'average' time thereafter before AIDS symptoms were experienced. Few respondents could correctly specify the asymptomatic period. Between one-quarter and one-half indicated that they 'did not know', with females substantially more likely to indicate they did not know compared to males across locations. Most of the remaining respondents felt that AIDS symptoms would appear within two years, and almost all the remainder indicated 3-5 years. Less than 10% of the respondents correctly stated the 'average' asymptomatic timeline as six or more years, with figures low across both males and females and across location.

The 2005/6 DHS showed that almost 100% of all respondents aged 15-49 had heard of AIDS (97.8% for females, 98.4% for males), with similar findings for 2010/11 (97.9% for females, 99.2% for males) (see CSO, 2006, and CSO, 2011, respectively). Figures for the Midlands and Manicaland were similar to the national average. The 2009 Concern monitoring data found that, in Gokwe North, 23.1% of respondents had never heard of HIV&AIDS. However, these findings are inconsistent with the DHS findings, and findings from the end-of-programme survey.

There was no difference between treatment and control locations overall, holding for both males and females. However, when this was checked against being a STAR member, having met with a STAR

member, or having met with a peer education. For treatment locations, there was a considerable difference between such exposure and higher levels of knowledge about HIV&AIDS. This was not, however, the case for control locations, where there was no clear difference between those exposed and those not exposed.

Conclusion: Programme impact: positive.

Understanding of How HIV is Spread and Not Spread

A number of true false questions were presented to respondents, aimed at assessing much they knew about how HIV is spread and is not spread.

Approximately two-thirds of respondents knew that it was possible for an HIV positive woman to give birth to an HIV negative child, but there were differences across location (higher in Nyanga, at over 80% for females and up to 75% for males), and lowest for males in Gokwe control locations, at 54.1%. Overall findings did not differ between treatment and control locations. However, when this was further sub-divided by those who were exposed to STAR or a peer educator, substantial differences were noted, with those who had been exposed far more likely to answer the question correctly.

A related statement was also presented: "there are drugs that can be used to reduce the risk of transmission of HIV from a pregnant women to her unborn child". Similar percentages correctly noted that the statement was true. Females were more likely to answer the question correctly, holding for both treatment and control locations. There was no difference across treatment and control groups. When comparing STAR/peer educator exposure and levels of knowledge, in most cases the higher the level of exposure, the more likely the respondent was to answer the question correctly. This held for treatment locations, but was less the case for control locations.

Between one-fifth and one-third of the respondents mistakenly noted that mosquitoes could transmit HIV, with females significantly more likely to mistakenly note this than males across all locations. There were no clear patterns of variation across those exposed to STAR/peer educator and those who had not been exposed.

In the previous section it was noted that people thought that the asymptomatic period from HIV infection to the appearance of AIDS-related illnesses was short, or did not know. Knowledge that someone with HIV could look healthy was therefore especially important. Across location, males were more likely to correctly note that this was true, although rates for both males and females were fairly high, falling between 75% and 95%. These was no difference between treatment and control locations. However, when controlling for exposure to STAR/peer educators, differences emerged. Those who had been exposed in both Gokwe and Nyanga treatment locations were much more likely to answer the statement correctly; this did not hold for the control locations.

Given that condoms were sometimes stigmatised by their association with HIV, one statement was included saying that "condom use during intercourse increases the risk of transmitting HIV". A high 40% of females in the Gokwe control group agreed with the statement, compared to around 15-20% for females elsewhere. Further, for males, those exposed to STAR/peer educators were *more* likely to mistakenly state that the statement was true; this was not the case for females. This held for both treatment and control locations.

A worrisome 30-40%+ of females thought that HIV could not be transmitted from an HIV positive person to a sexual partner if this sexual partner was a virgin; figures were especially high for Gokwe. Except for females in the Gokwe programme area, those in treatment locations were more likely to correctly disagree with the statement if they had been directly exposed to STAR/peer educators. For control locations, no clear patterns emerged.

Conclusion: Programme impact: positive.

Knowledge of Ways to Reduce the Risk of HIV Infection

Respondents were asked whether the risk of HIV infection could be reduced. In Nyanga, almost 100% of respondents in both treatment and control locations indicated that this was indeed possible, however 10% of the males in Nyanga could not name any means when asked. In Gokwe, levels of knowledge were lower and between 85-90%, and an additional 10% of males could not name any means when asked. This was checked against the same exposure mechanism as noted for the previous variable; this was only possible for Gokwe because figures were near 100% for Nyanga. For Gokwe, those who had been directly exposed were more likely to be able to identify risks.

The UNGASS Progress Report (NAC, 2010) noted that the 2009 Multiple Indicators Monitoring Survey found that 56.4% of women aged 20-24 knew 2+ ways of preventing HIV transmission. WHO/UNAIDS/ UNICEF (2008) noted that, in 2006, the figure was lower at 45% (46% males, 44% females).

Conclusion: Programme impact: positive.

Knowledge of STIs

Respondents were asked whether they had ever heard of any infections that could be transmitted sexually. Levels of knowledge were higher in Nyanga than in Gokwe, and higher for males than females. With the exception of females in Nyanga, those exposed to STAR/peer educator were more likely to be able to identify an STI than those who had not in treatment locations; findings were mixed for control locations.

Conclusion: Programme impact: positive.

Outcome Indicator 1.2: Male and Female Attitudes About HIV and GBV in the Programme Area

Outcome Indicator 1.2 was broken down into six sub-indicators:

- 1.2.1 – Attitudes About PLHIV
- 1.2.2 – Attitudes About Condom Use
- 1.2.3 – Attitudes About the Role of Women and Men in Sexual Decision-Making
- 1.2.4 – Attitudes About HIV&AIDS
- 1.2.5 – Perceived Level of Risk of HIV Infection
- 1.2.6 – Attitudes About Gender-Based Violence

Attitudes About PLHIV

A number of attitudinal statements were included about people living with HIV. The first statement was "I would still be friends with someone if I learned that they had HIV/AIDS". A majority of respondents agreed with the statement, holding for both males and females. Those with exposure to no or only a few types of information were least likely to agree with the statement, holding for both Gokwe and Nyanga, with levels of agreement even lower than for control locations. For both treatment and control locations, those exposed to STAR/peer educators were substantially more likely to agree with the statement, compared to those who had not been exposed.

A second statement was "if I had a family member who had HIV/AIDS, I would want it to be kept a secret". Findings were extremely mixed, but tended to be worse for those who had had no or little exposure to information on HIV&AIDS, with levels of agreement higher than for control locations. Females tended to have more negative attitudes than males across location. In most cases, for both treatment and control locations, those exposed to STAR/peer educators were less likely to agree with the statement, compared to those who had not been exposed.

Respondents were presented with the statement "if a teacher has HIV/AIDS, s/he should still be allowed to teach". A majority of respondents agreed with the statement, holding for both males and females, and higher for females over males. Those with exposure to no or only a few types of information were least likely to agree with the statement, holding for both Gokwe and Nyanga, with levels of agreement even lower than for control locations. For both treatment and control locations, in most cases those exposed to STAR/peer educators were substantially more likely to agree with the statement, compared to those who had not been exposed.

A related attitudinal statement was presented as follows: "if a student is found to have HIV/AIDS, s/he should be expelled from school". A significant majority of respondents disagreed with the statement, with figures especially low in Nyanga treatment locations where the respondents had been exposed to three or more sources of information on HIV&AIDS. There was no clear pattern across those who had been exposed to STAR/peer educator and those who had not.

Another attitudinal scale statement was read to the respondents: "a shopkeeper who is infected with HIV/AIDS should still be allowed to sell products, even fresh produce". In Gokwe, respondents who had been exposed to three or more sources of information were more likely to agree with the statement than those who had not, holding as well for males in Nyanga, but not females. Those with lower levels of exposure tended to have the least positive attitudes, even compared with control groups. When checked against STAR/peer educators, no clear patterns of variation were detected.

Qualitative respondents in the Programme area tended to feel that stigma had declined due to Programme activities, in part because the Programme dealt with stigma issues quite directly, and also because the Programme helped to overcome myths around how HIV is spread. The 2005/6 DHS found that 91% of female respondents were willing to care for a family member with HIV, compared to a lower 71% for males. Findings from the Concern survey suggest that male attitudes have improved to a similar level as females, holding for both treatment and control locations. Almost without exception, qualitative participants felt that the public in general were more empathetic with those who were HIV positive, were less likely to discriminate against those who were living with HIV, and more likely to feel that those who were HIV positive should receive help now than was the case at Programme start-up.

Conclusion: Programme impact: positive.

Attitudes About Condom Use

Three attitudinal scale statements were presented with regard to condom use, focusing on condom use under different relationship situations, and motivation for use.

One scale statement was intended to establish whether condom use changed when a relationship changed from casual to serious: "when a relationship among partners moves from casual to serious, condoms are no longer necessary anymore because you trust each other". Approximately half of the respondents agreed with the statement, with agreement higher in control locations for males than in control locations for both Gokwe and Nyanga, and also higher for those with three or more means of exposure to information on HIV compared to those with up to two sources. In most cases, holding for treatment and control locations, those who were not directly exposed to STAR/peer educators were more likely to agree with the statement, indicating that such exposure tended to result in a more positive attitudes.

When asked about condom use in casual relationships being primarily or entirely motivated by pregnancy prevention, most respondents agreed with the statement. This held for both males and females, for Gokwe and Nyanga, and for treatment and control groups. This did not vary across levels of exposure to information. When asked about condom use in marriage and pregnancy prevention being the primary motive, respondents were less likely to agree, especially in Gokwe treatment areas.

Qualitative respondents tended to feel that, while attitudes about condom use had improved, problems remained. In part this was felt to derive from condoms themselves being 'stigmatised' as something to do with HIV&AIDS, which tends to be how condoms have been marketed in the area (not as a means of pregnancy prevention, rather as a means of HIV prevention).

Conclusion: Programme impact: uncertain.

Attitudes About the Role of Women and Men in Sexual Decision-Making

Three attitudinal scale statements, two directed to condom use and one to abstinence, were presented to try and establish attitudes about the role of women and men in sexual decision-making. Regarding the statement "even if a single woman was worried that her sexual partner had other sexual partners, she could not insist on condom use". Findings were quite mixed, with no clear patterns emerging across treatment and control groups and across location. However, for all groups except for males in Gokwe, those with direct exposure to STAR/peer educators were more likely to disagree with the statement than those who were not exposed, holding for both treatment and control groups.

For the statement "really, within a marriage a woman cannot initiate condom use, even if she wants to prevent pregnancy, as it is up to the man". Females in Gokwe treatment locations with high exposure to HIV&AIDS information were less likely to agree with the statement compared to low/no exposure respondents and control areas. The same was the case for Nyanga, applying for both males and females. This was also the case for those exposed to STAR/peer educators, where levels of agreement were lower in treatment locations (but not in control locations).

For the statement "abstinence from sex is difficult for single women because men control decisions on sex". Agreement with the statement was substantially lower for those in Gokwe treatment areas who had high exposure to HIV&AIDS information. When checked against STAR/peer educator exposure, findings were mixed, with males more likely to hold positive attitudes but with no variation across levels of exposure for females.

Qualitative respondents were relatively ambivalent in considering whether there had been changes in the role of women in sexual decision-making. For unmarried women, economic empowerment was felt to have played a positive role in empowering women, but for married women it was felt that things may not have changed. In situations of marriage, economic decision-making was felt to have changed in cases when women were able to contribute to the household economy. Even here, however, the total number reached was noted to be relatively small compared to the population in the area, so impacts were felt to be very limited.

Conclusion: Programme impact: some positive aspects.

Summary Attitude About HIV&AIDS

At the end of the attitudinal scale statements respondents were presented with the following statement: "really, there are many things about HIV&AIDS that I simply do not understand". Well over three-quarters of the respondents agreed with the statement, rising to 90% for males in Nyanga for both treatment and control groups (and 100% for males who were in the 'low/no exposure' category. Those exposed to STAR/ peer educators in treatment locations were substantially less likely to agree with the statement; this was not the case for control locations.

Despite high levels of concern especially in control locations, most felt that the situation was better now than in the past. However, this was much higher for treatment area locations than control area locations. In Gokwe, those exposed to STAR/peer educators were more likely to indicate that they were 'more informed now' than three years ago, but this did not hold for Nyanga. Findings were very mixed in the control group locations.

Conclusion: Programme impact: limited positive aspects.

Perceived Level of Risk of HIV Infection

Respondents were asked about their perceived level of risk of HIV infection. Most respondents noted a level of risk, with 85-90% indicating one level of risk or other. Levels of risk did not show any patterns across treatment or control groups. For those who indicated that they were at low or no risk, the most common reason mentioned for this risk was that they lived with a faithful partner, followed by awareness of HIV test results (which was especially commonly mentioned in Nyanga).

Levels of risk were checked against some aspects of potential risk. Those who had tested were less likely to feel at risk of infection, holding for both males and females. Further, males with casual partners were more likely to feel that they were at 'high risk' compared to those with no casual sexual partners. However, most of the remainder who had casual sexual partners felt that they were at 'no risk'. This perception of risk did not seem to relate to condom use with casual sexual partners.

Conclusion: Programme impact: uncertain.

Attitudes About GBV

One attitudinal scale statement covered GBV, "if a wife tries to refuse sex from a husband, he has the right to discipline her". Of interest, females were considerably more likely to agree with this statement than males, with an average of half of all women agreeing (and most of them strongly agreeing) with the statement, compared to less than one-quarter for men. Those in treatment locations exposed to three or more means of information on HIV&AIDS were more likely to hold more positive views that those who had not. Similarly,

in treatment locations, both males and females exposed to STAR/peer educators were significantly more likely to disagree with the statement than those who had not; findings were mixed for control locations.

Qualitative findings suggest that attitudinal change regarding gender-based violence is difficult, as what the World Health Organisation may define as violence is often considered acceptable discipline. Violence in the Programme area appeared to be viewed as unacceptable if it resulted in injury requiring treatment, or if it occurred in public. Views of GBV in terms of what happens 'behind closed doors' are not known. Findings about sexual violence above suggest that there is considerable ambivalence about GBV, while discussions with extension officers suggest that the problem is indeed not perceiving violent acts as violence, and cultural acceptance of this 'discipline', especially among women.

Unfortunately the results of the 2010/2011 Demographic and Health Survey (DHS) were not available at the time of this evaluation. The 2005/6 DHS showed that GBV was indeed a problem, with 36.2% of all women aged 15-49 having experienced physical violence at least once since they turned 15 years of age. Rates were higher for married women compared to single women, and was highest in the Midlands Province (where Gokwe is located), at 54.6%, and also high in Mashonaland East where Nyanga is located (at 46.8%). Violence rates remain high across education status through secondary education, with rates only declining for those with more than a secondary education. For single women subject to violence, in most cases this violence was perpetuated by a parent, sibling, or a teacher.

Sexual violence was noted by 25% of all women interviewed for the 2005/6 DHS, with rates for the Midlands and Mashonaland East above the norm, at over 30%. In general, the lower the level of education, the higher the level of sexual violence.

Overall, 46.7% of women had been exposed to some time of violence, physical, sexual, or both; 8.3% of all women had been subject to physical violence during pregnancy. Emotional violence was also reported at almost 50%.

Conclusion: Programme impact: somewhat positive, but many uncertainties.

Outcome Indicator 1.3: Male and Female Practices Associated with HIV Risk in the Programme Area

Outcome Indicator 1.3 was broken down into five sub-indicators:

- 1.3.1 – Age at First Sexual Encounter
- 1.3.2 – Condom Use Practices
- 1.3.3 – HIV Testing Practices
- 1.3.4 – Sexual Partnerships
- 1.3.5 – Sexual Diseases

Age at First Sexual Encounter

Towards the end of the questionnaire questions were asked about sexual practices. Respondents who had ever had sex were asked their age at first sexual encounter. Some 90% of the respondents had had sex, and of these, the median age at first sex was 19 for males in Gokwe and 20 for males in Nyanga, and 18 for females in Gokwe and 19 for females in Nyanga. In Gokwe, one-third of female respondents were sexually active between the ages of 15-17, rising to almost 40% in the treatment locations. Rates were much lower in Nyanga, with one-fifth of females indicating being sexually active between the ages of 15-17. Some 1-3% of females noted being sexually active before the age of 15.

In discussing these findings in Gokwe with the field teams, a number of concerns were expressed about the likely understatement of the percentage of women sexually active before the age of 18, especially among those who were currently married. During interviews, some women were reported to note that they because sexually active at the onset of marriage, with the enumerators concerned that this was due to a desire not to show that they were sexually active before marriage. The extent to which this was the case cannot be established, and it should be noted that over 40% of those in Gokwe treatment locations indicated that they were sexually active before the age of 18. Further, the 2005/6 DHS (Macro International, 2007) found that 21.3% of all women indicated their first sexual intercourse was 'at the time of first marriage'. One possibility is that the DHS had the same problem as the survey in terms of overstatement of first sex at the time of marriage, but it may well be that the two sets of findings are correct. As noted, this cannot be confirmed.

