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LIST OF ACRONYMS AND ABBREVIATIONS

ABC	Abstinence, be faithful, use a condom
ACCZ	Apostolic Christian Council of Zimbabwe
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
AU	African Union
BCF	Behaviour Change Facilitator
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CHW	Community health worker
CSE	Comprehensive sexuality education
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
DSTV	Digital satellite television
EDUCAIDS	Global initiative on education and HIV & AIDS
ESA	Eastern and Southern African Region
FGD	Focus group discussion
GAP	Gender Action Plan
GBV	Gender-based violence
GoZ	Government of Zimbabwe
HIV	Human immunodeficiency virus
HTC	HIV testing and counselling
IAS	International AIDS Society
ICASA	International Conference on AIDS and STIs
IEC	Information, educational and communication

IPC	Interpersonal communication
MDG	Millennium Development Goal
MoHCC	Ministry of Health and Child Care
MoHCW	Ministry of Health and Child Welfare
MoWAGCD	Ministry of Women's Affairs, Gender and Community Development
MRCZ	Medical Research Council of Zimbabwe
NAC	National AIDS Council
NGO	Non-governmental organization
NHS	National Health Strategy
OPHID	Organization for Public Health Interventions and Development
PEPFAR	President's Emergency Plan for AIDS Relief
PhD	Doctor of philosophy degree
PLHIV	People living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
PrEP	Pre-exposure prophylaxis
PSI	Population Services International
SAA	Society for AIDS in Africa
SABC	South African Broadcasting Corporation
SADC	Southern African Development Community
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goal
SIDA	Swedish International Development Cooperation Agency
STI	Sexually transmitted infection

TB	Tuberculosis
UDACIZA	Union for the Development of Apostolic and Zionist Churches in Zimbabwe, Africa
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDESA	United Nations Department of Economic and Social Affairs
UNESCO	United Nations Educational, Scientific, and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNISA	University of South Africa
USAID	United States Agency for International Development
VHW	Village Health Worker
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZAMPS	Zimbabwe All Media Product Survey
ZARF	Zimbabwe Advertising Research Foundation
ZBC	Zimbabwe Broadcasting Cooperation
ZDHS	Zimbabwe Demographic Health Survey
ZIM ASSET	Zimbabwe Agenda for Sustainable Socioeconomic Transformation
ZIMSTAT	Zimbabwe National Statistics Agency
ZINASP	Zimbabwe National HIV and AIDS Strategic Plan
ZSE	Zimbabwe Stock Exchange
ZTV	Zimbabwe Television

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CHAPTER 1

1 ORIENTATION OF STUDY

1.1 Introduction

The first chapter gives an overview of the study and contextualizes it by explaining the key elements of the study. The chapter gives an overview of both the Human Immunodeficiency Virus (HIV) and the Acquired Immunity Deficiency Syndrome (AIDS), and highlights various global and regional figures. The background information is shifted to the context of HIV and AIDS in Zimbabwe, the country where the study was carried out. The background introduces the interest of the study, which is HIV and AIDS communication touching on both mass and interpersonal communication (IPC). There is also a brief introduction to the guidelines development process.

HIV and AIDS communication falls broadly under health communication, and the goal of this study is to develop guidelines for improving HIV and AIDS communication for women in Zimbabwe. This was achieved through exploring the perceptions and viewpoints of Zimbabwean women as well as those of the key informants, who are experts in the area studied, together with considering the context of Zimbabwean women with a focus on those living in urban areas.

1.2 Study rationale

The researcher carried out a research for her Master of Philosophy degree in HIV and AIDS Management in 2011 whose title was 'The Impact of billboards on HIV awareness in Zimbabwe' (Chiwara 2012:63). The study focused on the information content on display on the country's billboards and how it was perceived by the target population of working people aged 19 to 49 years. One of the key recommendations from this study was to carry out research that investigates HIV and AIDS awareness generated through other mass media channels and to see what effect the messages through these channels is having on different sub-populations. The researcher views it as strategic to explore both mass and interpersonal aspects of HIV and AIDS communication. It is important to explore and analyse in-depth, the viewpoints regarding HIV and AIDS communication from both the target population (in this case the sub-group of urban women) as well as the information facilitators/providers' perspective. The researcher excluded men from the study and selected urban rather than rural women because, according to a report for

Zimbabwe, “The HIV prevalence is slightly higher in urban areas than in rural area” (UNAIDS 2014:4). This has been confirmed by diverse sources. HIV prevalence in urban areas has been consistently higher than in rural areas, from 2011 to 2014 (GoZ & MoHCC [Sa]). An HIV study carried out in Zimbabwe concluded that people in the urban areas in Zimbabwe have a higher HIV prevalence than their rural counterparts (Chinomona & Mwambi 2015: [16]). HIV prevalence in the 15-24 age group women is 1.5 times higher than in men (UNAIDS 2014:4). Zimbabwe has 1.3 million people living with HIV (PLHIV); 720 000 are adult women (above 15 years) while significantly less, 510,000 are adult men, the remainder being children under 14 years (UNAIDS 2017a).

The researcher is passionate about contributing significantly to HIV and AIDS, particularly issues that affect women, hence one reason for selecting this sub-group for the study, another being that the age-group, together with the sex as well as geographical location (urban) is the one most affected in the Zimbabwean context. The researcher has interest in information sharing and believes communication is at the root of many challenges and that it facilitates acquiring information that is essential for good decision-making. To the researcher’s knowledge, at the time of the study, there were no previous HIV communication guidelines for young urban women that had been developed. By completing her doctorate, the researcher seeks to become an expert in HIV and AIDS communication and believes that she can also use her expertise to inform reproductive health and public health communication.

1.3 Source and background of research problem

1.3.1 Global perspective of HIV and AIDS

The HIV and AIDS epidemic has been a global challenge for several decades. According to the Joint United Nations Programme on HIV and AIDS (UNAIDS) Report on the Global AIDS Epidemic, an estimated 35.3 million people were living with HIV in 2012. This increased in 2015 to 36.7 million PLHIV because more people were now being kept alive as they were taking anti-retroviral therapy (ART) which is life-saving and prolongs life (UNAIDS 2016a:8). 2016 was also reported to have 36.7 million PLHIV (UNAIDS 2017a).

The HIV incidence globally declined significantly by 33% to 2.3 million in 2012 (down from 3.4 million in 2001). New infection in 2015 stood at 2.1 million (UNAIDS 2016a:3). In 2016, new infections dropped to 1.7 million (UNAIDS 2017c:12).

The number of HIV deaths has also declined from 2.3 million in 2005 to 1.6 million in 2012 (UNAIDS 2013:4). AIDS-related deaths went down in 2015 to 1.1 million (UNAIDS 2016a:8). The HIV-related deaths dropped further in 2016 to 1 million (UNAIDS 2017c:12).

Statistics over the years show a positive outlook: In June 2016, 18.2 million PLHIV were on antiretroviral therapy (ART) (UNAIDS 2016a:3). By end of 2016 the figure of PLHIV on ART had risen to 19.5 million (UNAIDS 2017b:33); this figure represents 53% of all PLHIV (UNAIDS 2017b:32). By June 2017, 20.9 million PLHIV were on ART (UNAIDS 2017a).

As impressive as the progress seems, more still needs to be done till global goals have been achieved. The overall vision of UNAIDS is 'Zero new infections, zero discrimination, zero AIDS-related deaths' (UNAIDS 2013:4). There were several goals and milestones set to progress in mitigating the HIV epidemic. The deadline against which the key UNAIDS goals were set was 2015 (UNAIDS 2013:4). One key goal achieved was the '15 by 15' one: UNAIDS released a report that described the factors contributing to the global achievement of the '15 by 15' target (UNAIDS 2015a). This was a follow-up on the UN Secretary-general, Ban Ki-Moon's announcement on 14 July 2015. The announcement stated that the world had reached the target of providing anti-retroviral therapy to 15 million PLHIV in 2015.

In 2000, the United Nations (UN) Millennium Declaration was made which outlined the eight Millennium Developmental Goals (MDGs), also to be met by end of 2015 (UNAIDS 2013:4). The MDG directly related to HIV and AIDS was the sixth one: 'To combat HIV and AIDS, malaria and other diseases'. In 2011 the UN Political Declaration on HIV and AIDS: 'Intensifying Our Efforts to Eliminate HIV and AIDS' was held, of which there were ten targets and elimination commitments. A target that must be singled out because of its relevance to the study (the study has a sub-group of women as the target population) is: 'Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV'. Gender inequalities and harmful norms continue to play a role in increasing vulnerability to HIV in women (UNAIDS 2013:4).

According to the MDG Report, achievements were made and there was progress with the MDG targets, though it was uneven across countries and regions; significant gaps still existed in 2015 (UN 2015:8). One of these is the persistence of gender inequality (UN

2015:8). Achievements included that more people were on ART and new infections were less, as compared to at the beginning of 2000 (UN 2015:6).

In previous years, on a global outlook, 52% of all people with HIV in low and middle-income countries were women; 48% were men (UNAIDS 2013:78). Current statistics show a similar trend, with the majority of 17.8 million women (above 15 years) of the 34.5 million adults, living with HIV (UNAIDS 2017c:12). The difference between the 36.7 million and 34.5 million PLHIV accounts for the children globally living with HIV.

1.3.2 Sub-Saharan and Eastern Southern Africa perspective of HIV and AIDS

The trends for new HIV infections varies from region to region but Sub-Saharan Africa (SSA) was affected significantly more than other regions and in 2012 contributed to 70% of new infections (UNAIDS 2013:12). Latest statistics, from 2016, show that 64% of new infections are in SSA, with 4,500 infections a day being among adults (15 years and older); almost 43% are among women and 22% are among young women aged between 15 and 24 (UNAIDS 2017c:13).

In the Eastern and Southern Africa region (ESA), 2016 statistics that are considering adults over 15 years, and not children, stand at: PLHIV – 19.4 million of which 60% were female and 40% were men; HIV prevalence – 7%, of which 8.6% were women and 5.5% were men (UNAIDS 2017a). New HIV infections stood at 790,000, of which 410,000 were women and 310,000 were men; AIDS-related deaths – 360,000 of which 170,000 were women and 190,000 were men (UNAIDS 2017a).

These figures show that women have directly been impacted more than men in most cases, as more women are living with HIV, and they also have more new infections. However, more men died of AIDS-related diseases. The good news is that HIV infection in the ESA, the most affected region globally, has declined by almost a third (UNAIDS 2017c:25).

Of relevance to this study, whose target population is urban women aged 20 to 29 years, is that national surveys in SSA have shown lower levels of accurate knowledge of women aged between 15 and 24 years than their male counterparts (UNAIDS 2013:78). It is also worth noting that particularly in SSA, HIV responses are giving attention to gender equality, which is a positive development (UNAIDS 2013:81).

1.3.3 The Zimbabwean context

1.3.3.1 Geographical outlook

Zimbabwe is a land-locked country located in Southern Africa. Its neighbours are Namibia, Botswana, South Africa, Mozambique and Zambia. It is divided into ten provinces, two of which are the cities of Harare (capital) and Bulawayo.



(www.maps.com)

Figure 1.1: Map of Zimbabwe showing geographical position in Southern Africa

1.3.3.2 Demographic information

In the last census carried out in Zimbabwe in 2012, Zimbabwe's population was estimated at just over 13 million, 52% of which were women. Harare and Bulawayo cities between them housed 65% of the urban population, with the remaining 35% of the urban population distributed among the other eight provinces which comprise mainly the rural population (ZIMSTAT 2013:3). The urban population was 33% of the total population and the rural population was 67% (ZIMSTAT 2013:13).

1.3.3.3 Overview of HIV and AIDS

- HIV and AIDS statistics

Zimbabwe is one of the countries most affected by the HIV and AIDS epidemic in SSA. The first HIV and AIDS case in Zimbabwe was reported in 1985 (GoZ 2012: 1-2). In 2001 the HIV prevalence was 23.7% and this went down to 18.4% in 2005 and 13.1% in 2011 in the adult (>15 years) population (GoZ 2012:1-2). “Zimbabwe is one of the few countries with a generalized HIV and AIDS epidemic and high prevalence to have recorded a sustained decline in prevalence” (UNFPA 2011:2). In a 2014 report, the decline in new infections is attributed to gains from positive behaviour change as well as high ART coverage (GoZ 2014:5). It is noteworthy that in both the 2012 and 2014 reports from the Government of Zimbabwe (GoZ), behaviour change is cited as a contributor, and this is one aspect HIV and AIDS communication can focus on.

According to a study done on the decline of HIV prevalence in Zimbabwe, the prevalence dropped from 29% in 1997 to 16% in 2007 (Halperin, Mugurungi, Hallett, Muchini, Campbell, Magure, Benedikt, Gregson 2011:1). To get a detailed appreciation of how HIV and AIDS has evolved in Zimbabwe, Table 1.1 shows the impact of the national response to HIV and AIDS.