In discussing this further, one common statement was that those who were sexually active at a younger age were more likely to have been forced, rather than agreeing to sex. In looking at DHS results for 2005/6 (Macro International, 2006), this was somewhat the case, with rates of forced sex at 23.7% for those who were sexually active before the age of 15. However, this only dropped to 22% for those aged 15-19, and 19.3% for those who had their first sexual encounter aged 20-24.

Conclusion: Programme impact: programme timeline too short to have impacts on this measure

Condom Use Practices

Condom use practices ranged considerably across location, from a low of 43.5% in Gokwe (treatment) to 74.3% for Nyanga (treatment). Overall, condom use rates were higher in Nyanga than in Gokwe, holding for both males and females. Condom use rates at first sex was consistent across the two treatment locations, as well as the two control locations, while condom use rates were higher for males in control locations than in treatment locations. For males in treatment and control locations, those exposed to STAR/peer educators were more likely to have used condoms than those who had not. This did not hold for females in treatment locations, and only help for females in control locations.

Conclusion: Programme impact: somewhat positive.

HIV Testing Practices

High numbers of women had sought testing, holding for all locations except Gokwe control wards, but even here over half of all females had gone for testing. In Gokwe, some 80% of all females had gone for testing, while in Nyanga the figure approached full coverage (96.3% treatment, 90% control). Males were less likely to have gone for testing, but in Nyanga figures were nevertheless high, at around 70%. In Gokwe, those who had been exposed to three or more sources of information on HIV were more likely to have gone for testing that those with low exposure (57.4% versus 29.2%), and those in treatment locations with high exposure to information on HIV were more likely to have gone for testing than those in control locations (57.4% versus 34.2%). In Nyanga, there was no difference between treatment and control locations, and little difference based on levels of exposure to information on HIV. When findings were checked against level of exposure to STAR/peer educators, findings were mixed, in some cases showing no difference, in others showing treatment areas higher and in others treatment areas lower. Findings suggest that such exposure bears little direct relationship with testing behaviours.

For females who had not gone for testing, in some cases the numbers were too low to draw conclusions (Gokwe treatment, Nyanga treatment, Nyanga control for women). For the remaining locations, it is of concern that, for males, the most common reason for not having gone for testing is that 'I am healthy, no testing is therefore needed', followed by 'all my sexual partners were healthy'. Findings suggest that the concerns raised earlier about a lack of understanding about the length of the asymptomatic period for HIV means that testing is still linked to the signs of illness among at least a minority of the population. Fear of results were rarely mentioned, except by males in Nyanga control locations. Of interest, for the 27.3% of females with low exposure to information on HIV, 61.6% noted that they had not gone for testing because this was forbidden by their spouses.

Conclusion: Programme impact: In Gokwe, it appears that roll out of VCT services under the Programme has resulted in increased access to testing, generally for females. In Nyanga this was not the case, perhaps due to the greater availability of testing services unrelated to the Programme. Conclusion: positive impacts in Gokwe.

Sexual Partnerships

The vast majority of respondents had a current regular, long-term partner, at over 90% for males and over 85% for females. In the majority of these cases, these are spouses, at over 80% for males and over 90% for females. The median number of regular partners for females across location was 1, although the mean was slightly higher, at up to 1.05 in Gokwe control locations and 1.02 in Nyanga treatment locations. For males in Gokwe, some 20% of males had a second or third regular partner, compared to under 10% for males in Nyanga. For these groups, in most cases these partnerships were concurrently rather than serial, suggesting

higher levels of risk, especially when considering low levels of condom use (at around 10% across location and across sex). In Gokwe, males with low levels of exposure to information on HIV were substantially more likely to have had more than one regular partner than those with higher levels of exposure, at 1.75 partners in the low exposure group to 1.18 in the high exposure group, and with 30.1% of those in the low exposure group having more than one regular partner compared to 13.7% for high exposure groups. In Nyanga, there was no difference across the two groups.

In Gokwe, some 8% of males in Gokwe treatment locations had at least one casual sexual partner in the year before the survey, compared to 18% for those in Gokwe control locations. In Nyanga, on the other hand, there was no difference across the two groups, with figures around 10%. For males in treatment locations, when comparing those exposed to STAR/peer educators to those who were not, those with exposure to STAR/peer educators were more likely to have had fewer regular partners in the year before the survey. This was not the case in control locations. Nor was it the case for casual partnerships, where findings were quite mixed in treatment locations, and where there was no differences in control locations. This is consistent with findings from the 2010/11 DHS, at 10% for Mashonaland East and 11.7% for the Midlands, and 11.7% for the male population nationally.

Low numbers of female respondents reported casual sexual partnerships, with a high of 3.7% in Gokwe control locations and 1% in Gokwe treatment locations, and a low of 0% in Nyanga treatment locations. This is consistent with findings from the 2010/11 DHS, at 0.9% for Mashonaland East, 2.2% in the Midlands, and 2.3% overall for females.

National findings from the 2005/6 DHS (Macro International, 2007) initially suggested that the number of sexual partners has declined in Zimbabwe. In 2006, the figure was 9% for males and 1% for females, a drop from 12.9% for males and 1.7% for females in 1999. Nationally, this has since risen to 11.9% for males and 2.3% for females in 2010/11. For Manicaland and Midlands, however, downward trends appear to continue, but at rates higher than national norms.

Conclusion: Programme impact: uncertain, but not likely to have affected behaviours in terms of partnerships, given the mixed findings for regular and casual partners.

Sexual Diseases

The sample size did not yield sufficient numbers to analyse the data from the quantitative survey, coupled with a 'skip' error in the questionnaire that did not ask the questions to those without casual partners. Unfortunately, preliminary findings from the 2010/11 DHS did not include a discussion of sexual diseases, so the only available data come from before the Programme implementation period.

Conclusion: No conclusions can be drawn.

Outcome Indicator 1.4: Level of HIV Seroprevalence

Outcome Indicator 1.4 comprised a single measure of HIV seroprevalence. In 2010, for adults aged fifteen and older, the HIV seroprevalence rate was 14.3% (see UNGASS progress report, NAC, 2010). This is substantially down from 23.7% in 2001, and 18.4% in 2005. For those aged 15-24, the trend was similar, at 17% in 2005, 13.1% in 2007, and 5.1% in 2009. Despite the trend, the rate still continues to be much higher for women than men, especially for younger age groups, where 15-24s showed a 6.9% rate for women and 3.2% for men. The number of people living with HIV continues to decline, from 1.3 million in 2007 to 1.2 million in 2009. Key factors, according to the NAC (2010) report, has been the improved availability of testing services and antiretrovial access (including the prevention of mother to child transmission), the premature deaths of those previously infected with HIV from peak years, and behavioural change, notably a reduction in the number of concurrent sexual partners and increased condom use in higher risk situations.

Conclusion: No conclusions can be drawn.

Outcome 2: Culture and Tradition and Sexual Decision-Making

The Evaluation Logframe repackaged outcomes from the original logframe, taking care to ensure that outcomes in the logframe were considered in this evaluation. Outcome 2 was "enhanced female decision-making role in sexual decision-making among those reached by the Programme relative to those not reached by the Programme". It should be noted that some of these same measures were discussed related to other indicators, and are repeated below.

Outcome Indicator 2.1: Percentage of Women and Girls, Men and Boys, Who Have Adopted at Least One Positive Behaviour Change Regarding HIV&AIDS

Outcome Indicator 2.1 was broken down into three sub-indicators:

- 2.1.1 – Condom Use
- 2.1.2 – Age Gap Between Sexual Partners
- 2.1.3 – Male Circumcision

Outcome Sub-Indicator 2.1.1: Condom Use

Condom use practices ranged considerably across location, from a low of 43.5% in Gokwe (treatment) to 74.3% for Nyanga (treatment). Overall, condom use rates were higher in Nyanga than in Gokwe, holding for both males and females. Condom use rates at first sex was consistent across the two treatment locations, as well as the two control locations, while condom use rates were higher for males in control locations than in treatment locations. For males in treatment and control locations, those exposed to STAR/peer educators were more likely to have used condoms than those who had not. This did not hold for females in treatment locations, and only help for females in control locations.

Conclusion: Programme impact: somewhat positive.

Age Gap Between Sexual Partners

Sexually active women were asked whether they had had a sexual partner who was ten or more years older and, if not, whether they had ever had a sexual partner 5-9 years older. One-quarter of the respondents had had a sexual partner ten or more years older, as follows: Gokwe treatment 24.3%, Gokwe control 26%, Nyanga treatment 27.1%, and Nyanga control 30.7%. Half of those who indicated that they did not have a sexual partner ten or more years older did have a sexual partner who was 5-9 years older. Adding the two together, and half of all women had a sexual partner who was at least five years older than they were. In treatment locations, those who had been exposed to STAR/peer educators were more likely to have not had a sexual partner ten or more years older, while this did not hold for the control locations. This was checked specifically for single women, and the relationship disappeared for Nyanga but held for Gokwe. This was also the case for those aged under 25, where those in Gokwe who had been exposed to STAR/peer educators were less likely to have had a partner aged ten or more years older.

Qualitative interviewees felt that age gaps this wide were increasingly being viewed as less acceptable now than in the past, with the Programme helping young people because it raised the issue of inter-generational sexual issues directly, and opened discussions on the risks associated with these age gaps.

Conclusion: Programme impact: uncertain, but may have had some impacts in Gokwe.

Male Circumcision

Male respondents were asked if they had been circumcised. Findings are as follows: Gokwe treatment 16.3%, Gokwe control 13%, Nyanga treatment 15.3%, Nyanga control 9.9%. This was checked against direct exposure to STAR/peer educators (this was not done for either of the control groups, however, as the number of respondents who were circumcised was too small for analysis). For both control locations, those aged 18-24 were more likely to have been circumcised if they had been exposed to STAR/peer educators. This also held for males aged 18-49.

The UNGASS report (NAC, 2010) noted that the male circumcision rate was a low 10.3% nationwide (2006 data from the DHS). Trends are not certain, and the 2005/6 DHS noted that circumcision did not covary with levels of HIV infection (16.6% of those who were circumcised were HIV positive, compared to 14.2% for those who were not), probably due to other factors. Zimbabwe launched the Male Circumcision Policy in 2009 with the intention of expanding the number of men who were circumcised (see NAC, 2010).

Conclusion: Programme impact: uncertain, but may have had some impacts.

Outcome Indicator 2.2: Open Discussions of Sexuality Issues

Outcome Indicator 2.2 had a single sub-indicator: "relationship attitudes". Eight attitudinal scale statements contributed to an understanding of the indicator, and are discussed below.

One attitudinal scale statement was "people my age talk openly about negative things about sex, such as sexual diseases". There were high levels of agreement with the statement across treatment and control groups, with agreement especially high for the two treatment locations where the respondents had been exposed to three or more means of information about HIV, where it rose to over 95% for males and around 90% for females in both locations. Such discussions were lease common among those who had only been exposed to no or a few forms of information on HIV. When checked against exposure to STAR/peer educators, treatment location males and females who had been exposed to STAR/peer educators were more likely to agree with the statement. This did not hold for control locations.

For the statement "virginity by the time one is married is not as highly prized as it was in the past", the majority of respondents agreed with the statement, with almost all of them 'strongly agreeing' Figures were high for both males and females, and across location.

Regarding the statement "in marriage, the wife has no right to refuse sex, it is entirely up to the husband", over half of female respondents agreed with the statement, while findings varied more for males, from some with those who had been exposed to few or no sources of information on HIV most likely to agree with the statement. With the exception of women in Nyanga, those in treatment locations were more likely to disagree with the statement if they had been directly exposed to STAR/peer educators; findings for control locations were mixed.

For the statement "if a wife tries to refuse sex from a husband, he has the right to discipline her", almost half of all female respondents disagreed with the statement, holding for both treatment and control groups and across Gokwe and Nyanga. Males, on the other hand, were significantly less likely to agree, at some 15-20%. In both treatment and control area locations, those directly exposed to STAR/peer educators were more likely to disagree with the statement, with the gap especially large in treatment area locations.

Regarding the statement "even if a single woman was worried that her sexual partner had other sexual partners, she could not insist on condom use", there was little difference across males and females and across Gokwe and Nyanga. However, those who had low levels of exposure to information on HIV were more likely to agree with the statement than those who had high exposure, and higher than was the case for control groups. For treatment locations, there was no variation across exposure to STAR/peer educators and this attitudinal statement. For control locations, on the other hand, higher levels of exposure covaried with disagreement with the statement.

For the statement "even if a single woman was worried that her sexual partner had other sexual partners, she could not insist on condom use". Findings were quite mixed, with no clear patterns emerging across treatment and control groups and across location. However, for all groups except for males in Gokwe, those with direct exposure to STAR/peer educators were more likely to disagree with the statement than those who were not exposed, holding for both treatment and control groups.

One scale statement was intended to establish whether condom use changed when a relationship changed from casual to serious: "when a relationship among partners moves from casual to serious, condoms are no longer necessary anymore because you trust each other". Approximately half of the respondents agreed with the statement, with agreement higher in control locations for males than in control locations for both Gokwe and Nyanga, and also higher for those with three or more means of exposure to information on HIV compared to those with up to two sources. In most cases, holding for treatment and control locations, those who were not directly exposed to STAR/peer educators were more likely to agree with the statement, indicating that such exposure tended to result in a more positive attitudes.

A final scale statement of relevance was "in marriage or when living together, condom use is motivated almost entirely by a desire to avoid unwanted pregnancy". Around half of the respondents agreed with the statement, holding for treatment and control locations. In Gokwe, there was a lower level of agreement with the statement, but this was not the case for Nyanga. No clear patterns of variation emerged for males or females, and for Nyanga and Gokwe, with regard to exposure to STAR/peer educators and responses to this attitudinal scale statement.

Conclusion: Programme impact: somewhat positive.

Outcome 3: Improved Attitudes and Practices Around HIV and the Drivers of the Epidemic

The Evaluation Logframe repackaged outcomes from the original logframe, taking care to ensure that outcomes in the logframe were considered in this evaluation. Outcome 3 was "improved attitudes and practices around HIV and drivers of HIV among those reached by the Programme relative to those not reached by the Programme". It should be noted that some of these same measures were discussed related to other indicators, and are repeated below.

Outcome Indicator 3.1: Age at First Sexual Encounter

Outcome Indicator 3.1 was broken down into three sub-indicators:

- 3.1.1 – Age at First Sexual Encounter
- 3.1.2 – Age Gap With Sexual Partners

Outcome Sub-Indicator 3.1.1: Age at First Sexual Encounter

Towards the end of the questionnaire questions were asked about sexual practices. Respondents who had ever had sex were asked their age at first sexual encounter. Some 90% of the respondents had had sex, and of these, the median age at first sex was 19 for males in Gokwe and 20 for males in Nyanga, and 18 for females in Gokwe and 19 for females in Nyanga. In Gokwe, one-third of female respondents were sexually active between the ages of 15-17, rising to almost 40% in the treatment locations. Rates were much lower in Nyanga, with one-fifth of females indicating being sexually active between the ages of 15-17. Some 1-3% of females noted being sexually active before the age of 15.

In discussing these findings in Gokwe with the field teams, a number of concerns were expressed about the likely understatement of the percentage of women sexually active before the age of 18, especially among those who were currently married. During interviews, some women were reported to note that they because sexually active at the onset of marriage, with the enumerators concerned that this was due to a desire not to show that they were sexually active before marriage. The extent to which this was the case cannot be established, and it should be noted that over 40% of those in Gokwe treatment locations indicated that they were sexually active before the age of 18. Further, the 2005/6 DHS (Macro International, 2007) found that 21.3% of all women indicated their first sexual intercourse was 'at the time of first marriage'. One possibility is that the DHS had the same problem as the survey in terms of overstatement of first sex at the time of marriage, but it may well be that the two sets of findings are correct. As noted, this cannot be confirmed.

In discussing this further, one common statement was that those who were sexually active at a younger age were more likely to have been forced, rather than agreeing to sex. In looking at DHS results for 2005/6 (Macro International, 2006), this was somewhat the case, with rates of forced sex at 23.7% for those who were sexually active before the age of 15. However, this only dropped to 22% for those aged 15-19, and 19.3% for those who had their first sexual encounter aged 20-24.

The 2005/6 DHS found that 5.3% of all women aged 15-24 had had sexual intercourse before the age of 15, compared to 4.5% for men, compared to our estimates of 1-3% noted above. Qualitative respondents argued that, in recent years, the onset of sexual activity was getting younger, rather than older, for girls, in part due to transactional sex work. However, in detailed consultations at Programme start-up, most respondents felt that transactional sex work was not common in the Programme areas.

Conclusion: Programme impact: programme timeline too short to have impacts on this measure

Outcome Sub-Indicator 3.1.2: Age Gap With Sexual Partners

Sexually active women were asked whether they had had a sexual partner who was ten or more years older and, if not, whether they had ever had a sexual partner 5-9 years older. One-quarter of the respondents had

had a sexual partner ten or more years older, as follows: Gokwe treatment 24.3%, Gokwe control 26%, Nyanga treatment 27.1%, and Nyanga control 30.7%. Half of those who indicated that they did not have a sexual partner ten or more years older did have a sexual partner who was 5-9 years older. Adding the two together, and half of all women had a sexual partner who was at least five years older than they were. In treatment locations, those who had been exposed to STAR/peer educators were more likely to have not had a sexual partner ten or more years older, while this did not hold for the control locations. This was checked specifically for single women, and the relationship disappeared for Nyanga but held for Gokwe. This was also the case for those aged under 25, where those in Gokwe who had been exposed to STAR/peer educators were less likely to have had a partner aged ten or more years older.

Qualitative interviewees felt that age gaps this wide were increasingly being viewed as less acceptable now than in the past, with the Programme helping young people because it raised the issue of inter-generational sexual issues directly, and opened discussions on the risks associated with these age gaps. In part this was noted as being due to less acceptance of age gaps between young girls and older men at marriage.

Conclusion: Programme impact: uncertain, but may have had some impacts in Gokwe.

Outcome Indicator 3.2: Prevalence of Gender-Based Violence and Child Sex Abuse in the Programme Area

Outcome Indicator 3.2 comprised two measures:

- 3.2.1 – Prevalence of Gender-Based Violence Affecting Women
- 3.2.2 – Incidence of Child Sexual Abuse

Outcome Sub-Indicator 3.2.1: Prevalence of Gender-Based Violence Affecting Women

The questionnaire was too short to include the thirty or more questions that would have had to be included to measure gender-based violence, and the single measure did not work because of a mistake on a 'skip' prompt in the questionnaire. The issue was nevertheless covered in one attitudinal scale statement on attitudes towards gender-based violence that would inform practices, as well as qualitative findings and findings from discussions with Programme personnel.

One attitudinal scale statement covered GBV, "if a wife tries to refuse sex from a husband, he has the right to discipline her". Of interest, females were considerably more likely to agree with this statement than males, with an average of half of all women agreeing (and most of them strongly agreeing) with the statement, compared to less than one-quarter for men. Those in treatment locations exposed to three or more means of information on HIV&AIDS were more likely to hold more positive views that those who had not. Similarly, in treatment locations, both males and females exposed to STAR/peer educators were significantly more likely to disagree with the statement than those who had not; findings were mixed for control locations.

Qualitative findings suggest that attitudinal change regarding gender-based violence is difficult, as what the World Health Organisation may define as violence is often considered acceptable discipline. Violence in the Programme area appeared to be viewed as unacceptable if it resulted in injury requiring treatment, or if it occurred in public. Views of GBV in terms of what happens 'behind closed doors' are not known. Findings about sexual violence above suggest that there is considerable ambivalence about GBV, while discussions with extension officers suggest that the problem is indeed not perceiving violent acts as violence, and cultural acceptance of this 'discipline', especially among women. In discussions with Programme personnel, there was general agreement that much needed to be done about GBV, in many respects because violent acts were not perceived as violence, consistent with qualitative findings. This meant that changes in attitudes towards GBV, in particular for women, would take time and behavioural change would therefore also take time.

Unfortunately the results of the 2010/2011 Demographic and Health Survey (DHS) were not available at the time of this evaluation. The 2005/6 DHS showed that GBV was indeed a problem, with 36.2% of all women aged 15-49 having experienced physical violence at least once since they turned 15 years of age. Rates were higher for married women compared to single women, and was highest in the Midlands Province (where Gokwe is located), at 54.6%, and also high in Mashonaland East where Nyanga is located (at 46.8%). Violence rates remain high across education status through secondary education, with rates only declining for those with more than a secondary education. For single women subject to violence, in most cases this violence was perpetuated by a parent, sibling, or a teacher.

Sexual violence was noted by 25% of all women interviewed for the 2005/6 DHS, with rates for the Midlands and Mashonaland East above the norm, at over 30%. In general, the lower the level of education, the higher the level of sexual violence.

Overall, 46.7% of women had been exposed to some time of violence, physical, sexual, or both; 8.3% of all women had been subject to physical violence during pregnancy. Emotional violence was also reported at almost 50%.

Conclusion: Programme impact: somewhat positive, but many uncertainties.

Outcome Sub-Indicator 3.2.2: Incidence of Child Sexual Abuse

Qualitative respondents tended to agree that child sexual abuse was on the decline, and that when it did occur it was more likely to be reported. This was in part attributed to in school Programme support activities that raised awareness about the forms of child abuse and the risk factors, while respondents were concerned that in schools not reached by the Programme, the problems remained. UNICEF (2010) notes that 25% of girls who were HIV positive had been exposed to sexual violence before they turned eighteen. According to the 2006 DHS (Macro International, 2007), 21% of women reported that their first sexual encounter was forced;

data were not yet available from the 2010/11 DHS. Concern monitoring data indicated that 44 child sexual abuse cases were reported during 2010 in the Gokwe area, covering both districts; data were not available for Nyanga, and no trend data were available for either location.

Conclusion: Programme impact: uncertain, but possibly positively impacted by the Programme.

Outcome Indicator 3.3: Prevalence of Forced Sexual Encounters Among Women

Outcome Indicator 3.3 comprised a single measure, "Forced Sexual Encounter in the Year Before the Survey for Females".

Outcome Sub-Indicator 3.2.1: Prevalence of Gender-Based Violence Affecting Women

The sample size was too small to pick up information on forced sexual encounters directly. In looking at DHS results for 2005/6 (Macro International, 2006), the overall forced sex rate was 21%, with rates of forced sex at 23.7% for those who were sexually active before the age of 15. This only dropped to 22% for those aged 15-19, and 19.3% for those who had their first sexual encounter aged 20-24.

Conclusion: Programme impact: uncertain, but felt to likely be insignificant because of the complexity of the problem and the many factors needing consideration to change GBV practices.

Outcome 4: VCT, PMTCT, STIs

The Evaluation Logframe repackaged outcomes from the original logframe, taking care to ensure that outcomes in the logframe were considered in this evaluation. Outcome 4 was "increased access to and use of VCT, PMTCT, and STI management services". It should be noted that some of these same measures were discussed related to other indicators, and are repeated below.

Outcome Indicator 4.1: Access to and Use of VCT

Outcome Indicator 4.1 was broken down into two sub-indicators:

- 4.1.1 – Attitudes Towards VCT
- 4.1.2 – VCT Practices

Outcome Sub-Indicator 4.1.1: Attitudes Towards VCT

Qualitative respondents tended to feel that attitudes towards VCT had improved in the Programme area, but that the supply of drugs for those who were found to be HIV positive had constrained demand for testing. Given that drug supply as well as testing services had improved, in particular in Gokwe compared to the earlier situation, and given high levels of actual testing (noted under the sub-indicator described below), it is likely that attitudes have been improving over time.

Conclusion: Programme impacts: likely to be positive.

Outcome Sub-Indicator 4.1.2: VCT Practices

High numbers of women had sought testing, holding for all locations except Gokwe control wards, but even here over half of all females had gone for testing. In Gokwe, some 80% of all females had gone for testing, while in Nyanga the figure approached full coverage (96.3% treatment, 90% control). Males were less likely to have gone for testing, but in Nyanga figures were nevertheless high, at around 70%. This is consistent with figures from the Programme monitoring system, which show 15,170 females having gone for counselling and testing services, compared to 5,851 men.

In Gokwe, those who had been exposed to three or more sources of information on HIV were more likely to have gone for testing that those with low exposure (57.4% versus 29.2%), and those in treatment locations with high exposure to information on HIV were more likely to have gone for testing than those in control locations (57.4% versus 34.2%). In Nyanga, there was no difference between treatment and control locations, and little difference based on levels of exposure to information on HIV. When findings were checked against level of exposure to STAR/peer educators, findings were mixed, in some cases showing no difference, in others showing treatment areas higher and in others treatment areas lower. Findings suggest that such exposure bears little direct relationship with testing behaviours, and that other factors are more important.

For females who had not gone for testing, in some cases the numbers were too low to draw conclusions (Gokwe treatment, Nyanga treatment, Nyanga control for women). For the remaining locations, it is of concern that, for males, the most common reason for not having gone for testing is that 'I am healthy, no testing is therefore needed', followed by 'all my sexual partners were healthy'. Findings suggest that the concerns raised earlier about a lack of understanding about the length of the asymptomatic period for HIV means that testing is still linked to the signs of illness among at least a minority of the population. Fear of results were rarely mentioned, except by males in Nyanga control locations. Of interest, for the 27.3% of females with low exposure to information on HIV, 61.6% noted that they had not gone for testing because this was forbidden by their spouses.

Conclusion: Programme impacts: In Gokwe, it appears that roll out of VCT services under the Programme has resulted in increased access to testing, generally for females. In Nyanga this was not the case, perhaps due to the greater availability of testing services unrelated to the Programme. Conclusion: positive impacts in Gokwe.

Outcome Indicator 4.2: Access to PMTCT Services

Outcome Indicator 4.2 was broken down into two sub-indicators:

- 4.2.1 – Access to PMTCT Services
- 4.2.2 – Use of PMTCT Services

Outcome Sub-Indicator 4.2.1: Access to PMTCT Services

PMTCT services have expanded rapidly in Zimbabwe, more than doubling from 2007 to 2009 (see NAC, 2010), and there have been increased services made available in the Programme Area. In the Programme Area, a total of 3,116 women had secured PMTCT services, but information is not available on the proportion of those in need reached.

Conclusion: Programme impacts: uncertain overall, but positive for those reached.

Outcome Sub-Indicator 4.2.2: Use of PMTCT Services

Key informants tended to feel that, because of expanded donor support and government commitment, PMTCT was rapidly expanding, and would continue to do so. The UNGASS report (NAC, 2010) noted dramatic increases in service availability, from 6.6% coverage in 2005 to 22% in 2007 and 42.6% in 2009. With high levels of ante-natal care access (WHO/UNAIDS/UNICEF, 2008, found coverage at 95% in 2008), continued rapid expansion in access and therefore use would be expected. Unfortunately, data are not available covering the Programme Area, beyond the fact that 3,116 women accessed PMTCT services (with no data on those *not* reach available).

Conclusion: Programme impacts: uncertain overall, but positive for those reached.

Outcome Indicator 4.3: Access to and Use of STI Services

Outcome Indicator 4.3 was broken down into two sub-indicators:

- 4.3.1 – Access to STI Services
- 4.3.2 – Use of STI Services

Outcome Sub-Indicator 4.3.1: Access to STI Services

Unfortunately no data are available on levels of STI infection, none on levels and trends in the Programme area, nor on Programme impacts on STI services. Unfortunately, data are not available covering the Programme Area.

Conclusion: Programme impacts: uncertain overall, but positive for those reached.

Outcome Sub-Indicator 4.2.2: Use of STI Services

Unfortunately no data are available on levels of STI infection, no on levels and trends in the Programme area, nor on Programme impacts on STI treatment-seeking behaviours. Programme monitoring data indicate that 636 women and 557 men sought STI services during Programme implementation, but no data are available on the proportion of those in need so reached.

Conclusion: Programme impacts: uncertain overall, but positive for those reached.

Outcome 5: Livelihoods Enhancement

The Evaluation Logframe repackaged outcomes from the original logframe, taking care to ensure that outcomes in the logframe were considered in this evaluation. Outcome 5 was "increased access to cash through livelihoods enhancement".

Outcome Indicator 5.1: Attitudes About Impacts of Livelihoods Enhancement Activities on Women and HIV Outcomes

Outcome Indicator 5.1 was broken down into two sub-indicators:

- 5.1.1 – Perceived Relevance of Livelihoods Support to Desired HIV Outcomes
- 5.1.2 – Perceived Impacts of Livelihoods Support on Desired HIV Outcomes

Outcome Sub-Indicator 5.1.1: Perceived Relevance of Livelihoods Support to Desired HIV Outcomes

Qualitative respondents tended to agree that livelihoods support was central to a reduction in risk behaviours by young women, but that Programme reach was insufficient to have much impact. In qualitative discussions and key informant interviews, the Gokwe goat intervention was felt to have failed, but there were positive impacts of the intervention with local NGOs in Nyanga. The problem with the Gokwe goat intervention appears to relate to lack of clear objectives on what this was intended to accomplish, lack of effective consultation throughout the process, poor targeting, and lack of follow-up.

In discussions with Programme personnel, they noted that they felt that there was strong support for livelihoods activities among Programme area residents, largely due to the overwhelming need for improved livelihoods and currently constrained choices.

In this respect, relevance was felt to be very high. Relevance to transactional sex was likely to be minor, but relevance to the economic empowerment of women, giving them greater control over decisions made in households and given them more power in the household, was of specific relevance as a desired HIV outcome.

Conclusion: Programme impacts: little in Gokwe, some reach in Nyanga.

Outcome Sub-Indicator 5.1.2: Perceived Impacts of Livelihoods Support on Desired HIV Outcomes

A 2011 impact assessment of ASAP's activities for the Programme (ASAP was the local implementing partner in Nyanga, see Hamadziripi, 2011), found that the success of income generation support had a direct impact on the lives of women reached by the Programme in Nyanga, but that the number of persons so reached was considered to be quite small compared to the need. Key informants interviewed for the end-of-programme evaluation were ambivalent about impacts on desired HIV outcomes, however, mentioning the depth of poverty and the need for transactional sex work at times. These key informants also mentioned the restricted number of persons reached. Findings are even more uncertain when one considers that the prevalence of transactional sex work was felt to be low at Programme start-up, noted in the baseline reports.

In a review workshop held in Nyanga in early 2011 ("HIV/AIDS Review and Planning Workshop – Village Inn; Nyanga 22-24 February 2011), participants who had been involved in "A Self Assistance Programme" (ASAP) noted that mainstreaming HIV into livelihoods had had an important impact on risk reduction by

women involved in the programme. Day to day nutrition needs and the requirement for funds to meet regular costs were served, as were special costs such as the need to purchase school uniforms, purchase seasonal inputs for agriculture, etc. Some participants also noted an improved ability to care for those suffering from various illnesses. In an impact assessment of the Internal Savings and Loans programme supported by Concern and implemented by ASAP in Nyanga District, Hamadziripi (2011) noted that the programme had led to the establishment of 297 Internal Savings and Lending groups (compared to a target level of 250), with 1,709 female members (compared to a target of 250), of who 1,604 had received management training and 736 were provided with support for capital purchases.

The evaluation found that the activities supported by ASAP consistently contributed between 60-80% of total monthly household income, and was particularly important in flattening income spikes and supporting more regular income (Figure 7 shows dramatic differences between women in the groups and women not in the groups in this regard). Income was used to purchase capital assets that yielded higher returns and improved income stability, with investments in smallstock most commonly noted. Beyond capital purchases and a strengthened ability to run their businesses, group members also noted enhanced financial discipline and focused expenditures, and an improved ability to control one's own expenditures.

A number of the groups interviewed noted that they were able to take what they had learned and apply them to other livelihood aspects of their lives, including in cases of own production for consumption. This included a growing assertiveness and willingness to speak up, and becoming more active in community affairs.

Group members reported initial resistance among family members to the women having more control over earnings and resource allocation, but as time passed and the economic impacts of the programme were felt by family members to be positive, resistance declined.

It is especially important to remember that the group members were engaged in market activities at precisely the time that the economy was collapsing. Hyperinflation was a constant problem, and shortages of a variety of inputs were commonly noted. In this respect the perseverance of members in the face of these challenges were said to be appreciated by family members, both males and females. Further, the groups were said by key informants to have shifted from money to a barter approach at the height of the hyperinflation problem, so that labour could be invested in capital goods that retained value and had a barter 'price' that yielded a positive return on investment.

The impact assessment considered whether the women involved in the programme were able to avoid 'negative coping mechanisms' such as selling sex, because they had alternative income options. The impact

assessment concluded that this was indeed the case, with participants noting the importance of meeting household expenditure needs 'through decent means'.

While the impact assessment largely concluded that impacts had been position, key informants were more ambivalent, arguing that the economic collapse overwhelmed the Programme. The Programme was felt to have provided what, under normal economic conditions, would have allowed women to attain a degree of economic independence, but in the face of such profound challenges, the longer-term outcomes were questionable. Indeed, a number of key informants raised concerns that the ephemeral impacts of the component meant that changes in relationships within families would not 'take hold', and that in the absence of longer-term impacts, no changes would show. This did not imply that the component was unimportant, rather it meant that any future support in this arena needed to focus specifically on sustainability.

Conclusion: Programme impacts: little in Gokwe, some reach in Nyanga.