Table 1.1: Performance of impact indicators – HIV Estimates (2011-2015)

Impact indicators	2011	2012	2013	2014	2015
Deaths averted by ART (Thousands)	40.42	48.22	45.70	57.40	62.30
Infections averted by PMTCT (Thousands)	6.41	12.75	15.11	16.30	13.90
Life years gained by ART and PMTCT (Thousands)	210.02	269.79	323.47	428.30	501.60
Deaths averted by PMTCT (0-4) (Thousands)	2.91	4.06	5.40	5.90	5.65
HIV incidence rate	1.29	1.25	0.98	0.92	0.74
Annual HIV-related deaths	115,117	87,335	61,476	54,994	31,217
Total AIDS orphans	1,151,235	1,084,906	810,135	719,477	524,581

(GoZ 2016a:4)

At a glance, the situation regarding the HIV epidemic has been improving for almost all the indicators up to 2015 as shown in Table 1.1. However, as mentioned earlier, one of the goals of UNAIDS is to ultimately achieve zero new infections. To attain that goal, the HIV incidence rate of 0.74% must be seen to keep dropping, and eventually reach the zero-percentage mark. The second goal is the attainment of zero deaths from HIV infection. In part, these goals can be attained by having a targeted approach which involves designing programmes, including effective communication strategies, for specific

groups within a country. In the context of Zimbabwe, one such group comprises young urban women. This study aims to make its contribution to the communication aspect of the programmes, with these goals in mind.

Trends and changes in the HIV epidemic are interesting to note, and indicate progress or a lack thereof. In Zimbabwe, the National Behaviour Change programme is part of the combination prevention strategy that the country has adopted (GoZ 2014). The communication programme related to this, shortened to SBCC (Social and Behaviour Change Communication) programme is aimed at 15-49-year olds who are sexually active. Person exposures (those exposed to the SBCC) of 7,947,109 were achieved in 2013 against a 5,480,000 target (GoZ 2014). This communication programme, is acknowledged in reviews as a high impact programme in Zimbabwe and a key intervention in the HIV prevalence decline. SBCC interventions were intensified in schools, at the workplace and in the community with a focus on key and risk populations (GoZ 2014). In 2015, the communication programme reached 2,437,632 persons against a target of 2,649,600. Of those reached, 44.2% were referred for integrated HIV services (GOZ 2016a:7). Here, we see that in 2013, the target of persons reached by the communication programmed was exceeded, whereas in 2015, the target was not attained.

At the end of 2011, 1,159,097 adults and children were living with HIV and AIDS while an estimated 597, 293 adults and children were in urgent need of help at the end of 2011 (GoZ 2012 1:1-2). In 2013, the total number of PLHIV and receiving ART in Zimbabwe was 665,299 (618,980 adults and 46,319 children) (GoZ 2014:12). By June 2017, 975,000 PLHIV on ART in Zimbabwe had gone up to 975,000 (UNAIDS 2017a).

It is interesting to note that for the age group 15-24 years, the HIV prevalence rate was higher for females in 2011, at 6.6% compared to the males who had an HIV prevalence rate of 3.4% (GoZ 2012:10). The same pattern applies to the adult population where 59.4% of the adult population (people aged over 15) living with HIV and AIDS were women. Thus, of those living with HIV and AIDS, women were in the majority (GoZ 2012:12).

Regarding the transmission of HIV, over 90% of new infections were attributable to heterosexual transmission with most new infections coming from the 20-29 age group

(GoZ 2012:13). This contributes hugely to the rationale to select this sub-group for the study.

In 2016, the number of PLHIV in Zimbabwe was recorded as 1,3 million, with 1,2 million (720,000 women and 510,000 men) aged 15 and over (UNAIDS 2017a). In 2016 for those aged 15 and over, Zimbabwe's prevalence rate stood at 13.5%:16.1% for women and 10,7% for men; 37,000 new HIV infections - 20,000 women and 17,000 men; 28,000 AIDS-related deaths -14,000 men and women each (UNAIDS 2017a).

As with the regional scenarios of East and Southern Africa, the figures are skewed toward the women primarily, with only the AIDS-related deaths being the same as that of men.

The current information on the HIV situation in Zimbabwe comes from preliminary findings published from a house-hold based survey to investigate the HIV epidemic; it was held between October 2015 and August 2016 (MoHCC 2016a:1-2). Key HIV indicators measured include annual incidence, prevalence and knowledge of HIV status: for 15-64 years, the annual incidence was 0.45, corresponding to 32,000 new HIV cases annually; it was higher for women (MoHCC 2016a:1-2). The prevalence was 14.5% for the same age group, but notably 16.7% for women and 12.4% for men. The disparity in the HIV prevalence is also seen among young adults (20-24 years) – it is three times higher in females (MoHCC 2016a:1-2). More HIV positive women of the age group 15-64 years (74.2%), knew their status than HIV positive men of the same age range (69.7%); the HIV positive female numbers of those knowing their status and on treatment, and those virally suppressed were higher than for men (MoHCC 2016a:3).

The 90-90-90 global goals aim at ensuring that 90% of PLHIV know their status, that 90% of PLHIV who know their status, are on treatment, and that 90% of those on treatment are virally suppressed by 2020 (UNAIDS 2017b:8). The survey shows that the national HIV programme has made great progress in responding to the HIV epidemic and moving towards the global 90-90-90 goals, including the estimate of the national HIV incidence. The conclusion of the survey was that “The goal of ending the AIDS epidemic in Zimbabwe by 2030 is within reach, provided there is continued expansion of HIV treatment programmes and targeted HIV testing, especially for men and young women.” It is expected that the results of the survey, funded by the President's Emergency Plan for AIDS Relief (PEPFAR), will guide policy and funding priorities (MoHCC 2016a:4).

Statistics for the 90-90-90 country scorecards, show that Zimbabwe has progressed as follows: 75% (knowledge of status among those with HIV); 89%, for those living with HIV who know their status and are on treatment and 81% of PLHIV on treatment who are virally suppressed (UNAIDS 2017c:16).

- HIV and AIDS knowledge

The 2015 Zimbabwe Demographic Health Survey (ZDHS) covered issues relating to knowledge of prevention methods and reflects that knowledge for 15-49-year-olds is generally widespread throughout Zimbabwe (ZIMSTAT & ICF International 2016:33). HIV prevention knowledge increased since the 2010-11 ZDHS (ZIMSTAT & ICF International 2016:33). For example, the fact of 79% of the women (compared to 77%) and 85% of the men (compared to 79%) cited using condoms during sexual intercourse and limiting sexual intercourse to one uninfected partner, is thought to have contributed to reduction in the possibility of HIV infection (ZIMSTAT & ICF International 2016:33).

Indications are that urban dwellers are more knowledgeable on each described HIV prevention method than those in the rural areas. In the 15-24-year-old group, nearly half were knowledgeable on HIV prevention methods. It was concluded that the knowledge level had a strong positive association with education and wealth (ZIMSTAT & ICF International 2016:34-35). National policy and the prevailing legal framework also had a role to play.

- Policy and Legal framework

In 2000, a National AIDS Levy was introduced. It was pegged at 3% of tax on the incomes of those in the formal sector. It was introduced to act against HIV and AIDS (Nyoni 2008:63). There were, however, allegations of mismanagement and underutilization of the funds raised thereby (Nyoni 2008:63).

The National AIDS Council (NAC) became operational in 2010 after the National Policy on HIV and AIDS was adopted in Parliament in 1999. Thereafter, various strategic frameworks to guide the response to HIV and AIDS were designed and instituted. These are discussed in detail in Chapter 3 under Zimbabwe's policies and strategies. Internationally, Zimbabwe is committed to several HIV and AIDS agreements including the MDGs and the 2011 UN Political Declaration on HIV and AIDS (GoZ 2012:14-15).

Despite these agreements, the Zimbabwe 2012 Millennium Development Goals Progress Report states that Zimbabwe has found itself facing challenges in being on target for 2015 for the sixth millennium goal (GoZ & UN 2013:55). Goal six is further divided into three parts, of which the first two are HIV and AIDS-related as follows: 6a: have halted by 2015 and begun to reverse the spread of HIV and AIDS. Zimbabwe stated that it was likely to achieve this goal by 2015 provided that current efforts continued. 6b: achieve by 2015, universal access to treatment for HIV and AIDS for all those in need. In this case, Zimbabwe stated that it had the potential to achieve these specific goals. The challenges specifically related to Goal Six were the inadequate allocation of funds from the national budget, the inadequacy of human resources for health and weak health information systems for data collection, analysis and interpretation. A crucial notable challenge was the low paediatric ART coverage (GoZ & UN 2013:55). Overall, a key challenge facing all six goals was the lack of up-to-date information for policy-making (GoZ & UN 2013:77). When there were 168 days left of 2015, Zimbabwe, together with other developing countries, had failed to attain most of the MDGs (Matabvu, 2015). The Final Progress Report on Zimbabwe's MDGS highlights that the MDGs era coincided with one of the most challenging times in Zimbabwe's economic history. Despite this, considerable progress was made on some MDGs, especially certain aspects of HIV, gender equality, provision of ARVs, to name a few. The Sustainable Development Goals (SDGs) were introduced before the MDGs were fully achieved (GoZ & UN 2015:15). This therefore means that there was an overlap between the MDGs and the SDGs; the progress is ongoing in Zimbabwe.

Concerning human rights, commercial sex work and homosexuality are illegal. Nevertheless, the fact that these groups have no legal standing notwithstanding, services are not denied these population groups (GoZ 2012:17).

Even though there are policies and laws responsive to gender issues (such as the Domestic Violence Act), gender inequality is still in existence (UNFPA 2011:2). An example of this, is the under-representation of women in Parliament (UNFPA 2011:2). Women occupy few decision-making positions even though Zimbabwe has achieved gender parity at the levels of primary and secondary school education (GoZ & UN 2013:9). In addition to the National HIV Policy 1999, the NAC Act and the Domestic Violence Act, the national HIV and AIDS response is guided by the following policies and strategic documents: Income Tax Act, National Health Policy, Zimbabwe Agenda for

Sustainable Socioeconomic Transformation (ZIM Asset), Zimbabwe National HIV and AIDS Strategic Plan (ZNASP, 2011-2015) and the National Health Strategy (2011-2015) (GoZ 2014:6).

Political support has also been demonstrated by the establishment of the Zimbabwe Parliamentarian Portfolio Thematic Committee on HIV and AIDS. The Zimbabwe Parliamentarians on HIV and AIDS have since participated in HIV prevention programmes to be role models (GoZ 2014:14).

- Women

There are many issues generic to women in relation to HIV and AIDS, in general, and these also apply to women in Zimbabwe. These issues include the prevention of mother-to-child-transmission (PMTCT), post exposure prophylaxis (PEP) commercial sex work, gender inequalities, violence including rape as well as cultural issues.

According to The United Nations Population Fund (UNFPA), the leading causes of maternal mortality (contributing 25%) are HIV and AIDS-related. In addition, HIV prevalence was found to be higher among women aged 15 to 24 (11%) than in young men of the same age range (4.2%) and this is fuelled by intergenerational sex. The epidemic was concentrated in women aged 18 to 29 and men aged 20 to 44. (UNFPA 2011:2).

50% of the women in Zimbabwe have been subjected to sexual and/or physical violence. The factors that have hampered efforts at reducing gender-based violence (GBV) range from negative traditional norms to inadequate implementation of the national gender policy as well as the problem of women having limited access to legal aid and the means of production (UNFPA 2011:2).

From the researcher's observation in Zimbabwe over the years, the phenomenon of 'sugar daddies' and 'small houses' also impacts upon the HIV and AIDS situation. A sugar daddy is a much older man who has a sexual relationship with a much younger woman usually in exchange for material goods, money or other things. Such a case constitutes trans-generational sex. A small house is when a married man has a secret girlfriend who he looks after and has sex with. One married man may even have several small houses

as may a young lady have several sugar daddies. This does not help in curbing HIV and AIDS.

- Young generation

About 33% of the population in Zimbabwe comprises young people aged 10 to 24 (UNFPA 2011:2). Indications from the evidence on the ground suggest that young people are hard-hit by HIV and AIDS and their predicament is compounded by the lack of employment, GBV, and limited access to services (UNFPA 2011:2).

- Economy and general environment

In the researcher's previous Master's research on billboards, carried out in 2012, she cited that recent crises in Zimbabwe have had included a near collapse of the health system, a cholera epidemic, high unemployment levels, political violence and an unprecedented rise in inflation of 231 million percent in July 2008 (Chiwara 2012:23). The economy declined by 50.5% in the same period (UNFPA 2011:2).

What this means is that the depressed economic environment in Zimbabwe has tended to fuel poverty and to create a situation that is not conducive to adequate mitigation of HIV and AIDS. The researcher, who lives in Zimbabwe, has observed that while the country is in a state of recovery, it is still dealing with many of these issues. Thus, the environment within which HIV and AIDS are combated, is a challenging one, given that Zimbabwe has one of the highest HIV prevalence rates in SSA, as stated earlier. However, the country has experienced a comparatively more stable economic situation since the introduction of the multicurrency system February 2009. In the same year inflation dropped to 7,7% and the economy grew by 5,7% (UNFPA 2011:2).