Outcome Indicator 5.2: Attitudes About Impacts of Livelihoods Enhancement Activities on Transactional Sex

Outcome Indicator 5.2 was broken down into two sub-indicators:

- 5.2.1 – Perceived Relevance of Livelihoods Support on Reduction in Transactional Sex
- 5.2.2 – Perceived Impacts of Livelihoods Support on Reduction in Transactional Sex

Outcome Sub-Indicator 5.2.1: Perceived Relevance of Livelihoods Support on Reduction in Transactional Sex

As noted in the previous sub-section, livelihoods support was felt to offer a means to reduce the risk of transactional sex work, but that key informants were concerned that the depth of poverty was such that livelihoods support would have little immediate impacts on transactional sex. The Hamadziripi (2011) evaluation suggested that, for those directly reached, the impacts were positive, and that the risks had likely been reduced. Qualitative respondents tended to feel that the integration of HIV&AIDS into a livelihoods initiative helped people draw links between economic security and greater control over one's life and decision-making and an ability to avoid infection. The STAR groups included in their discussions how this link might be strengthened through various channels, including Concern's livelihoods initiative. However, Programme personnel felt that, unless livelihoods was integrated under an HIV initiative, the link between livelihoods and HIV would be lost. Indeed, the HIV Programme arose because of limitations found with regard to HIV mainstreaming in previous Concern livelihoods initiatives.

In this respect, relevance was felt to be very high. However, its relevance to *transactional sex* was less clear. Economic empowerment of women, giving them greater control over decisions made in households and given them more power in the household, was a key outcome of the STAR group activities in particular. If

the shift was more towards increasing the influence and power of women in the household, relevance could be considered much higher.

Conclusion: Programme impacts: uncertain.

Outcome Sub-Indicator 5.2.1: Perceived Impacts of Livelihoods Support on Reduction in Transactional Sex

As noted in the previous sub-section, the 2011 impact assessment of ASAP's activities for the Programme (Hamadziripi, 2011) found that the success of income generation support had a direct impact on the lives of women reached by the Programme in Nyanga, but that the number of persons so reached was considered to be quite small compared to the need. Key informants interviewed for the end-of-programme evaluation were ambivalent about impacts on desired HIV outcomes, however, mentioning the depth of poverty and the need for transactional sex work at times. These key informants also mentioned the restricted number of persons reached, which was also noted in the mid-term review of the Programme.

Conclusion: Programme impacts: uncertain.

Annex B: Evaluation Logframe Findings- Impact Assessment

Problems were encountered in trying to operationalise the log frame and measuring the proposed and ambitious indicators. In response, an end line/impact assessment was developed as part of the end of project evaluation, with reformulated and realistic indicators. Below are the findings of the impact assessment. Indicator values are summarised in the following tables, by outcomes.

Outcome Indicator Findings	**Outcome Level Sub-Indicator Findings**
Goal To reduce the prevalence and impact of HIV&AIDS through community empowerment of women and girls, men and boys in the Programme Area **Outcome 1** Increased levels of knowledge, improved attitudes, and improved practices about HIV among those reached by the Programme relative to those not reached by the Programme **Other Measures** Covers measures under outcome indicators under Output 1a **Limitations and Issues Arising** For outcome 1, no outcome sub-indicators exist for the indicator of achievement 'improved KAP in the Programme Area', so they have been created as part of this Evaluation Logframe	
Outcome Indicator 1.1: Level of knowledge of males and females about HIV across the Programme Area	
Outcome Sub-Indicator 1.1.1 Basic knowledge of HIV&AIDS	Survey results: Correct knowledge of the relationship between HIV&AIDS and the asymptomatic period for HIV (of those who had ever heard of HIV/AIDS, at almost 100%): under 10%. No clear variation across treatment and control locations. The 2005/6 DHS showed that almost 100% of the respondents aged 15-49 had heard of AIDS (97.8% for females, 98.4% for males), with similar findings for 2010/11 (97.9% for females, 99.2% for males) (see CSO, 2006 and CSO 2011). Figures for the Midlands and for Manicaland were similar to the national average. By 2009 some 13,000 people had been reached via STAR, according to the Concern monitoring system. Concern monitoring system noted that two patrons per school for reached school had been trained in 2010 (22 schools, 44 patrons). Qualitative findings at STAR schools highlight high levels of knowledge about HIV&AIDS in these schools. Concern monitoring data indicated that, in Gokwe North in 2009, 23.1% of respondents had never heard of HIV&AIDS.
Outcome Sub-Indicator 1.1.2 Understanding of how HIV is spread and not spread	Survey results: Knowledge of PMTCT: some 2/3rds knew. No clear variation across treatment and control locations. Knowledge that mosquitoes could not transit the virus: 2/3rds – 3/4s knew, with no clear variation across treatment and control locations. Knowledge that touching could not spread the virus: some 90% knew, with no clear variation across treatment and control locations.

Outcome Indicator Findings	Outcome Level Sub-Indicator Findings
	Knowledge that someone with HIV could look healthy: some 80%, with no clear variation across treatment and control locations. Perception that condom use could *increase* the risk of HIV infection: 15-20%, higher in control than in treatment locations. Belief that HIV can be 'created' through sex, even if neither partner is HIV+: higher for women than men, at one-quarter versus 10% for males. Slightly higher for control locations. Perception that HIV is not possible to transmit if it is the first time a person is having sex: between 30-40% of females answered this incorrectly, compared to 20% average for males. Those in treatment locations more likely to answer question correctly.
Outcome Sub-Indicator 1.1.3 Knowledge of ways to reduce the risk of HIV infection	Survey results: Knowledge of means of reducing the risk of HIV infection: over 90%. Over 10% of these noted that HIV infection risks could be reduced by using a condom 'if you suspect AIDS'. However, most others gave multiple responses, all correct. UNGASS Progress Report (NAC, 2010) noted that 2009 Multiple Indicator Monitoring Survey found that 56.4% of women aged 20-24 knew 2+ ways of preventing HIV transmission. WHO/UNAIDS/UNICEF (2008) noted that, in 2006, the figure was 45% (46% males, 44% females). 2005/6 DHS noted that, for women, 80.9% of 15-49 year olds mentioned 'using condoms' to prevent infection with HIV. 75.4% noted sticking to one uninfected partner. For me, 82.4% mentioned 'using condoms', while 91.1% mentioned sticking to one uninfected partner. Rates were substantially lower for those with no education than those with even primary education. For 2010/11, the rates changed only modestly (females 75.7% condoms, 80.8% one partner; males 81.4% condoms, 84.7% one partner).
Outcome Sub-Indicator 1.1.4 Knowledge of STIs	Survey results: Around 80% of females and 90% of males had heard of any STI. Higher for Nyanga than Gokwe. No variation across treatment and control groups. Of those who had heard of STIs, 20% of females and between 15-30% of males could not name any specific type of symptoms in males. For females and symptoms, 1/3-1/2 of males could not specify symptoms (nor did they mention 'females do not often show symptoms'), now could 15% of females.
Outcome Indicator 1.2: Male and female attitudes about HIV and GBV in the Programme Area	
Outcome Sub-Indicator 1.2.1 Attitudes about PLHIV	Survey results: "I would still be friends with someone if I learned that they had HIV/AIDS". 60-75% agreed. Those with higher levels of exposure to information on HIV&AIDS were more likely to agree in Gokwe, but this did not hold for Nyanga. "If I had a family member who had HIV/AIDS, I would want it to be kept a secret". Over half of female respondents disagreed, compared to under half for males. No clear patterns of variation across treatment and control groups. "I would be willing to care for a family member who had HIV/AIDS when they became sick, even if I thought that there was a risk of infection". Well over 90% agreement, with no variation across treatment and control groups. "If a teacher has HIV/AIDS, s/he should still be allowed to teach". Between 60-80% agreement, with agreement stronger for males than females. No clear variation across treatment and control groups. "If a student is found to have HIV/AIDS, s/he should be expelled from school". Under one-fifth agreed, with no variation across treatment and control groups. "A shopkeeper who is infected with HIV/AIDS should still be allowed to sell products, even fresh produce". Considerable variation on levels of agreement, across treatment and control (with treatment values higher for treatment except for Nyanga females) groups, and considerably different for males and females (higher for females in some cases, higher for males in some cases).

Outcome Indicator Findings	Outcome Level Sub-Indicator Findings
	Qualitative respondents tended to agree that stigma has declined due to Programme activities, in part because it dealt with these issues quite openly, and also in part because it helped overcome myths around how HIV is spread. DHS (2005/6) found that 91% of female respondents were willing to care for a family member with HIV, compared to a much lower 71% for males. 56.8% would purchase fresh vegetables from shopkeepers who were HIV+, compared to 67.1% for males. 71.4% of females indicated that they would allow a female teacher to continue to teach even if she was HIV+, compared to 74.4% for males. Data for 2010/11 were not available at the time of preparing this report.
Outcome Sub-Indicator 1.2.2 Attitudes about condom use	Survey results: "When a relationship among partners moves from casual to serious, condoms are no longer necessary anymore because you trust each other". Almost half agreed with the statement. No clear patterns of variation across location, sex and treatment/control. "In a casual relationship, condom use is motivated almost entirely by a desire to avoid unwanted pregnancy". Some two-thirds of the respondents agreed with the statement, holding for both males and females. Mixed findings regarding treatment/control groups and level of agreement. "In marriage or when living together, condom use is motivated almost entirely by a desire to avoid unwanted pregnancy". Approximately half agreed, holding for both males and females. Agreement tended to be higher for males than females. For Gokwe, agreement lower for the treatment group than the control group; this was not the case for Nyanga. Concern monitoring data showed 19.6% condom use at baseline in Gokwe North, while comparative data for December 2010 appears to cover the full project area, suggesting the figure was 50.8%. Qualitative respondents tended to argue that attitudes about condom use had improved significantly in recent years, and that Programme activities were important in this regard. Nevertheless, felt to be a considerable barrier for married women unless the husband agreed, probably linked to pregnancy prevention.
Outcome Sub-Indicator 1.2.3 Attitudes about the role of women and men in sexual decision-making	Survey results: "Really, within a marriage a woman cannot initiate condom use, even if she wants to prevent pregnancy, as it is up to the man". In most cases over half agreed with the statement, with females consistently more likely to agree than males. Agreement levels lower for those in treatment locations than in control locations. "Even if a single woman was worried that her sexual partner had other sexual partners, she could not insist on condom use". Males somewhat more likely to agree than females. Little variation across treatment and control groups. "Abstinence from sex is difficult for single women because men control decisions on sex". Mixed findings, no clear patterns emerged. Qualitative respondents were relatively ambivalent in considering whether there had been changes in the role of women in sexual decision-making. For unmarried women, economic empowerment was felt to have played a positive role in empowering women, but for married women it was felt that things may not have changed. In situations of marriage, economic decision-making was felt to have changed in cases where women were able to contribute to the household economy. Even here, however, the total numbers reached were relatively small compared to the population it the area, so impacts were felt to be limited.
Outcome Sub-Indicator 1.2.4 Attitudes about HIV&AIDS	Survey results: "Really, there are many things about HIV&AIDS that I simply do not understand". Well over three-quarters agreed with the statement, rising to over 90% for males in Nyanga. No clear patterns of variation across treatment and control groups. Despite high levels of agreement, most respondents felt that they were more informed now than 3 years ago. Qualitative respondents, almost without exception, felt that the public in general was more empathetic with those who were HIV positive, were less likely to discriminate against those HIV positive, and more likely to feel that those who were HIV should receive help now than at Programme start up.

Outcome Indicator Findings	Outcome Level Sub-Indicator Findings
Outcome Sub-Indicator 1.2.5 Perceived level of risk of HIV infection	Survey results: Perceived high or medium risk: 1/3rd to ½. Higher for control group than treatment group locations. Those who perceived themselves as low or no risk did so because they were living with a faithful partner (most commonly mentioned, especially by male respondents). Others indicated that they had gone for testing and were negative, most commonly mentioned in Nyanga. Concern monitoring system indicated that, in 2007, 30% of respondents felt at risk of HIV infection in Gokwe South, compared to 23.3% for women and 24.8% for men in Gokwe North.
Outcome Sub-Indicator 1.2.6 Attitudes about GBV	Survey results: "In marriage, the wife has no right to refuse sex, it is entirely up to the husband". Agreement higher for females than males. Agreement higher for control locations than treatment locations. "If a wife tries to refuse sex from a husband, he has the right to discipline her". Agreement much higher for females than males. No clear patterns of variation across treatment and control locations. "Even if a single woman was worried that her sexual partner had other sexual partners, she could not insist on condom use". Males somewhat more likely to agree than females. Little variation across treatment and control groups. Among those qualitative respondents who spoke about gender-based violence, there was acknowledgement that it was something that was quite difficult to change, but that it was increasingly being viewed negatively.
Outcome Indicator 1.3: Male and female practices associated with HIV risk in the Programme Area	
Outcome Sub-Indicator 1.3.1 Age at first sexual encounter	Survey results: Mean values between 18-19, lower for females by one year compared to males. % sexually active under the age of 18: around 30% for females, 20% for males. Concern monitoring data indicated that, for those below the age of 15, 12.1% of boys and 5.7% of girls had ever had sex in Gokwe South, compared to 6.9% for boys and 5.3% for girls in Gokwe North in 2009. No 2010 data were available. The DHS for 2005/6 noted that, among women aged 15-24, 16.4% had used a condom the first time they had had sex. A much higher 43.7% of males did so. Data were not yet available for 2010/11.
Outcome Sub-Indicator 1.3.2 Condom use practices	Survey results: Ever used a condom: 30-45%. Higher in control locations than in treatment locations. Higher for males than females in both treatment locations, but not for control locations. Condom use first time sex: one-quarter for females, one-seventh for males. No variation across treatment and control locations. Female initiation of condom use higher than male initiation in the case of first sex, holding for treatment and control groups. UNGASS Report (NAC, 2010): condom use last sex 71.1% males in 2007; not measured in 2009. Condom use last sex for those with multiple concurrent partners was 36.3% for males and 40.8% for females in the 2006 DHS, a drop from 40.1% for males and 45.9% for females in 1999 (see WHO/UNAIDS/UNICEF, 2008).
Outcome Sub-Indicator 1.3.3 HIV testing practices	Survey results: High levels of testing, especially for females, at well over three-quarters. Testing lower for control than treatment locations for Gokwe, but not for Nyanga. Most received the results of their tests, at almost 100% across location. For those who had not gone for testing, low perceived level of risk was commonly mentioned. However, of concern, the most common reason that those who had not been tested stated that they had not gone for testing was because "I am healthy, no testing is needed". This was much higher for males than females, reaching some two-thirds in Gokwe.