According to the Zimbabwean government, "The political, legal, social and economic situation in 2013 was conducive for a broad-based multi-sectorial and multilevel participation in the national response to HIV and AIDS" (GoZ 2014:14). The researcher concludes that though the environment was challenging, particularly before the introduction of the multicurrency system, it has been possible to make some noteworthy progress in the HIV epidemic in Zimbabwe.

1.3.4 HIV and AIDS communication

The researcher has observed over the years that there are various modes of HIV and AIDS communication, although the modes may not necessarily be unique to HIV and AIDS. These modes include IPC, for example communication from health professionals, parents, friends and community leaders such as teachers and religious leaders. There is also creative communication in the form of theatre dramas and the use of music. Mass media or mass communication includes television, radio (both are broadcast media), newspapers, magazines, outdoor advertising such as billboards and small media such as pamphlets and posters. Recently, other more technologically advanced options such as the use of mobile phones (via small message services, WhatsApp etc.) have come on board, and there is also wide use of the internet including social media such as Facebook, Twitter and LinkedIn.

The observations on mass media made herein are supported by a comment made in a UNAIDS report under the sub-heading, 'Reinvigorating Social and Behaviour Change' which states, "The global revolution in information and communications technology – which has dramatically altered the ways in which people network, interact, communicate and share information – offers new opportunities to expand and reinvigorate social-behavioural and structural programming. These include the strategic use of 'old' media opportunities (such as fictional television series that promote HIV prevention in Zambia), as well as increased leveraging of additional information tools such as strategies that integrate mobile telecommunications within health programmes for improved delivery of services" (UNAIDS 2013:15-16).

Some of the research done in HIV and AIDS communication is discussed in parts of the following subsections but more so in Chapter 2.

1.3.4.1 Mass communication

According to a research paper related to newspapers and HIV and AIDS, researchers in media began analysing HIV and AIDS coverage from the mid-1980s (D'Angelo, Pollock, Kiernick and Shaw 2013:105).

In Nigeria, empirical studies in this field focused on incidences of HIV and AIDS information, the depth of HIV and AIDS information and the nature of HIV and AIDS

information in the media. The studies only briefly compared individual and contextual information (Okidu 2013: [3]).

Empirical studies done in developing countries have tended to focus less on HIV and AIDS information types and more on the volume and quantity of HIV and AIDS information. For example, in 2005 a study carried out on media content by the International Federation of Journalists found a low incidence of HIV and AIDS information in South Africa, Zambia, India, Cambodia and the Philippines (Okidu, 2013: [3]).

One study analysed the impact of press-state relations on the HIV and AIDS agenda in African news coverage (D'Angelo et al 2013:100). The study involved four African countries in SSA, namely South Africa and Nigeria (Contained Democratic media systems) and Zimbabwe and Kenya (Repressive Autocratic Media Systems). A key finding was that Contained Democratic media systems can aid in stronger positive responses from the society as compared to their counterparts. Content was analysed from each of the country's leading Anglophone newspapers, from 2002-2007 (D'Angelo et al 2013:100). One prior observation by the researchers of this second study was that politicians in their respective countries tend to view newspaper coverage (more than broadcast coverage), as an opportunity for furthering their arguments about HIV and AIDS among the public (D'Angelo et al 2013:113). Another conclusion was that "Sub-Saharan Africa is home to the highest prevalence of AIDS in the world, and news organizations there play a pivotal role in shaping individual, social and political responses to the disease" (D'Angelo et al 2013:119).

In a newspaper-related study done to see the extent of coverage for older adults and HIV and AIDS in terms of risk information for an invisible population, the study looked at the period from 1989 to 2005 (LaVail 2010:170). The key findings in this study were that risk information was distorted and that this could contribute to rising infection rates. Inter-coder reliability was used (LaVail 2010:184).

1.3.4.2 Interpersonal communication

In a mixed methods study related to voluntary medical male circumcision (VMMC), one HIV prevention method, in the survey part of the study, the sources of information for VMMC there were fifteen options, the last of which was the one that said 'other' (Hatzold, Mavhu, Jasi, Chatora, Cowan, Taruberekera, Mugurungu, Ahanda and Njeuhmeli 2014:4). Among the IPC channels, most respondents cited the health and community

worker as the primary source of information (28.7%), followed by peers, friends and relatives (26.2%), small group discussions (7.3%), road shows organised by Population Services International (PSI) (5.6%), door-to-door visits by community mobilizers (5.2%) and community drama (3.4%) (Hatzold et al 2014:3). A recommendation from the study was that materials should be tailored for women because firstly, they appeared to be less knowledgeable about VMMC and secondly, they play an influential role in generating support for their partners and sons to be circumcised (Hatzold et al 2014:5).

1.3.4.3 Perceptions of target population

A look at the perceptions of the target sub-population, gives insights into their perspective of HIV and AIDS communication. A study was carried out in Kenya, on a sub-group of rural Samburu women. It investigated the perceptions of this sub-group. Perceptions play a prominent role in the communication process and can determine success or failure. Additionally, the background from which the person receiving the communication comes, the intensity of the communication and the concreteness of the message all influence perception (Wanyoike 2011:25-27).

A study carried out in 2007 in Angola, and focusing on women, who were bringing a sick child to a specific hospital in the capital city of Luanda, investigated their knowledge about the causes of HIV and AIDS. The study concluded that although the respondents were aware of the key issues surrounding HIV and AIDS, there were some areas of great uncertainty such as the cause of the disease, the prevention methods, risk factors and precautions to be taken when living with an HIV positive person. One of the key recommendations was to encourage media such as radio, television and newspapers, to report on and inform people about HIV and AIDS and allow interactive communication on the topic but in an appropriate language (Panda 2007:87).

1.3.5 Developing guidelines

This section introduces the concept and process of developing guidelines by analysing one study whose goal was similar: to formulate guiding principles or guidelines for specific areas.

A study was carried out whose purpose was to make recommendations and suggest guiding principles for future clinical practice in HIV rehabilitation (O'Brien, Wilkins, Zack and Solomon 2011:457). In terms of methodology, the study used literature review and consultation. As was the case in this study, a search of the literature may not reveal any

existing guidelines in an area. The consultation phase comprised focus group discussions (FGDs) and key informant interviews. This was with a view of identifying recommendations and guiding principles which would then inform the future of Clinical Practice Guidelines in HIV Rehabilitation (O'Brien et al 2011:459). The study concluded that the resulting recommendations and guiding principles should inform and build on existing guidelines to produce evidence-informed, consensus-based, useful, practical and accessible guidelines. In addition, the study also showed that current knowledge should be used so that high quality guidelines that are specific, relevant, and that consider the context, are produced (O'Brien 2011:466). The researcher adopted these guideline formulation recommendations together with those from WHO, described in Chapter 6.

1.4 Statement of Research problem

As seen in earlier statistics in Chapter 1, Zimbabwe has one of the highest HIV prevalence rates in the world. Also, the proportion of women in Zimbabwe was 52% in the general population and 59,4% of the adult population (aged over 15) living with HIV and AIDS. Of this, the 20-29 age group has the highest number of new infections. Recent figures indicate that has not changed: 55% of women in the general population are living with HIV while 60% of the adult population (aged over 15) are living with HIV (UNAIDS 2017a). Against this background, the problem is that 20-29-year-old urban women are affected greatly, despite all the communication efforts being made.

An assumption was made that the HIV and AIDS communication efforts for the target group are not optimal and appear to have gaps. Therefore, certain areas were to be explored in-depth regarding HIV and AIDS communication as it relates to young urban Zimbabwean women. The investigation was aimed at determining which were the most suitable and effective communication channels, the knowledge and perceptions, and the context of the young urban Zimbabwean women.

An in-depth study at doctorate level was considered broad enough and assumed to have enough depth to generate new insights and knowledge in this regard. The target group's input contributed to the guidelines for HIV and AIDS communication, and it is anticipated that these will influence policy formulation and ultimately also influence communication programmes so that they are better tailored for this target group. The long-term effect is for the perceptions and ultimately the behaviour of women to improve, thus reducing HIV

incidences for this sub-group, hence moving Zimbabwe forward in terms of mitigating HIV and AIDS together with other countries.

HIV and AIDS practitioners have initiated community-based and community-wide programmes and these are more sustainable than communications or media campaigns (UNAIDS/PennState 1999:72). Here we can see that a sense of ownership by the community plays a big part in the success of a communications strategy. It is therefore further justification for the development of guidelines with communities playing a key role or a more prominent role than may currently be the case, as demonstrated in the guidelines in Chapter 6 (Community involvement). The use of an old reference, from 1999 UNAIDS/PennState, is justifiable because of its relevance to the study, and given that it contains the theoretical framework for the study, and that 'community' is one of the variables.

1.5 Research Aim

The study aimed to explore HIV and AIDS communication from the perspective of young urban Zimbabwean women, thus generating new insights. The study explored the communication channels through which this sub-group received its information on HIV and AIDS, the knowledge gained and the extent to which the sub-group's perceptions were shaped by this information. In addition, the research aimed to describe the women's context in detail. The current study went beyond exploration, because at the end of the study, guidelines were the main output, guided by the analysis of the research.

1.6 Research objectives

The specific objectives of the study were:

- To explore the HIV and AIDS communication channels through which young urban Zimbabwean women receive their information
- To examine the HIV and AIDS knowledge and perceptions acquired by young urban Zimbabwean women
- To describe the context of young urban Zimbabwean women
- To draft guidelines for HIV and AIDS communication providers, for improving the HIV and AIDS information targeted at young urban Zimbabwean women.

1.7 Research questions

The following research questions guided the study and were answered on completion of the study:

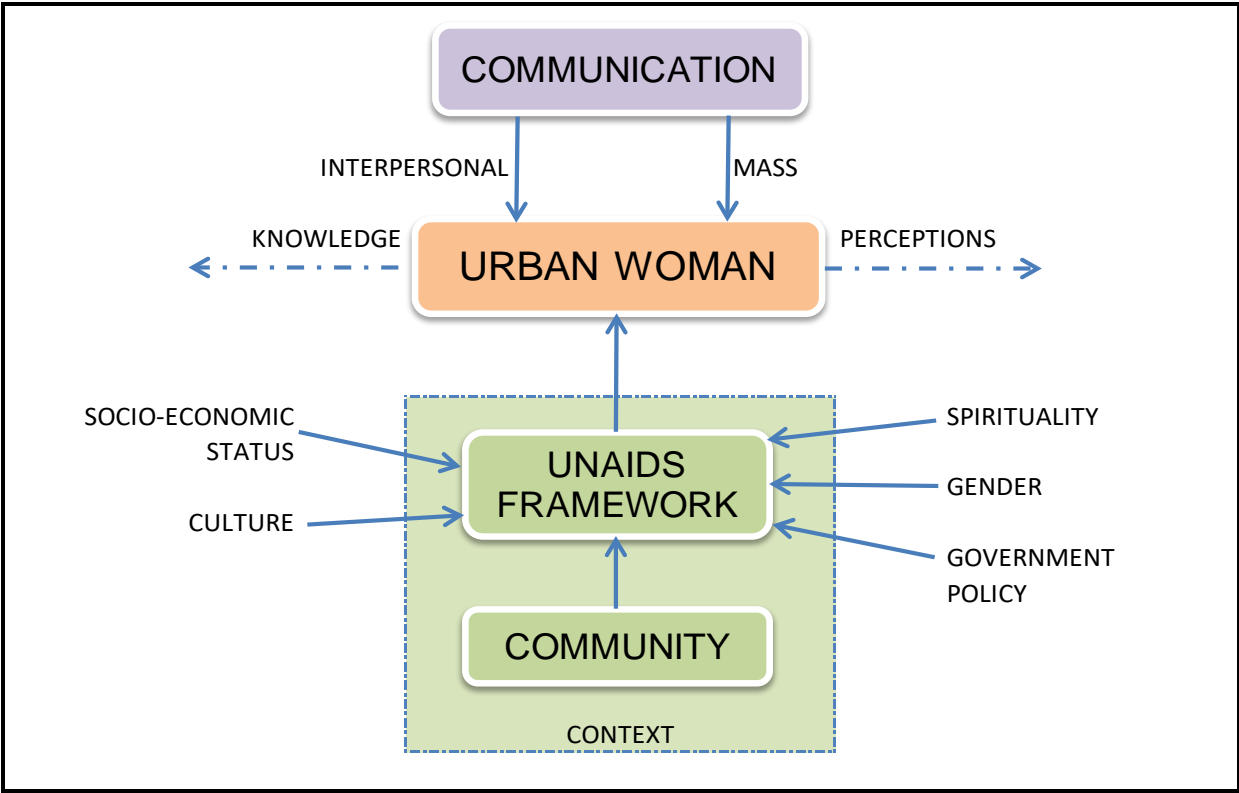
- Which are the communication channels through which young urban Zimbabwean women receive HIV and AIDS information?
- What HIV and AIDS knowledge and perceptions have young urban Zimbabwean women gained?
- What is the context of young urban Zimbabwean women?