Outcome Indicator Findings	Outcome Level Sub-Indicator Findings
	Most qualitative respondents argued that HIV testing was not easily available.
Outcome Sub-Indicator 1.3.4 Sexual partnerships	Survey results: Ever had sex: over 90%. Current regular partner: Over 90% for males, nearly 90% for females. Mean number of regular partners in the past year: Over 1 for males, 1 for females. In Gokwe, some 30% of males had more than 1 regular partner, compared to just over 10% for males in Nyanga. For those who had more than one regular partner, in almost all cases they were concurrent. Low levels of condom use with regular partners, at around 10%. Current casual partners: 10%+ of males had a casual partner in the year before the survey, compared to under 5% for females. No clear patterns of variation across treatment and control locations. Age gap between sexual partners (females only): Percentage who had ever had a sexual partner 10+ years older: around 25% for Gokwe, around 28% for Nyanga. Of those who said 'no' to this question, half had a sexual partner 5-9 years older, meaning that well over half of all women had a sexual partner at least five years older. For 15-49 year olds in 2006, the figure was 9% for males and 1% for females (DHS), a drop from 12.9% for males and 1.7% for females in 1999. Preliminary findings for 2010/11 showed that 11.9% of males and 2.3% of females had two or more sexual partners in the year before the survey, higher than for 2005/6. Figures for Manicaland were as follows: 16.8% males, 0.7% females in 2005/6, 12.8% males, 1.5% females in 2010/11. Figures for Midlands were as follows: 13.4% males, 0.9% females in 2005/6, 11.7% males, 2.2% females in 2010/11.
Outcome Sub-Indicator 1.3.5 Sexual diseases	Survey results: Sample size did not yield sufficient cases to draw conclusions.
Outcome Indicator 1.4: Level of HIV seroprevalence	
Outcome Sub-Indicator 1.4 Level of HIV seroprevalence	2010 – 14.3% for adults aged 15+ (see UNGASS progress report; NAC, 2010) Down from 23.7% in 2001, 18.4% in 2005, 14.3% in 2009. For those aged 15-24: 17% in 2005, 13.1% in 2007, 5.1% in 2009. Rate in 2009 was 6.9% for females aged 15-24, twice the rate for males at 3.2%. Key factors: mortality; PMTCT; behavioural change. Number of people living with HIV: small decrease from 2007 to 2009 from 1.3 to 1.2m

Outcome Indicator Findings	Outcome Level Sub-Indicator Findings
Objective 1.1 To improve successful negotiation of safe and voluntary sexual encounters by women and girls, 10-49 years **Outcome 2** Enhanced female decision-making role in sexual decision-making among those reached by the Programme relative to those not reached by the Programme **Other Measures** None **Limitations and Issues Arising** Data were not collected on those aged 10-17, given sample size issues and ethical considerations. However, for interviewees, data were collected on behaviours in their adolescence. Findings are therefore presented for 18-49 year olds for quantitative data, although other age groups are discussed using qualitative and secondary materials.	
Outcome Indicator 2.1: Percentage of women and girls, men and boys, who have adopted at least one positive behaviour change regarding HIV&AIDS	
Outcome Sub-Indicator 2.1.1: Condom use	Survey results: Ever used a condom: 30-45%. Higher in control locations than in treatment locations. Higher for males than females in both treatment locations, but not for control locations. Condom use first time sex: one-quarter for females, one-seventh for males. No variation across treatment and control locations. Female initiation of condom use higher than male initiation in the case of first sex, holding for treatment and control groups. Concern monitoring data indicated that condom availability was felt to be adequate for only 62% of respondents in Gokwe South, and 51.8% in Gokwe North. For female condoms, the figures (respectively) were 8% and 7.5%. Concern monitoring data also noted 30% condom use (males and females combined) for Gokwe South, and 38.8% for men and 20.3% for women in Gokwe North, in 2007. Qualitative interviewees virtually all argued that condom use had accelerated during Programme implementation, with the Programme playing an important role in destigmatising condom use. Key gaps in terms of reach and demand included younger persons, and married couples.
Outcome Sub-Indicator 2.1.2: Age gap between sexual partners	Survey results: Age gap between sexual partners (females only): Percentage who had ever had a sexual partner 10+ years older: around 25% for Gokwe, around 28% for Nyanga. Of those who said 'no' to this question, half had a sexual partner 5-9 years older, meaning that well over half of all women had a sexual partner at least five years older. Qualitative interviewees felt that this was becoming less accepted now than in the past, with the Programme helping because it raised the issue of inter-generational sexual issues and the risks associated with these gaps in a manner handled in a culturally appropriate manner.
Outcome Sub-Indicator 2.1.3: Male circumcision	Survey results: Gokwe treatment: 16.3%; Gokwe control: 13%; Nyanga treatment 15.3%; Nyanga control 9.9%. UNGASS Report (NAC, 2010) noted that the male circumcision rate was a low 10.3% in 2006 (DHS). Male Circumcision Policy launched in 2009. Important gaps in information about the acceptability of male circumcision culturally, while political commitment was also not certain. The 2005/6 DHS found that HIV seroprevalence was 16.6% for circumcised males, compared to 14.2% for uncircumcised males.

Outcome Indicator Findings	Outcome Level Sub-Indicator Findings
Outcome Indicator 2.2: Open discussions of sexuality issues	
Outcome Sub-Indicator 2.2.1: Relationship attitudes	Survey results: "People my age talk openly about negative things about sex, such as sexual diseases". Agreement higher for both males and females in both locations. No clear variation across treatment and control groups. "Virginity by the time one is married is not as highly prized as it was in the past". Agreement higher for males than females. No clear patterns of variation across treatment and control locations. "In marriage, the wife has no right to refuse sex, it is entirely up to the husband". Agreement higher for females than males. Agreement higher for control locations than treatment locations. "If a wife tries to refuse sex from a husband, he has the right to discipline her". Agreement much higher for females than males. No clear patterns of variation across treatment and control locations. "Even if a single woman was worried that her sexual partner had other sexual partners, she could not insist on condom use". Males somewhat more likely to agree than females. Little variation across treatment and control groups. "When a relationship among partners moves from casual to serious, condoms are no longer necessary anymore because you trust each other". Almost half agreed with the statement. No clear patterns of variation across location, sex and treatment/control. "In a casual relationship, condom use is motivated almost entirely by a desire to avoid unwanted pregnancy". Some two-thirds of the respondents agreed with the statement, holding for both males and females. Mixed findings regarding treatment/control groups and level of agreement. "In marriage or when living together, condom use is motivated almost entirely by a desire to avoid unwanted pregnancy". Approximately half agreed, holding for both males and females. Agreement tended to be higher for males than females. For Gokwe, agreement lower for the treatment group than the control group; this was not the case for Nyanga. Concern monitoring data noted a Gokwe South baseline of 18% and Gokwe North baseline of 12.8% (women) and 8.2% (men) of sexual partners who had discussed sexual issues. Figure for midline appears to be for all Programme areas grouped, showing 18% for women and 14% for men. In 2009 the Concern monitoring system reports that 42.5% of men accept that women can access reproductive health services. No 2010 data are available. Concern monitoring data found that, in 2009, 32.1% of girls and 24.7% of boys in Gokwe South discussed HIV&AIDS with parents/guardians, compared to 17.5% for girls and 15.1% for boys for Gokwe North.

Outcome Indicator Findings	Outcome Level Sub-Indicator Findings
Objective 1.2 To decrease incidence of male-dominated, negative cultural practices fuelling the spread of HIV **Outcome 3** Improved attitudes and practices around HIV and drivers of HIV among those reached by the Programme relative to those not reached by the Programme **Other Measures** Covers measures under outcome indicators under Output 1b **Limitations and Issues Arising** Data were not collected on those aged 10-17, given sample size issues and ethical considerations. However, for interviewees, data were collected on behaviours in their adolescence. Findings are therefore presented for 18-49 year olds for quantitative data, although other age groups are discussed using qualitative and secondary materials	
Outcome Indicator 3.1: Age at first sexual encounter	
Outcome Sub-Indicator 3.1.1: Age at first sexual encounter	Survey results: Mean values between 18-19, lower for females by one year compared to males. % sexually active under the age of 18: around 30% for females, 20% for males. Qualitative respondents argued that, in recently, the onset of sexual activity was quite young, especially for women. Transactional sex was felt to be a problem for younger women in this regard, who had few economic alternatives. 2005/6 DHS found that 5.3% of all women aged 15-24 had had sexual intercourse before the age of 15, compared to 4.5% for men. Data are not yet available for 2010/11.
Outcome Sub-Indicator 3.1.2: Age gap with sexual partners	Survey results: Age gap between sexual partners (females only): Percentage who had ever had a sexual partner 10+ years older: around 25% for Gokwe, around 28% for Nyanga. Of those who said 'no' to this question, half had a sexual partner 5-9 years older, meaning that well over half of all women had a sexual partner at least five years older. Most qualitative respondents noted that inter-generational sex was a common practice years ago, specifically arising from early marriage, and that this was less common today.
Outcome Indicator 3.2: Incidence of gender-based violence and child sex abuse in the Programme Area	
Outcome Sub-Indicator 3.2.1: Prevalence of gender-based violence (females only)	Survey results: Sample size too small to yield results. The 2005/6 DHS found that 36.2% of women had experienced physical violence since they turned fifteen, and 25% had experienced sexual assault at some point in their lives. Overall a total of 47% of all women had experienced physical or sexual violence. In Manicaland, the rate was 32.2%, in Midlands 54.6%. A 2010 study quoted in UNICEF (2010) indicated that GBV had cost the Zimbabwean economy an estimated US$2 billion, including direct costs incurred by survivors and providers, and indirect and multiplier costs.

Outcome Indicator Findings	Outcome Level Sub-Indicator Findings
Outcome Sub-Indicator 3.2.2: Incidence of child sex abuse	Qualitative respondents tended to agree that child sexual abuse was on the decline, and that when it did occur it was more likely to be reported. However, this was in cases where schools had been reached by the Programme, and respondents felt that outside of reached areas, reporting sex abuse was less likely. UNICEF (2010) notes that 25% of girls who are HIV positive had been exposed to sexual violence before they turned eighteen. According to the 2006 DHS (Macro International, 2007), 21% of women reported that their first sexual encounter was forced. Concern monitoring data indicated that 44 child sexual abuse cases were reported during 2010 (not clear if this for Gokwe North and Gokwe South).
Outcome Indicator 3.3: Prevalence of forced sexual encounters (females)	
Outcome Sub-Indicator 3.3.1: Forced sexual encounter in the year before the survey (females)	Survey results: Sample size too small to yield results. 2005/6 DHS found that 21% of women had been forced to have sex the first time they had had intercourse. The figure was significantly higher for those who had first had sex before the age of 15 (23.7%) and those who had first had sex between the ages of 15 and 19 (22%), compared to 19.3% for those aged 20-24 and 6.4% for those aged 25-29 the first time they had had sex.

Outcome Indicator Findings	Outcome Level Sub-Indicator Findings
Objective 2 To increase access to, and uptake of, VCT, PMTCT, and STI management services, in a stigma-reduced environment in the Programme Area **Outcome 4** Increased access to and use of VCT, PMTCT, and STI management services **Other Measures** Covers measures under outcome indicators under Output 2 **Limitations and Issues Arising** Quantitative data collected directly on VCT, but sample size would not allow PMTCT data collection nor treatment seeking behaviours for STIs. Measured through secondary materials.	
Outcome Indicator 4.1: Access to and use of VCT	
Outcome Sub-Indicator 4.1.1: Attitudes towards VCT	Qualitative respondents tended to feel that attitudes towards VCT had improved in the Programme area, but that the supply of drugs for those who were found to be HIV positive constrained demand for testing.
Outcome Sub-Indicator 4.1.2: VCT practices	UNGASS (NAC, 2010) number of stand-alone testing and counselling sites grew from 547 in 2006 to 649 by the end of 2007. There were also over 1000 counselling and referral centres. 2005/6 DHS noted that 74.7% of females and 74.3% of males knew where to go for HIV testing; data are not yet available for 2010/11. 2005/6 DHS found that 25.8% of females and 18.6% of males had gone for testing, of which 6.6% (for both males and females) had been tested and received results in the year before the survey. Data are not yet available from the 2010/11 DHS.
Outcome Indicator 4.2: Access to and use of PMTCT services	
Outcome Sub-Indicator 4.2.1: Access to PMTCT services	UNGASS (NAC, 2010) notes that the number of PMTCT sites increased from 110 in 2007 to 260 in 2009.
Outcome Sub-Indicator 4.2.2: Use of PMTCT services	UNGASS (NAC, 2010) coverage: 6.6% in 2005, 22% in 2007, 42.6% in 2009. WHO/UNAIDS/UNICEF (2008) found antenatal care coverage at a high 95% in 2008. Key informants tended to feel that, because of donor support and consistent government commitment, PMTCT was rapidly expanding, and would continue to do so.
Outcome Indicator 4.3: Access to and use of STI services	
Outcome Sub-Indicator 4.3.1: Access to STI services	[no data yet available]
Outcome Sub-Indicator 4.3.2: Use of STI services	[no data yet available]

Outcome Indicator Findings	Outcome Level Sub-Indicator Findings
Objective 3 To reduce the negative impact of HIV&AIDS on women and girls aged 10-49 through improved, increased, safe and appropriate livelihood activities in the Programme Area **Outcome 5** Increased access to cash through livelihoods enhancement **Other Measures** Covers measures under outcome indicators under Output 3 **Limitations and Issues Arising** Measured qualitatively only, impacts of livelihoods improvements on desired HIV-related factors difficult to establish	
Outcome Indicator 5.1: Attitudes about impacts of livelihoods enhancement activities on women and HIV outcomes	
Outcome Sub-Indicator 5.1.1: Perceived relevance of livelihoods support to desired HIV outcomes	Qualitative respondents tended to agree that livelihoods support was central to a reduction in risk behaviours by young women, but that Programme reach was insufficient to have much impact. Key conclusion drawn in the document "Sex, Rights and the Law in a World With AIDS" (Chirawu, 2009: 3) was consistent with her hypothesis that "… for the law … to be meaningful in the era of HIV and AIDS, there has to be a radical shift towards gender equality by promoting women's economic empowerment … Although not a panacea to the HIV and AIDS epidemic, women's economic empowerment gives women options and hence better protection against HIV and AIDS effects". Elsewhere IPPF/UNFPA/Young Positives (nd: 30) concluded that "Programmes need to go beyond satisfying the practical, short-term survival needs to addressing the strategic (empowerment) interests of the young women and adolescent girls". Impact assessment of the ASAP initiative in Nyanga was felt to be largely positive in terms of linking economic empowerment with reduced risk of HIV infection (see Hamadziripi, 2011). However, key informants were more ambivalent, with concerns raised that the magnitude of the economic challenges and the depth of poverty meant that transactions sex was still an important coping mechanism, even for populations reached with income generation support.
Outcome Sub-Indicator 5.1.2: Perceived impacts of livelihoods support on desired HIV outcomes	Qualitative respondents familiar with the livelihoods initiatives tended to feel that the integration of HIV&AIDS into a programme focused on livelihoods was a sound way of proceeding, and that risk behaviours were reduced as a consequence of this. Without livelihoods support, it was less likely that risk behaviours would be reduced because the factors driving the risk would not have changed. However, such an approach meant that few people could be reached compared to the number at risk.
Outcome Indicator 5.2: Attitudes about impacts of livelihoods enhancement activities on transactional sex	
Outcome Sub-Indicator 5.1.1: Perceived relevance of livelihoods support to a reduction in transactional sex	Qualitative respondents tended to feel that the integration of HIV&AIDS into a livelihoods initiative helped people drawn links between economic security and greater control over one's life and decision-making and an ability to avoid infection. The STAR groups included in their discussions how this link might be strengthened through various channels, whatever support Concern was providing.
Outcome Sub-Indicator 5.1.2: Perceived impacts of livelihoods support to a reduction in transactional sex	Most qualitative respondents argued that transactional and commercial sex work was on the decline, especially in Nyanga, in part because the most difficult years were behind (2008 in particular), but because of changing attitudes due, in part, to the Programme. Livelihoods support, while important for a few, did not have a broad reach. Most of those who advocated a continuation of the Programme focused heavily on the income generation support activities.

Annex C: Tabular Findings from the Quantitative Survey

Table A 1: Administration

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Interview Status								
Fully Completed	100	100	100	100	100	100	100	100
Partially Completed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Number of Visits								
One	95.1	99.7	92.9	97.5	100	100	100	100
Two	4.6	0.3	5.8	2.5	0.0	0.0	0.0	0.0
Three +	0.3	0.0	1.3	0.0	0.0	0.0	0.0	0.0
Substitution Status								
Sample Household	95.3	96.9	94.2	97.5	100	100	100	100
Substituted Household	4.7	3.1	5.8	2.5	0.0	0.0	0.0	0.0
Enumerator Self Check								
Yes	100	100	100	100	100	100	100	100
No	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Survey Supervisor Check Status								
Yes	95.6	100	97.5	98.2	71.6	62.9	72.0	69.7
No	4.4	0.0	2.5	1.8	28.4	37.1	28.0	30.3
Time								
Mean	26.5	23.2	23.6	19.9	16.4	15.5	14.1	14.8
Median	25	23	23	20	16	15	14	14

Table A 2: Demographic Status

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Number of Listed Persons Aged 18-49 in Households								
One	82.2	74.2	78.4	88.3	96.6	97.5	98.0	98.0
Two	10.6	17.6	15.0	10.5	2.0	2.5	1.4	0.0
Three	5.9	6.1	5.9	0.8	1.4	0.0	0.7	2.0
Four	1.2	2.1	0.3	0.4	0.0	0.0	0.0	0.0
Five	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0
Age of Respondent								
Mean	29.8	30.3	29.8	31.5	30.3	30.5	31.2	33.1
Median	28	29	29	29	30	28	30	32
18-24	36.0	32.2	26.2	27.3	28.4	29.4	29.3	20.0
25-34	25.2	40.1	48.6	36.6	36.8	39.9	33.1	35.9
35-49	28.8	27.7	25.2	36.1	34.8	30.8	37.6	44.1
Marital Status of Respondent								
Married – legal	17.9	1.8	10.8	3.5	2.6	0.7	1.9	1.4
Married – traditional	63.9	79.3	62.0	81.1	72.3	80.4	63.7	75.2
Living together in long-term relationship (unmarried)	0.0	0.3	0.0	0.3	0.0	0.0	0.0	0.0
Divorced	0.3	2.4	2.2	5.0	0.6	4.9	1.9	6.9
Widowed	0.3	9.8	2.6	3.1	2.6	9.8	2.5	11.0
Never married/no living together	17.7	6.4	22.4	7.0	21.9	4.2	29.9	5.5
If Married, Age At First Marriage								
Mean	22.3	18.5	22.8	19.1	23.7	19.2	24.8	19.5
Median	22	18	23	18	24	19	25	19
< 16	3.0	9.1	2.2	13.7	0.0	4.3	0.0	3.7
16-17	1.0	25.7	0.4	15.6	0.0	15.7	2.9	13.1
18+	96.0	65.2	97.3	70.7	100	80.0	97.1	83.2
If Married, Spouse Currently Live in Household								
yes	100	88.0	99.6	88.9	99.1	86.2	98.1	74.8
no	0.0	12.0	0.4	11.1	0.9	13.8	1.9	25.2
If Married, # of Wives for Husband								
Mean	1.10	na	1.07	na	1.03	na	1.05	na
Median	1	na	1	na	1	na	1	na
One	91.4	na	92.9	na	97.4	na	95.1	na
Two	8.3	na	7.1	na	2.6	na	4.9	na
Three or more	0.3	na	0.0	na	0.0	na	0.0	na
Highest Education of Respondent								
None	1.9	8.5	2.2	5.3	1.9	4.2	0.6	4.1
Lower Primary (Grades 1-4)	6.8	12.5	8.3	12.0	10.3	9.1	1.9	4.8
Upper Primary (Grades 5-7)	44.5	44.5	40.4	38.1	44.5	61.5	39.5	34.5
Junior Secondary (Secondary Levels 1-2)	19.6	9.4	16.6	14.3	11.6	9.1	17.2	16.6
Senior Secondary (Secondary Levels 3-4)	25.0	25.1	32.5	30.3	26.5	16.1	36.9	39.3
A Level (Secondary Level 5)	1.1	0.0	0.0	0.0	2.6	0.0	1.3	0.7
Graduate/Diploma Holder	1.1	0.0	0.0	0.0	2.6	0.0	2.5	0.0
Still in School								
Yes	5.0	1.6	2.3	1.3	4.0	0.7	1.9	0.7
No	95.0	98.4	97.7	98.7	96.0	99.3	98.1	99.3
If Not In School, When Leave School								
Within the past year	2.6	0.3	3.7	0.0	2.7	0.0	3.3	1.4
Longer again than the past year	97.4	99.7	96.3	100	97.3	100	96.7	98.6
Head of Household								
Male	93.5	79.2	91.5	83.3	94.8	87.4	88.5	82.1
Female de facto	1.6	3.1	3.6	1.9	2.0	0.0	8.9	1.4
Female de jure	4.9	17.7	4.9	14.8	3.3	12.6	2.5	15.9
Female child	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7

Table A 3: Socio-Economic Characteristics and Number of Household Members

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Number of People in Household								
Mean Aged 0-17	3.5	4.0	3.5	4.1	2.9	3.4	2.4	3.2
Mean Aged 18+	3.0	3.1	3.0	2.9	2.5	2.6	2.5	2.7
Median 0-17	3	4	3	4	3	3	2	3
Median 18+	2	2	3	2	2	2	2	2
Mean (all ages)	6.4	7.1	6.5	7.0	5.4	5.9	4.9	5.9
Median (all ages)	6	6	6	6	5	6	5	5
# Earning Cash Income								
Mean	1.3	0.5	1.1	0.4	1.1	0.6	1.1	0.7
Median	1	0	1	0	1	0	1	1
% indicating 'none'	9.9	68.2	21.3	71.9	11.0	50.3	9.6	44.4
% indicating 'some'	90.1	30.8	78.7	28.1	89.0	49.7	90.4	55.6
Respondent Earning Cash Income								
Yes	43.1	10.6	36.8	7.8	41.9	4.9	49.7	12.4
No	56.9	89.4	63.2	92.2	58.1	95.1	50.3	87.6

Table A 4: Knowledge of HIV

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Ever Heard of HIV&AIDS								
Yes	99.5	97.5	99.7	96.2	98.7	100	98.7	100
No	0.5	2.5	0.3	3.8	1.3	0.0	1.3	0.0
Relationship Between HIV and AIDS								
HIV causes AIDS	43.7	21.5	25.2	13.6	42.5	33.6	33.5	30.3
Wrong answer	30.3	26.5	24.9	29.7	31.4	42.0	40.0	49.0
Do not know	26.0	52.0	49.8	56.7	26.1	24.5	26.5	20.7
Knowledge of Asymptomatic Period for HIV								
Do not know	25.5	45.6	39.4	46.6	25.5	37.1	20.0	27.6
Immediately	5.2	2.2	1.9	2.9	5.9	5.6	5.8	4.8
Within a year	18.8	18.8	15.7	13.4	21.6	20.3	26.5	18.6
1-2 years	18.8	9.3	17.1	13.6	17.6	12.6	21.3	17.9
3-5 years	23.5	17.8	18.7	17.6	24.2	16.1	20.6	16.6
6-8 years	3.0	1.9	3.9	3.6	2.0	1.4	1.9	4.1
> 8 years	5.2	4.4	3.5	2.3	3.3	7.0	3.9	10.3
% correct	8.2	6.3	7.4	5.9	5.3	8.4	5.8	14.4
% incorrect	91.8	93.7	92.6	94.1	94.7	91.6	94.2	85.6
Knowledge of Means of Reducing Risk of HIV Infection								
Yes	91.2	84.5	89.6	86.3	96.7	99.3	99.4	96.6
No	1.4	5.2	1.6	5.9	2.0	0.7	0.0	2.1
Do not know/not certain	7.4	10.3	8.7	7.8	1.3	0.0	0.6	1.4
If Yes, What Can Be Done								
Cannot name way, just know	14.1	5.7	7.9	2.3	11.5	0.0	13.5	2.1
Do not share needles	12.7	5.2	5.0	7.8	7.4	24.6	4.5	12.8
Avoid contact with blood	7.8	3.0	3.2	0.7	2.7	2.1	1.3	4.3
Test before having unprotected sex	14.6	12.9	15.3	11.7	15.5	18.3	14.2	8.5
Use a condom every time, all partners	55.9	58.8	58.8	54.3	64.9	78.9	61.9	81.6
Sex one long term partner no signs of illness ten years	4.2	0.0	2.5	0.4	1.4	0.0	2.6	0.0
Abstain from sex until tested and shown HIV-	19.9	9.4	10.3	6.8	25.0	4.2	21.9	7.8
Always abstain, never have sex	10.2	9.8	7.6	3.0	8.1	8.5	6.5	12.8
Pregnant women drugs prevent transmission to child	0.3	4.6	0.4	3.8	0.7	2.8	1.9	2.1
Only have one partner at a time	19.5	15.1	16.4	10.9	12.2	10.6	32.9	22.0
Use condom if suspect AIDS	7.2	11.7	14.5	18.3	8.8	7.0	2.6	2.1
Use condom if have other sexual infection	12.8	8.4	9.4	1.9	8.1	0.7	5.2	0.7
No sex with sex workers	7.8	0.0	7.5	1.5	7.4	0.0	0.0	0.0
Protection via traditional healer	0.0	0.0	0.0	1.5	3.4	0.0	0.0	0.0
Male circumcision	3.0	0.0	1.8	0.0	0.0	0.0	3.9	1.4
Being faithful to one faithful partner	25.9	27.6	27.3	26.5	38.5	26.8	43.2	28.4
Delayed sexual debut until married	0.0	2.3	0.4	4.9	0.7	0.7	4.5	0.7

Table A 5: True-False Questions

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
A woman who is infected with HIV can deliver a child who is not infected								
Correct	67.4	66.7	54.1	66.1	75.8	81.8	69.0	82.1
Incorrect/Not Know	32.6	33.2	45.9	33.9	24.2	18.2	31.0	19.9
A person can get HIV from a mosquito bit								
Correct	72.3	63.9	71.3	61.0	80.4	72.0	82.6	75.2
Incorrect/Not Know	27.7	36.1	28.7	39.0	19.6	28.0	17.4	24.8
HIV can be spread by someone with the virus touching you								
Correct	92.6	82.9	82.9	82.1	91.5	91.6	89.7	96.6
Incorrect/Not Know	7.4	17.1	17.1	17.9	8.5	8.4	10.3	3.4
HIV can be spread by sharing a drink or eating from the same plate as someone who has the virus								
Correct	88.5	74.7	78.4	77.8	88.9	90.9	88.4	94.5
Incorrect/Not Know	11.5	25.3	21.6	22.2	11.1	9.1	11.6	5.5
A healthy-looking person can have HIV								
Correct	87.1	74.5	83.2	79.5	92.8	81.1	93.5	80.0
Incorrect/Not Know	12.9	25.5	16.8	20.5	7.2	18.9	6.5	20.0
HIV can be transmitted through vagina-penis sexual intercourse								
Correct	96.5	95.6	95.2	95.2	96.7	98.6	96.8	95.9
Incorrect/Not Know	3.5	4.4	4.8	4.8	3.3	1.4	3.2	4.1
Condom use during intercourse increases the risk of transmitting HIV								
Correct	86.3	78.5	80.1	60.2	90.2	86.7	85.2	81.4
Incorrect/Not Know	13.7	21.5	19.9	39.8	9.8	13.3	14.8	18.6
There are drugs that can be used to reduce the risk of transmission of HIV from a pregnant woman to her unborn child								
Correct	61.6	74.8	63.1	70.9	78.4	91.6	76.1	91.0
Incorrect/Not Know	38.4	25.2	36.9	29.1	21.6	8.4	23.9	9.0
HIV can be created by having sex, even if neither person had the virus before								
Correct	91.2	76.0	87.6	72.7	86.9	74.8	85.2	71.0
Incorrect/Not Know	8.8	24.0	12.4	27.3	13.1	25.2	14.8	29.0
HIV can be transmitted from a mother to her infant through breastfeeding								
Correct	91.5	90.7	83.4	86.8	79.1	90.2	76.8	80.0
Incorrect/Not Know	8.5	9.3	16.6	13.2	20.9	9.8	23.2	20.0
If it is the first time that a person is having sex, that person cannot be infected with HIV								
Correct	85.8	59.1	66.6	58.0	78.4	62.2	81.9	67.6
Incorrect/Not Know	14.2	40.9	33.4	42.0	21.6	37.8	18.1	32.4
The risk of HIV transmission can be reduced by having sex with only one uninfected partner who has no other partners								
Correct	87.0	82.7	85.2	84.1	89.5	83.9	90.3	89.7
Incorrect/Not Know	13.0	17.3	14.8	15.9	10.5	16.1	9.7	10.3

Table A 6: Knowledge of STIs

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Heard of any STI								
Yes	81.1	75.9	83.0	79.1	92.2	79.0	94.2	79.2
No	13.4	23.5	9.9	16.6	5.2	21.0	4.5	19.4
Do not know/cannot say	5.5	0.6	7.1	4.3	2.6	0.0	1.3	1.4
If Yes, Symptoms of STIs in a Male								
Do not know	16.5	18.8	13.4	22.2	27.7	19.5	32.2	25.9
Males often do not usually/ever have symptoms	0.0	2.5	0.4	1.7	0.0	0.0	0.0	0.0
Abdominal pain	25.9	16.8	27.2	5.4	24.8	10.6	23.3	6.2
Discharge from the penis	44.2	11.3	34.8	21.0	39.0	19.5	34.2	23.2
Itching in genital area	13.2	3.7	17.1	2.0	13.5	15.9	13.7	10.7
Burning pain during urination	18.3	10.5	19.0	4.1	13.5	6.2	13.0	10.7
Pain during intercourse	5.3	0.4	3.1	0.4	7.1	3.5	11.6	2.7
Genital ulcers/open sores	58.0	59.4	57.1	66.3	48.9	66.4	41.8	63.4
Swelling in genital area	21.6	8.3	26.3	12.3	22.0	14.2	24.0	8.9
Blood in urine	2.4	3.3	6.1	5.8	7.1	6.2	3.4	2.7
Failure to pass urine	1.7	1.7	0.0	0.0	0.7	0.0	2.1	0.0
Failure to maintain an erection	0.0	0.4	1.6	0.4	1.4	0.9	0.0	0.0
Failure to impregnate	0.0	0.4	0.0	0.0	0.7	0.0	1.4	0.0
Forced limp	5.8	13.9	6.6	9.6	5.0	1.8	7.5	1.8
If Yes, Symptoms in a Female								
Do not know	39.3	20.5	37.7	8.6	48.2	18.6	52.4	13.4
Females often do not usually/ever have symptoms	0.0	0.0	0.4	0.0	0.0	0.0	2.8	0.0
Abdominal pain	23.4	15.4	23.1	17.0	18.4	15.0	13.8	14.3
Discharge from the vagina	35.8	23.1	27.8	22.1	26.2	27.4	26.9	25.9
Itching in genital area	15.1	11.5	12.3	8.2	9.9	24.8	6.9	22.3
Burning pain during urination	5.6	8.2	8.0	8.3	7.1	8.8	4.8	10.7
Pain during intercourse	3.9	3.9	6.8	0.8	4.3	1.8	2.8	1.8
Genital ulcers/open sores	35.0	66.6	30.7	78.0	31.2	70.8	31.0	76.8
Swelling in genital area	9.8	4.7	9.1	13.8	12.1	8.8	11.0	5.4
Blood in urine	3.5	3.9	4.7	0.8	5.7	1.8	2.1	1.8
Failure to pass urine	0.3	0.0	0.0	0.0	0.7	0.0	2.8	0.0
Failure to get pregnant	0.3	2.1	4.0	3.4	5.0	0.0	6.2	0.0

Table A 7: Exposure to Information (Indirect)

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
TV/Radio/Phone/Internet/Other Mass Media – Commercial/Advert/Programme Focused on HIV&AIDS								
Yes	77.9	50.8	78.8	49.2	84.5	51.7	87.9	61.4
No	22.1	49.2	21.2	50.8	15.5	48.3	12.1	38.6
How Compared with 2-3 Years Ago								
Higher	78.9	67.4	66.2	83.7	80.8	83.8	87.7	84.3
Same	7.7	19.9	14.5	9.2	5.4	8.1	5.1	7.9
Lower	9.1	11.5	9.8	3.2	6.9	4.1	2.9	3.4
Cannot say	4.2	1.2	9.5	3.9	6.9	4.1	4.3	4.5
Read an Article in a Newspaper/Magazine That Discussed HIV&AIDS								
Yes	45.8	21.9	45.2	29.8	66.5	35.7	68.8	45.8
No	54.2	78.1	54.8	70.2	33.5	64.3	31.2	54.2
How Compared with 2-3 Years Ago								
Higher	87.6	87.4	73.8	93.4	84.5	80.0	75.9	83.3
Same	6.5	7.0	7.9	4.5	2.9	6.0	2.8	15.2
Lower	3.0	5.6	10.6	2.2	2.9	2.0	3.7	0.0
Cannot say	2.9	0.0	7.8	0.0	9.7	12.0	17.6	1.5
TV/Radio/Phone/Internet/Other Mass Media – Commercial/Advert/Programme Sexual Content that Included HIV&AIDS								
Yes	75.8	42.2	72.1	46.2	85.7	39.9	86.6	51.0
No	24.2	57.8	27.9	53.8	14.3	60.1	13.4	49.0
How Compared with 2-3 Years Ago								
Higher	82.4	73.0	69.5	93.3	81.4	82.1	89.5	90.4
Same	7.9	15.3	7.9	1.5	5.4	12.5	4.5	5.5
Lower	6.1	9.6	12.3	0.0	5.4	1.8	1.5	0.0
Cannot say	3.6	2.1	10.2	5.3	7.8	3.6	4.5	4.1
In Class Devoted to a Discussion of HIV&AIDS (current attendance or recent graduates only)								
Yes	na	na	na	na	na	na	na	na
No	na	na	na	na	na	na	na	na
Not Applicable (not in school/not recently graduated)	na	na	na	na	na	na	na	na
At School Drama/Play/Club/Other That Discussed HIV&AIDS								
Yes	na	na	na	na	na	na	na	na
No	na	na	na	na	na	na	na	na
Not Applicable (no in school/not recently graduated)	na	na	na	na	na	na	na	na
Community-Based Drama/Play/Club/Other That Discussed HIV&AIDS								
Yes	71.5	74.6	50.1	41.0	79.4	79.7	69.9	70.3
No	28.5	25.4	49.9	59.0	20.6	20.3	30.1	29.7
How Compared with 2-3 Years Ago								
Higher	91.2	89.0	69.5	75.9	86.1	83.2	75.2	86.3
Same	4.6	4.9	9.6	18.7	3.3	12.4	8.3	4.9
Lower	2.3	5.0	16.4	3.8	7.4	4.4	15.6	6.9
Cannot say	1.9	1.2	4.5	1.5	3.3	0.0	0.9	2.0
Read a Pamphlet That Included Information on HIV&AIDS								
Yes	52.4	34.2	43.2	37.4	69.7	44.8	66.2	60.0
No	47.6	65.8	56.8	62.6	30.3	55.2	33.8	40.0