1.8 Theoretical Framework

The model of HIV and AIDS communication that guided the study was designed through UNAIDS facilitating, between 1997 and 1999, discussions among leading researchers and practitioners from various parts of the world (Airhihenbwa, Makinwa & Obregon 2000:101). The rationale for the model or UNAIDS framework is the fact that the context that a population lives in influences its reception of the HIV and AIDS information and, therefore, also influences its subsequent perceptions and behaviour. Five main domains that summarize this context were identified and are as follows: government policy, socioeconomic status, culture, gender and spirituality. This information was applied and contributed to generating the variables of the study. In addition, during the discussions led by UNAIDS, each region was required to further emphasize certain areas depending on their circumstances. In this regard, Africa's focus was community involvement. The domains typically affected decision-making in the HIV and AIDS context and therefore had an impact on communication programmes (Airhihenbwa et al 2000:104-108). The results of the current study highlighted the role community plays in HIV and AIDS communication.

The new model still recognized the importance of the individual (Airhihenbwa et al 2000:103). The model's framework is described as a house with a roof, foundation and body and one that is responsive to the environmental (physical and social) conditions. The double doors are representative of the implementation and evaluation elements, while the windows enable countries to avail themselves of the opportunity to address specific issues related to the epidemic in their country or region (Airhihenbwa et al 2000:104). This theory is of great relevance to the study as the women's perspective of HIV and AIDS communication cannot be explored in isolation. The UNAIDS Communication Framework was adapted for the study as follows: the variables were HIV

and AIDS knowledge, HIV and AIDS perceptions, IPC, mass communication and the urban women’s context (covering the five domains as presented in the UNAIDS framework, as well as community involvement).



(Chiwara 2017)

Figure 1.2: Relationship between study variables of context, interpersonal communication, mass communication, knowledge and perceptions

1.9 Definition of key concepts

HIV and AIDS

“HIV stands for human immunodeficiency virus. It is the virus that can lead to the acquired immunodeficiency syndrome, or AIDS. Unlike with other viruses, the human body cannot get rid of HIV”. One therefore has HIV for life. While there is no cure for HIV, it however, can be controlled with proper medical care (CDC [s.a.]).

Operational definition: The viral infection known as HIV, which can lead to the disease AIDS.

Interpersonal communication

This is defined by Books and Health as “the process by which information, meanings and feelings are shared by persons through the exchange of verbal and nonverbal messages” (Hargie 2011:15).

Operational definition: Communication between individuals.

Mass communication

The industrialized production and multiple distribution of messages through technological devices. Mass media are the technological instruments (Turow, 2011:14).

Operational definition: Communication targeted at the masses with the aid of various technologies.

Young urban women

In this study, ‘young urban women’ refers to women living in towns or cities, specifically those living in Harare and Bulawayo (both in Zimbabwe) and who are aged 20-29 years.

Perceptions (of young urban women)

“Perception is a mode of apprehending reality and experience through the senses, thus enabling discernment of figure, form, language, behaviour, and action. Individual perception influences opinion, judgment, understanding of a situation or person, meaning of an experience, and how one responds to a situation” (Munhall 2008).

Operational definition: The knowledge, beliefs, opinions and attitudes (of the young urban women) towards HIV and AIDS and communication thereof (Wanyoike 2011:28).

Guidelines

From WHO’s perspective, a guideline is a document “containing recommendations for clinical practice or public health policy” (WHO 2014:1). Recommendations inform end-users of the guideline and what they can or should do to achieve the best possible health outcomes, individually or collectively, in specific situations. Choices are given between several interventions and there is also guidance on how to prioritize and select interventions (WHO 2014:1).

In the case of the current study, the guidelines contain recommendations for public health policy specifically for HIV and AIDS. It was outside the scope of this study to give options and prioritize interventions. The guidelines from the study will be presented to the policy makers who are better-positioned to consider these guidelines, debate them and select,

prioritize, give options, adopt and implement recommended interventions. Therefore, in the context of this study, guidelines are taken to mean consolidated and structured recommendations or guiding principles developed with guidance from the analysis of the study results and literature review.

1.10 Research methodology

1.10.1 Research paradigm

The researcher selected the philosophy of an interpretivist for the study. An alternative name for interpretivism is 'naturalism'. Interpretivism/naturalism is based on the 'objective knowledge of an individual' rather than 'absolutism' as in the case of positivism. Naturalists use qualitative methodologies and case studies as a way of being responsive and sensitive to individuals and their contexts (Eslami 2013:192).

The research paradigm that was selected for this study is a qualitative one. This being an exploratory study, it is focused on probing the respondents' thoughts, ideas, perceptions and understanding. Qualitative research is an effective way of exploring more deeply the lives and perspectives of individuals and groups (Christensen et al 2011:361).

1.10.2 Research design

There are four major qualitative research methods and these are namely phenomenology, ethnography, grounded theory and case study research. It is permissible to mix the approaches with the goal of meeting the research objectives (Christensen et al 2011:367).

One design that was employed in the study was phenomenology. The researcher attempted to understand and describe how the respondents (young urban women) experience a phenomenon, in this case HIV and AIDS communication. Significant statements were recorded and analysed (Christensen et al 2011:368-369). To achieve triangulation, the case study became the second design. Case study research is also a qualitative research method. It involves the researcher providing a detailed description and account of one or more cases (Christensen et al 2011:374). In the study, the case was the group of women who were interviewed, from the target population. The specific design was an instrumental case study, where the researcher studied selected young urban women with a view to understanding better young urban women in general. This demonstrates that "The specific case is not as important as gaining an understanding of the phenomenon or event" (Christensen et al 2011:375).

1.10.3 Setting and population of study

The selected population came from urban areas of Zimbabwe, specifically from two cities, Harare and Bulawayo, where the majority (65%) of the urban population lives. The sample of the respondents was 20-29-year-old Zimbabwean women.

1.10.4 Sample and sampling method

Purposive sampling was used as the desired features can easily be explained and located (Christensen et al 2011:159). The MoHCC was purposively selected as the major key informant. Thereafter, the snowball strategy was also used to obtain other key informants, envisaged to be partners of MoHCC such as non-governmental organisations (NGOs). In a similar study in Kenya, investigating perceptions, key informants were interviewed until data saturation was reached (Wanyoike 2011:153). The researcher, who undertook the current study which is similar in nature, interviewed key informants up to the point of data saturation, when no additional information was available. Key informants were selected that are experts in HIV and AIDS communication. This was important to inform the guidelines and to triangulate some of the information from the sub-population. The key informants were selected from organizations and not the sub-population.

Cluster sampling was used in selecting women from the high, medium and low-density areas in both Harare and Bulawayo. Thereafter, the snowball method was also used where respondents were asked to refer other similar women for the study (Christensen et al 2011:159). The total number of women in the current study, in FGDs, was 62, less than the 85 for the study in Kenya, which focused on perceptions of HIV and AIDS of rural women; these women were in 10 FGDs (Wanyoike 2011:136). It is recommended that sample sizes like those of other similar research studies should be used (Christensen et al 2011:160). In the current study, an additional 25 respondents undertook in-depth interviews, bringing the total number of young urban women respondents to 87.