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
How Compared with 2-3 Years Ago								
Higher	82.3	78.5	75.7	72.1	86.0	80.6	74.0	79.1
Same	3.6	10.7	13.2	7.6	9.3	12.9	11.5	8.1
Lower	14.0	7.2	7.3	13.5	3.7	4.8	13.5	9.3
Cannot say	0.0	3.6	3.7	6.8	0.9	1.6	1.0	3.5
Saw a Poster or Billboard That Included Something on HIV&AIDS								
Yes	71.5	45.7	71.0	54.2	95.5	59.4	89.8	64.1
No	28.5	54.3	29.0	45.8	4.5	40.6	10.2	35.9
How Compared with 2-3 Years Ago								
Higher	86.1	84.6	67.5	73.2	74.3	78.0	79.4	85.9
Same	7.5	4.6	18.5	17.5	16.2	13.4	14.2	8.7
Lower	4.9	8.1	7.6	7.5	6.1	7.3	4.3	2.2
Cannot say	1.5	2.7	6.4	1.7	3.4	1.2	2.1	3.3

Table A 8: Exposure to Information (Direct)

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Discussed HIV&AIDS With Any of Your Peers								
Yes	89.1	76.1	80.7	68.0	94.2	79.0	94.9	84.1
No	10.9	23.9	19.3	32.0	5.8	21.0	5.1	15.9
How Compared with 2-3 Years Ago								
Higher	92.4	85.5	85.0	83.1	93.2	92.0	96.0	95.1
Same	2.7	7.6	6.4	13.1	4.1	6.2	2.0	3.3
Lower	2.4	4.8	6.9	3.8	2.7	1.8	2.0	0.8
Cannot say	2.4	2.0	1.6	0.0	0.0	0.0	0.0	0.8
Discussed HIV&AIDS With Any Sexual Partner								
Yes	82.4	65.7	75.4	63.7	83.0	83.7	83.8	83.9
No	17.6	34.3	24.6	36.3	17.0	16.3	16.2	16.1
How Compared with 2-3 Years Ago								
Higher	83.2	84.9	81.6	72.0	85.7	79.7	89.9	81.2
Same	10.0	10.9	6.9	22.3	7.1	17.8	6.2	15.4
Lower	4.4	2.9	6.0	4.6	3.2	2.5	3.1	0.9
Cannot say	2.4	1.4	5.6	1.0	4.0	0.0	0.8	2.6
Discussed HIV&AIDS With a Peer Educator								
Yes	45.0	47.8	19.0	28.7	49.0	51.7	45.5	59.3
No	55.0	52.2	81.0	71.3	51.0	48.3	54.5	40.7
How Compared with 2-3 Years Ago								
Higher	77.2	89.8	65.5	77.8	75.0	91.9	71.4	91.9
Same	11.1	0.6	7.2	19.9	10.5	6.8	15.7	5.8
Lower	11.7	7.0	23.7	2.3	14.5	1.4	11.4	1.2
Cannot say	0.0	2.6	3.6	0.0	0.0	0.0	1.4	1.2

Table A 9: STAR

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Heard of STAR								
Yes	82.7	90.5	12.2	13.1	55.2	64.3	9.7	9.0
No	17.3	9.5	86.5	86.9	44.8	35.7	90.3	91.0
Do not know/cannot say	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0
If Yes, Member of a STAR Circle								
Yes	17.1	20.0	na	na	21.2	31.5	na	na
No	82.9	80.0	na	na	78.8	68.5	na	na
If No (not STAR Circle Member), Ever Met Member of a STAR Circle								
Yes	80.4	83.4	na	na	80.0	78.7	na	na
No	19.6	16.6	na	na	20.0	21.3	na	na
If Yes (met with STAR Circle Member), Discussed HIV&AIDS With This Member								
Yes	83.3	67.7	na	na	79.7	72.9	na	na
No	16.7	32.3	na	na	20.3	27.1	na	na

Table A 10: Nyanga Income Generation Support

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Any Income Generation Support Past 3 Years								
Yes					28.8	43.0	15.0	50.3
No					71.2	57.0	85.0	49.7
If Yes, Come from ASAP								
Yes					23.3	82.3	13.0	94.5
No					69.8	16.1	82.6	5.5
Do not know/cannot say					7.0	1.6	4.3	0.0
If Yes (ASAP), Member of an Internal Savings and Loan Club								
Yes					na	na	na	na
No					na	na	na	na

Table A 11: Ever Heard of an NGO Called Concern

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Yes	100	98.7	98.1	98.1	100	100	100	100
No	0.0	1.3	1.9	1.9	0.0	0.0	0.0	0.0

Table A 12: "I would still be friends with someone if I learned that they had HIV/AIDS"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	69.8	57.1	38.2	43.5	54.5	59.9	65.2	77.4	42.9	49.2	68.8	71.7
Somewhat Agree	4.6	10.7	16.1	8.8	7.0	5.0	7.1	0.0	14.3	3.4	5.1	4.8
Somewhat Disagree	3.3	0.0	7.3	0.0	6.1	1.6	2.1	0.0	0.0	0.0	0.6	0.0
Strongly Disagree	22.3	32.2	38.4	47.7	30.7	32.9	25.5	22.6	35.7	47.5	25.5	23.4
Collapsed												
Agree	74.4	67.8	54.3	52.3	62.6	65.3	72.3	77.4	61.5	52.5	73.9	76.6
Disagree	25.6	32.2	45.7	47.7	37.4	34.7	27.7	22.6	38.5	47.5	26.1	23.4

Table A 13: "If I had a family member who had HIV/AIDS, I would want it to be kept a secret"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	50.4	34.5	22.0	54.1	38.3	40.7	33.3	51.2	14.3	55.9	29.3	39.3
Somewhat Agree	4.3	1.7	13.3	9.4	8.0	3.4	5.7	3.6	14.3	1.7	4.5	6.9
Somewhat Disagree	1.3	3.0	14.7	5.6	8.9	3.7	7.8	3.6	7.1	0.0	3.2	3.4
Strongly Disagree	43.6	60.7	44.1	30.9	44.2	51.5	52.5	40.5	64.3	42.4	61.1	50.3
Collapsed												
Agree	54.9	36.3	37.5	63.5	46.6	44.4	39.3	55.4	28.6	57.6	34.4	46.2
Disagree	45.1	63.7	62.5	36.5	53.4	55.6	60.7	44.6	71.4	42.4	65.6	53.8

Table A 14: "I would be willing to care for a family member who had HIV/AIDS when they became sick, even if I thought that there was a risk of infection"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	92.1	88.1	72.0	76.3	84.9	87.9	93.6	97.6	92.9	84.7	94.3	96.6
Somewhat Agree	6.3	3.6	7.3	8.7	10.6	3.1	5.0	1.2	0.0	5.1	4.5	2.1
Somewhat Disagree	0.3	0.0	13.3	3.1	1.9	0.0	0.7	0.0	0.0	1.7	0.0	0.7
Strongly Disagree	1.3	8.3	7.3	11.8	2.2	7.8	0.7	1.2	7.1	8.5	1.3	0.7
Collapsed												
Agree	98.4	91.7	79.4	85.0	95.8	92.1	98.6	97.6	92.9	89.8	98.7	98.6
Disagree	1.6	8.3	20.6	15.0	4.2	7.9	1.4	2.4	7.1	10.2	1.3	1.4

Table A 15: "If a teacher has HIV/AIDS, s/he should still be allowed to teach"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	76.0	76.3	50.0	50.7	54.6	76.2	67.4	77.4	50.0	66.1	70.1	72.4
Somewhat Agree	3.0	4.7	7.3	6.3	8.9	3.1	9.9	2.4	7.1	5.1	7.6	8.3
Somewhat Disagree	3.6	0.0	8.8	4.4	4.2	0.3	7.1	2.4	7.1	1.7	2.5	2.8
Strongly Disagree	15.3	10.6	19.2	27.4	25.3	15.7	14.9	14.3	28.6	22.0	16.6	13.8
Do Not Know	2.0	8.4	14.7	11.2	7.1	4.7	0.7	3.6	7.1	5.1	3.2	2.8
Collapsed												
Agree	80.6	88.4	67.2	64.2	68.4	83.2	77.9	82.7	61.5	75.0	80.3	83.0
Disagree	19.4	11.6	32.8	35.8	31.6	16.8	22.1	17.3	38.5	25.0	19.7	17.0

Table A 16: "If a student is found to have HIV/AIDS, s/he should be expelled from school"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	14.4	11.3	19.2	28.0	19.6	17.0	8.5	4.8	14.3	16.9	10.8	11.0
Somewhat Agree	2.0	3.6	13.3	4.4	0.3	1.3	1.4	1.2	14.3	1.7	1.3	2.8
Somewhat Disagree	3.4	2.3	1.4	5.0	8.0	0.6	7.1	2.4	7.1	0.0	3.2	0.7
Strongly Disagree	87.6	79.8	58.8	60.8	70.5	76.1	83.0	90.5	64.3	79.7	84.7	85.5
Do Not Know	1.7	3.0	7.3	1.8	1.6	5.0	0.0	1.2	0.0	1.7	0.0	0.0
Collapsed												
Agree	16.7	15.3	35.0	33.0	20.2	19.2	9.9	6.0	28.6	19.0	12.1	13.8
Disagree	83.3	84.7	65.0	67.0	79.8	80.8	90.1	94.0	71.4	81.0	87.9	86.2

Table A 17: "A shopkeeper who is infected with HIV/AIDS should still be allowed to sell products, even fresh produce"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	49.7	51.4	39.8	22.9	33.0	43.6	37.6	54.8	28.6	33.9	39.5	44.1
Somewhat Agree	13.8	3.5	11.6	8.7	7.6	9.4	7.8	6.0	14.3	5.1	7.0	9.7
Somewhat Disagree	5.0	3.0	8.8	5.6	4.4	4.4	5.0	3.6	7.1	1.7	8.9	3.4
Strongly Disagree	29.5	36.2	33.9	61.0	48.5	40.4	48.9	34.5	50.0	57.6	43.3	42.8
Do Not Know	2.0	6.0	5.9	1.8	6.4	2.2	0.7	1.2	0.0	0.0	1.3	0.0
Collapsed												
Agree	64.8	58.3	54.7	32.2	43.4	54.2	45.7	61.4	42.9	39.7	47.1	53.8
Disagree	35.2	41.7	45.3	67.8	56.6	45.8	54.3	38.6	57.1	60.3	52.9	46.2

Table A 18: "When a relationship among partners moves from casual to serious, condoms are no longer necessary anymore because you trust each other"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	29.0	36.9	33.9	37.9	46.9	38.1	20.6	21.4	42.9	39.0	33.8	24.8
Somewhat Agree	17.2	6.6	26.5	3.7	14.1	4.1	6.4	7.1	7.1	1.7	5.7	2.8
Somewhat Disagree	12.0	1.7	13.3	8.6	10.5	4.0	27.0	3.6	7.1	55.9	26.1	3.4
Strongly Disagree	41.4	54.2	24.9	44.7	27.0	50.1	45.4	66.7	42.9	3.4	33.8	66.9
Collapsed												
Agree	46.4	43.7	61.3	43.9	61.9	43.8	27.1	28.9	50.0	40.4	39.7	28.2
Disagree	53.6	56.3	38.7	56.1	38.1	56.2	72.9	71.1	50.0	59.6	60.3	71.8

Table A 19: "Really, within a marriage a woman cannot initiate condom use, even if she wants to prevent pregnancy, as it is up to the man"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	28.0	31.5	28.0	55.3	32.3	56.5	15.6	29.8	50.0	40.7	21.7	38.6
Somewhat Agree	15.0	11.9	19.2	5.6	13.8	2.5	8.5	7.1	35.7	6.8	8.3	2.8
Somewhat Disagree	16.4	9.5	8.8	8.7	15.3	4.6	19.1	9.5	0.0	8.5	24.8	9.0
Strongly Disagree	39.0	44.1	26.3	23.0	27.7	30.7	51.1	52.4	7.1	44.1	40.1	48.3
Do Not Know	1.6	3.0	17.8	7.5	10.9	5.7	5.7	1.2	7.1	0.0	5.1	1.4
Collapsed												
Agree	43.7	44.7	57.3	65.8	51.7	62.6	25.6	37.3	53.8	47.5	31.5	42.0
Disagree	56.3	55.3	42.7	34.2	48.3	37.4	74.4	62.7	46.2	52.5	68.5	58.0

Table A 20: "Even if a single woman was worried that her sexual partner had other sexual partners, she could not insist on condom use"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	13.2	19.7	19.2	15.7	22.5	24.1	22.0	17.9	42.9	25.4	13.4	15.9
Somewhat Agree	9.9	1.7	14.7	8.3	8.6	6.0	1.4	1.2	0.0	5.1	4.5	4.8
Somewhat Disagree	22.1	7.1	16.1	11.4	18.8	6.9	27.0	7.1	7.1	8.5	17.8	4.8
Strongly Disagree	53.5	69.1	32.2	54.9	40.7	55.5	46.1	73.8	50.0	61.0	62.4	73.8
Do Not Know	1.3	2.4	17.8	9.6	9.3	7.6	3.5	0.0	0.0	0.0	1.9	0.7
Collapsed												
Agree	23.4	21.9	41.2	26.6	34.3	32.5	24.3	19.0	42.9	30.5	18.2	20.8
Disagree	76.6	78.1	58.8	73.4	65.7	67.5	75.7	81.0	57.1	69.5	81.8	79.2

Table A 21: "In a casual relationship, condom use is motivated almost entirely by a desire to avoid unwanted pregnancy"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	43.1	60.3	33.9	53.4	52.3	53.1	49.6	64.3	71.4	52.5	41.4	55.9
Somewhat Agree	23.9	5.5	32.4	11.8	20.7	13.2	21.3	13.1	14.3	20.3	12.1	13.8
Somewhat Disagree	12.6	4.8	4.3	7.5	11.4	5.9	11.3	2.4	7.1	3.4	14.0	5.5
Strongly Disagree	20.0	29.3	29.4	16.7	8.5	23.2	13.5	19.0	7.1	22.0	30.6	22.8
Do Not Know	0.3	0.0	0.0	10.6	7.1	4.7	4.3	1.2	0.0	1.7	1.9	2.1
Collapsed												
Agree	67.2	65.8	66.3	72.9	78.5	69.5	74.1	78.3	85.7	74.1	54.5	71.1
Disagree	32.8	34.2	33.7	27.1	21.5	30.5	25.9	21.7	14.3	25.9	45.5	28.9

Table A 22: "In marriage or when living together, condom use is motivated almost entirely by a desire to avoid unwanted pregnancy"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	27.6	29.1	19.0	35.3	35.4	33.0	44.7	39.3	42.9	35.6	38.2	37.2
Somewhat Agree	20.3	5.4	13.3	11.8	15.3	11.5	12.8	16.7	7.1	16.9	14.0	12.7
Somewhat Disagree	16.6	7.7	2.9	15.1	14.0	7.2	20.6	4.8	21.4	0.0	13.4	8.3
Strongly Disagree	32.5	56.6	64.9	31.8	18.9	42.3	14.2	39.3	21.4	47.5	29.3	40.7
Do Not Know	2.9	1.2	0.0	6.2	16.4	6.0	7.8	0.0	7.1	0.0	5.1	2.1
Collapsed												
Agree	49.4	34.9	32.2	50.1	60.7	47.4	62.3	56.0	53.8	52.5	55.0	50.0
Disagree	50.6	65.1	67.8	49.9	39.3	52.6	37.7	44.0	46.2	47.5	45.0	50.0

Table A 23: "People my age talk openly about negative things about sex, such as sexual diseases"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	78.6	85.9	42.7	56.0	69.8	56.3	78.7	81.0	64.3	54.2	67.5	66.2
Somewhat Agree	16.7	6.5	22.0	20.6	16.0	20.5	17.7	8.3	14.3	16.9	24.8	17.2
Somewhat Disagree	2.7	2.3	7.3	8.6	4.8	1.9	1.4	3.6	7.1	6.8	3.8	2.1
Strongly Disagree	2.0	5.3	16.1	12.9	3.9	19.4	2.1	7.1	14.3	18.6	3.2	13.8
Do Not Know	0.0	0.0	11.8	1.8	5.5	1.9	0.0	0.0	0.0	3.4	0.6	0.7
Collapsed												
Agree	95.4	92.4	73.4	78.1	90.8	78.3	96.5	89.3	78.6	73.7	92.9	84.0
Disagree	4.6	7.6	26.6	21.9	9.2	21.7	3.5	10.7	21.4	26.3	7.1	16.0

Table A 24: "Abstinence from sex is difficult for single women because men control decisions on sex"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	na	na	na	na	na	na	na	na	na	na	na	na
Somewhat Agree	na	na	na	na	na	na	na	na	na	na	na	na
Somewhat Disagree	na	na	na	na	na	na	na	na	na	na	na	na
Strongly Disagree	na	na	na	na	na	na	na	na	na	na	na	na
Do Not Know	na	na	na	na	na	na	na	na	na	na	na	na
Collapsed												
Agree	30.8	40.3	50.0	14.0	76.8	25.8	52.0	na	na	na	na	55.6
Disagree	69.2	59.7	50.0	86.0	21.2	74.2	48.0	na	na	na	na	44.4

Table A 25: "Abstinence from sex is difficult for single men because single women really are not allowed to tell men no"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	20.1	26.3	75.0	na	13.6	0.0	na	na	na	na	10.9	na
Somewhat Agree	15.9	21.2	0.0	na	13.4	6.1	na	na	na	na	10.9	na
Somewhat Disagree	3.9	0.0	0.0	na	28.5	25.2	na	na	na	na	13.0	na
Strongly Disagree	50.3	31.4	0.0	na	29.6	43.5	na	na	na	na	60.9	na
Do Not Know	9.8	21.2	25.0	na	14.9	25.2	na	na	na	na	4.3	na
Collapsed												
Agree	39.9	60.2	100	na	31.7	8.1	na	na	na	na	22.7	na
Disagree	60.1	39.8	0.0	na	68.3	91.9	na	na	na	na	77.3	na

Table A 26: "There are a number of single women in this area who have no choice, they have to exchange sex for money at least sometimes"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	43.8	49.5	23.5	33.6	51.6	31.1	46.8	38.1	50.0	45.8	42.7	48.6
Somewhat Agree	17.5	10.1	25.1	18.6	16.9	12.9	28.4	17.9	7.1	18.6	19.7	13.2
Somewhat Disagree	9.9	6.6	2.9	5.5	4.8	2.2	4.3	1.2	14.3	1.7	7.6	2.8
Strongly Disagree	27.5	25.5	48.6	20.5	24.5	44.1	12.8	27.4	28.6	15.3	23.6	24.3
Do Not Know	1.3	8.4	0.0	21.8	2.2	9.7	7.8	15.5	0.0	18.6	6.4	11.1
Collapsed												
Agree	62.1	65.0	48.6	66.8	70.0	48.7	81.5	66.2	57.1	79.2	66.7	69.5
Disagree	37.9	35.0	51.4	33.2	30.0	51.3	18.5	33.8	42.9	20.8	33.3	30.5

Table A 27: "Virginity by the time one is married is not as highly prized as it was in the past"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	66.7	78.6	73.5	64.6	73.4	63.0	65.2	71.4	85.7	78.0	66.2	64.8
Somewhat Agree	18.9	7.7	7.3	11.8	15.0	6.8	17.0	3.6	7.1	10.2	12.1	6.2
Somewhat Disagree	5.0	0.6	5.9	1.2	2.5	1.2	8.5	3.6	0.0	0.0	7.6	2.1
Strongly Disagree	9.4	12.5	7.3	21.1	7.7	28.6	9.2	21.4	7.1	8.5	10.8	25.5
Do Not Know	0.0	0.6	5.9	1.2	1.3	0.3	0.0	0.0	0.0	3.4	3.2	1.4
Collapsed												
Agree	85.6	86.8	85.9	77.4	89.6	70.0	82.3	75.0	92.9	91.2	80.9	72.0
Disagree	14.4	13.2	14.1	22.6	10.4	30.0	17.7	25.0	7.1	8.8	19.1	28.0

Table A 28: "In marriage, the wife has no right to refuse sex, it is entirely up to the husband"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	22.0	36.2	45.7	59.1	23.7	45.9	17.0	44.0	50.0	49.2	26.1	46.9
Somewhat Agree	8.0	8.4	7.3	5.6	9.0	5.0	1.4	3.6	0.0	5.1	0.6	2.8
Somewhat Disagree	9.0	5.9	5.9	3.7	5.4	5.0	5.0	6.0	7.1	5.1	3.2	2.8
Strongly Disagree	59.7	47.1	29.2	29.2	56.4	41.2	73.8	46.4	35.7	40.7	66.9	46.9
Do Not Know	1.3	2.4	11.8	2.5	5.5	2.8	2.8	0.0	7.1	0.0	3.2	0.7
Collapsed												
Agree	30.4	45.7	60.2	66.3	34.6	52.5	19.0	47.6	53.8	54.2	27.6	50.0
Disagree	69.6	54.3	39.8	33.7	65.4	47.5	81.0	52.4	46.2	45.8	72.4	50.0

Table A 29: "If a wife tries to refuse sex from a husband, he has the right to discipline her"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	8.3	35.0	14.7	52.1	13.1	39.9	7.8	36.9	42.9	59.3	12.1	35.9
Somewhat Agree	7.3	7.1	8.8	6.9	4.5	5.1	1.4	4.8	7.1	3.4	1.9	7.6
Somewhat Disagree	6.0	10.8	0.0	7.5	5.1	4.2	2.8	2.4	0.0	3.4	0.0	4.8
Strongly Disagree	77.4	44.6	58.8	33.5	71.6	50.9	85.1	56.0	50.0	33.9	83.4	50.3
Do Not Know	1.0	2.4	17.8	0.0	5.8	0.0	2.8	0.0	0.0	0.0	2.5	1.4
Collapsed												
Agree	15.8	43.2	28.5	59.0	18.6	45.0	9.5	41.7	50.0	62.7	14.4	44.1
Disagree	84.2	56.8	71.5	41.0	81.4	55.0	90.5	58.3	50.0	37.3	85.6	55.9

Table A 30: "Really, there are many things about HIV&AIDS that I simply do not understand"

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Strongly Agree	36.6	25.4	82.4	58.4	71.5	56.8	61.0	34.5	78.6	61.0	55.4	45.8
Somewhat Agree	39.9	44.3	11.6	24.8	20.5	30.0	30.5	38.1	21.4	27.1	31.2	25.7
Somewhat Disagree	10.7	19.0	5.9	4.3	7.6	5.6	5.0	19.0	0.0	6.8	9.6	14.6
Strongly Disagree	12.8	11.3	0.0	12.5	0.3	7.5	3.5	8.3	0.0	5.1	3.8	13.2
Collapsed												
Agree	76.5	69.7	94.1	83.2	92.0	86.8	91.5	72.6	100	88.1	86.6	72.0
Disagree	23.5	30.3	5.9	16.8	8.0	13.2	8.5	27.4	0.0	11.9	13.4	28.0
How would you compare your response to this statement, say, three years ago?												
More informed now	88.5	91.8	42.5	60.1	63.9	70.7	95.7	97.6	100	79.7	96.8	82.6
Less informed now	8.4	1.2	0.0	13.1	2.9	1.9	2.8	1.2	0.0	3.4	1.9	5.6
No difference	1.7	7.1	57.5	23.0	28.4	27.4	1.4	1.2	0.0	15.3	0.6	9.7
Do not know	1.4	0.0	0.0	3.7	4.8	0.0	0.0	0.0	0.0	1.7	0.6	2.1

Table A 31: Perceived HIV Risk Status

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
High Risk	9.9	13.6	13.3	11.1	15.6	17.9	27.0	18.1	42.9	22.0	16.0	23.4
Medium Risk	21.3	21.3	16.1	29.7	24.7	38.6	24.8	24.1	14.3	28.8	32.1	19.3
Low Risk	13.0	28.2	20.6	16.9	11.1	13.2	14.2	10.8	0.0	5.1	17.3	8.3
No Risk	39.9	29.7	48.6	29.8	30.7	24.4	27.0	45.8	42.9	37.3	21.2	39.3
Do not know	16.0	7.1	1.4	12.5	17.9	6.0	7.1	1.2	0.0	6.8	13.5	9.7
Why feel low to no risk?												
Do not know/ cannot say	1.9	5.2	0.0	14.6	10.7	11.8	8.8	2.1	na	8.0	15.0	8.7
Live with faithful partner	69.6	38.1	66.1	61.7	63.2	49.1	41.2	44.7	na	52.0	48.3	39.1
Never share razors or sharp objects	16.0	0.0	8.6	1.3	2.2	0.0	2.9	4.3	na	0.0	6.7	0.0
No infection with non-sterilised needles	15.4	0.0	8.6	0.0	0.0	0.0	0.0	0.0	na	0.0	0.0	1.4
Never had sex	5.1	4.2	0.0	0.0	1.5	3.4	5.3	2.1	na	8.0	6.7	0.0
Abstain from sex	7.0	15.5	0.0	3.9	3.8	9.1	15.8	12.8	na	0.0	6.7	18.8
Tested HIV negative	20.2	39.1	8.3	17.2	12.2	24.0	24.6	48.9	na	56.0	18.3	52.2
Always use a condom	3.1	13.5	17.1	1.3	12.3	4.2	10.5	8.5	na	0.0	13.8	1.4

Table A 32: Personal Knowledge of Someone Who is Living With HIV or Who Had Died of an AIDS-Related Illness

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Know Someone Living With HIV/AIDS								
Yes	86.3	61.8	75.1	68.6	74.8	72.5	85.4	89.0
No	9.6	35.5	22.1	30.4	20.0	26.1	10.2	10.3
Not Certain	4.1	2.8	2.8	0.9	5.2	1.4	4.5	0.7
Know Someone Died of AIDS-Illness								
Yes	85.8	77.3	86.2	80.5	84.5	75.5	89.8	87.6
No	12.9	22.1	13.2	19.2	12.3	21.0	8.3	11.0
Not Certain	1.3	0.6	0.6	0.3	3.2	3.5	1.9	1.4

Table A 33: Ever Had Sex

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Yes	91.6	97.3	90.6	95.9	84.5	98.6	82.6	96.6
No	8.4	2.7	9.4	4.1	15.5	1.4	17.4	3.4

Table A 34: Age At First Sex

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Mean	19.7	18.1	19.7	18.4	20.4	18.8	20.8	19.4
Median	19	18	19	18	20	19	20	19
< 15	3.9	1.0	2.4	4.7	1.6	2.9	0.0	1.5
15-17	18.8	39.7	18.7	26.9	13.4	20.6	11.6	20.3
18+	77.3	59.3	78.9	58.4	85.0	76.5	88.4	78.2

Table A 35: Age Gap With Sexual Partner (females only)

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Partner 10+ Years Older								
Yes		24.3		26.0		27.1		30.7
No		75.7		73.7		71.4		69.3
If No, Partner 5-9 Years Older								
Yes		48.4		51.2		47.5		51.6
No		51.6		48.8		52.5		48.4

Table A 36: Use of Family Planning (excluding condoms)

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Yes	83.3	82.6	51.4	74.3	53.6	74.1	80.5	87.8	84.6	83.1	75.4	86.4
No	16.7	17.4	48.6	25.7	46.4	25.9	19.5	12.2	15.4	16.9	24.6	13.6

Table A 37: Condom Use

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Ever Used								
Yes	43.5	27.7	60.2	33.8	74.3	47.1	65.4	41.4
No	56.5	72.3	39.8	66.2	25.7	52.9	34.6	58.6
Used Condom First Sex								
Yes	18.8	11.4	27.0	9.8	19.3	11.7	23.3	6.9
No	81.2	88.6	73.0	90.2	80.7	88.3	76.7	93.1
If Yes, Who Initiated								
Self	49.1	45.1	52.6	38.0	na	na	na	na
Partner	21.4	45.1	14.9	62.0	na	na	na	na
Both	29.5	9.7	32.5	0.0	na	na	na	na

na = not applicable, too few respondents to calculate totals

Table A 38: Sexual Partnerships (Regular Partner)

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Current Regular Partner												
Yes	97.4	83.1	93.7	86.8	90.0	93.2	95.8	89.0	100	89.8	90.8	86.3
No	2.6	16.9	6.3	13.2	10.0	6.8	4.2	11.0	0.0	10.2	9.2	13.7
# of Regular Partners Past Year												
Mean	1.18	1.00	1.75	1.00	1.29	1.05	1.14	1.00	1.15	1.04	1.08	1.02
Median	1	1	1	1	1	1	1	1	1	1	1	1
% with > 1	13.7	0.0	30.1	0.0	16.4	1.4	11.3	0.0	7.7	1.9	6.8	0.9
% of Concurrent Regular Partners > 1 Past Year												
	89.0	na	55.6	na	92.5	na	85.3	na	na	na	na	na
Exchange Sex for Regular Partnership (females only)												
Yes	na	na	na	na	na	na	na	na	na	na	na	na
No	na	na	na	na	na	na	na	na	na	na	na	na
Condom Use Last Time Sex Regular Partner												
Yes	12.7	14.6	9.6	1.7	6.0	9.3	10.0	13.8	0.0	23.1	14.4	14.6
No	87.3	85.4	90.4	98.3	94.0	90.7	90.0	86.2	100	76.9	85.6	85.4

Table A 39: Sexual Partnerships (Casual Partner)

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
# of Casual Partners Past Year												
% Indicating 1+	10.6	0.6	6.7	1.2	18.0	3.7	17.1	0.0	7.7	0.0	13.2	2.3
% Indicating None	89.4	99.4	93.3	98.8	82.0	96.3	82.9	100	92.3	100	86.8	97.7
% of Concurrent Regular Partners > 1 Past Year												
Mean	na	na	na	na	na	na	na	na	na	na	na	na
Median	na	na	na	na	na	na	na	na	na	na	na	na
% > 1	na	na	na	na	na	na	na	na	na	na	na	na
Exchange Sex for Casual Partnership (females only)												
Yes	na	na	na	na	na	na	na	na	na	na	na	na
No	na	na	na	na	na	na	na	na	na	na	na	na
Condom Use Last Time Sex Casual Partner												
Yes	na	na	na	na	na	na	na	na	na	na	na	na
No	na	na	na	na	na	na	na	na	na	na	na	na

Table A 40: VCT

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Ever Tested												
Yes	57.4	84.0	29.2	72.7	34.2	53.1	75.9	96.3	69.2	88.1	74.4	90.0
No	42.6	16.0	70.8	27.3	65.8	46.9	24.1	3.7	30.8	11.9	25.6	10.0
If Yes, Receive Results												
Yes	92.8	96.9	100	86.9	89.9	94.1	96.6	100	100	100	100	99.2
No	7.2	3.1	0.0	13.1	10.1	5.9	3.4	0.0	0.0	0.0	0.0	0.8
If No, Why Not Tested												
Fear results	12.7	0.0	3.1	17.1	5.9	22.6	na	na	na	na	40.7	na
Do not have funds	1.1	0.0	0.0	4.3	6.0	1.1	na	na	na	na	0.0	na
Not feel at risk	19.9	33.7	0.0	0.0	26.1	5.7	na	na	na	na	14.8	na
Already HIV+	9.4	0.0	0.0	0.0	0.7	9.2	na	na	na	na	0.0	na
Not want be observed	9.4	0.0	0.0	0.0	0.0	4.6	na	na	na	na	0.0	na
Afraid consequences of testing	1.1	0.0	12.9	0.0	0.0	1.1	na	na	na	na	3.7	na
Not heard of testing	5.9	0.0	12.9	0.0	0.0	0.0	na	na	na	na	3.7	na
No treatment so why bother	0.0	0.0	0.0	0.0	3.7	0.0	na	na	na	na	7.4	na
No cure so why bother	0.0	0.0	0.0	0.0	0.0	1.1	na	na	na	na	0.0	na
Spouse forbid testing	0.0	8.1	0.0	61.6	0.0	14.8	na	na	na	na	0.0	na
Not trust results	1.1	0.0	0.0	0.0	0.0	0.0	na	na	na	na	0.0	na
No support provided if HIV+	2.3	0.0	0.0	0.0	0.0	2.2	na	na	na	na	0.0	na
Testing services not offered in area	3.4	8.1	0.0	4.3	39.7	28.6	na	na	na	na	3.7	na
I am healthy, no testing needed	62.9	50.0	83.9	12.8	48.5	21.5	na	na	na	na	77.8	na
All sexual partners still healthy	18.4	0.0	0.0	0.0	1.5	0.0	na	na	na	na	25.9	na

Table A 41: Male Circumcision

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Yes	16.3		13.0		15.3		9.9	
No	83.7		87.0		84.7		90.1	

Table A 42: Gender-Based Violence (females only)

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Physically Struck by a Sexual Partner in the Past Year												
Yes		na		na		na		na		na		na
No		na		na		na		na		na		na
Cannot Remember		na		na		na		na		na		na

Table A 43: Sexual Violence

	Gokwe Treatment (exposed)		Gokwe Treatment (no/low-exposure)		Gokwe Control		Nyanga Treatment (exposed)		Nyanga Treatment (no/low-exposure)		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Forced to Have Sex by Partner Over Past Year												
Yes		na		na		na		na		na		na
No		na		na		na		na		na		na
Cannot remember		na		na		na		na		na		na

Table A 44: STIs

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Females – Sore or Discharge								
Yes	na	na	na	na	na	na	na	na
No	na	na	na	na	na	na	na	na
Do not know	na	na	na	na	na	na	na	na
Males – Sore or Discharge								
Yes	na	na	na	na	na	na	na	na
No	na	na	na	na	na	na	na	na
Do not know	na	na	na	na	na	na	na	na

Table A 45: Level of Co-operation

	Gokwe Treatment		Gokwe Control		Nyanga Treatment		Nyanga Control	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
High	88.0	88.1	80.8	73.2	93.3	94.6	87.9	95.2
Medium	11.7	6.6	19.2	25.6	6.4	2.8	12.1	3.6
Low	0.3	4.8	0.0	1.2	0.3	2.5	0.0	1.2

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