For the individual interviews, women who were not part of any of the FGDs, but who qualified to be in the study (aged 20-29), were purposely selected to participate in face-to-face in-depth interviews. As described earlier, the in-depth interviews for the key informants, the snowball effect was used until data saturation was reached.

Detailed information regarding the sample and sampling method are provided in Chapter 3.

1.10.5 Data collection

A pre-test of the two data collection tools for the target population, was carried out and adjustments made accordingly to refine the data collection procedure.

For the key informants, in-depth interviews were carried out. The interviews were of an in-depth and face-to-face nature with key informants. Key informants were those informants deemed to be experts in the area to be studied (HIV and AIDS communication). An interview guide with a series of open-ended questions allowing for prompting for additional information, was designed to give room for the informant to explain fully (Christensen et al 2011:56). The interview followed a conversational mode (Yin 2011:134). The conversational mode is a dialogue between the interviewer and interviewee.

For the young urban women, the data collection tool was the FGDs and in-depth individual interviews. The FGDs entailed collecting data in a group set-up. An experienced moderator led the discussions with a small number of urban women aged 20-29 and groups comprising 6-12 people. The sessions were each recorded with a Dictaphone, as were the individual interviews, to maintain scientific rigour and ensure that the data are trustworthy.

1.10.6 Data analysis

For the key informant and individual interviews, the study used Colaizzi's method for the data analysis. The method has seven distinct steps (Morrow, Rodriquez & King 2015: [7]). The analysis involved writing in narrative form, after reading, rereading and reflecting and finally explaining in detail the significant statements (Christensen et al 2011:369). The FGDs and individual interviews were audio-recorded following which the recordings were transcribed and translated to facilitate the data analysis. This was in addition to the notes taken during data collection. NVivo software was also used for the FGD analysis, while the in-depth interviews for the young urban women and for the key informants was analysed manually.

1.10.7 Trustworthiness

Interviews provide a moderately high measurement of validity (high reliability and validity) for well-constructed and well-tested interview protocols (Christensen et al 2011:58). The useful strategy of member checking was used. This entails asking those interviewed if the significant statements, meanings, and phenomenological summary is accurately

expressed (Christensen et al 2011:369 -370). This applied to both the individual interviews as well as the key informants' interviews. The recordings were transcribed for accurate data analysis. A pilot study was carried out and included one individual in-depth interview and one FGD. The tools were adjusted accordingly to ensure clarity. The findings were not used in the main study.

1.11 Ethical considerations

Informed consent forms (explaining the study's objectives, assuring confidentiality and anonymity) were given to the respondents for the FGDs, and signatures were sought from everyone before proceeding with data collection. This was also done for the individual study in-depth interviews. The phone number for the Medical Research Council of Zimbabwe (MRCZ) was written on each form to enable them to report anything unethical and to safeguard the respondents.

The study was of an insignificant risk nature. There was probably a degree of discomfort for some respondents during the FGDs in that people within the FGD could hear the opinions expressed by people other than themselves. This was a possible area of concern with some participants uncomfortable with being identified and linked to specific responses or the audio tape being used for recording. Verbal assurance was given and in addition, the researcher directed the attention of participants to the confidentiality clause and the consent form. The biographical data, which was collected together with the consent form, was anonymous and this was also highlighted to the respondents. The moderator and research assistant counter-signed a confidentiality clause on each of the consent forms.

The ethical clearance from UNISA is shown in Annexe A. Annexes B and C show the application to MRCZ and the subsequent approval it gave to carry out the study in Zimbabwe. Letters were written and given to the heads of all organisations from which key informants hailed – see Annexe D.

1.12 Significance of study

The output of guidelines, targeting young urban Zimbabwean women, currently the subgroup with the highest incidence of HIV and AIDS, are based on the study recommendations, with a view of improving distinct aspects of communication for HIV and AIDS and ensuring the contextual factors that affect young urban women as

mentioned in the UNAIDS Communication Framework for HIV and AIDS, are considered. Those identified as most accessible to the sub-group can also be trained to improve their interpersonal skills.

1.13 Scope

The women, aged 20-29, were selected from the urban population in Harare and Bulawayo, two cities which between them are host most of the country's urban population. Other cities, towns and urban areas were not considered for this study, as it was not feasible to go to all of them. Rural women were not considered for the study.

1.14 Outline of thesis chapters

The outline of the chapters for the thesis is as shown in Table 1.2.

Table 1.2: Flow of thesis chapters

	Chapter Title
Chapter 1	Orientation of Study
Chapter 2	Literature Review
Chapter 3	Research Methodology
Chapter 4	Data Analysis and presentation of results
Chapter 5	Discussion, conclusions, challenges and limitations
Chapter 6	Recommendations, guidelines and concluding remarks

1.15 Conclusion

The first chapter gives an overview of the study; it contextualizes the study and gives the relevant background to the research problem. It summarizes the global, regional and local outlook on HIV and AIDS. It introduces communication for HIV and AIDS, briefly explains guidelines' development and describes the research problem, aim, objectives, and questions. The theoretical framework of the study, definitions of key concepts and research methodology are then outlined. Thereafter it summarizes the ethical considerations, significance of the study, scope and outlines of the thesis chapters.

CHAPTER 2

2 LITERATURE REVIEW

2.1 Introduction

This chapter focuses on what is currently known about the study topic by reviewing related literature. In addition to the literature review being of a global and regional nature, where possible, it will detail the Zimbabwean experience so that the context of the study is better understood.

The HIV and AIDS epidemic is elaborated on while health communication strategies are discussed. The UNAIDS Communication Framework was used by the researcher and therefore discussed in detail, including how variables were generated for the study. A community-based approach, together with regional cooperation, is important when the framework is applied in the African context.

The literature review concludes with investigating what is involved in developing the required guidelines. It also examines previous research related to the study topic. Prior research shows that the study that was undertaken can indeed contribute to the existing body of knowledge.

The researcher chose HIV and AIDS, an area that is dynamic and is continually changing and being updated. Therefore, much of the literature is from recent electronic sources. These come in the form of articles and reports from international organizations including UN organs like UNAIDS. There are also several news reports used as well as GoZ documents.

The following databases were used:

- Bielefeld Academic Search Engine
- Centers for Disease Control and Prevention (CDC)
- Directory of Open Access Journals (DOAJ)
- Google Books
- Google Scholar
- Health Communication Capacity Collaborative
- Health Compass
- International Labour Organization (ILO)

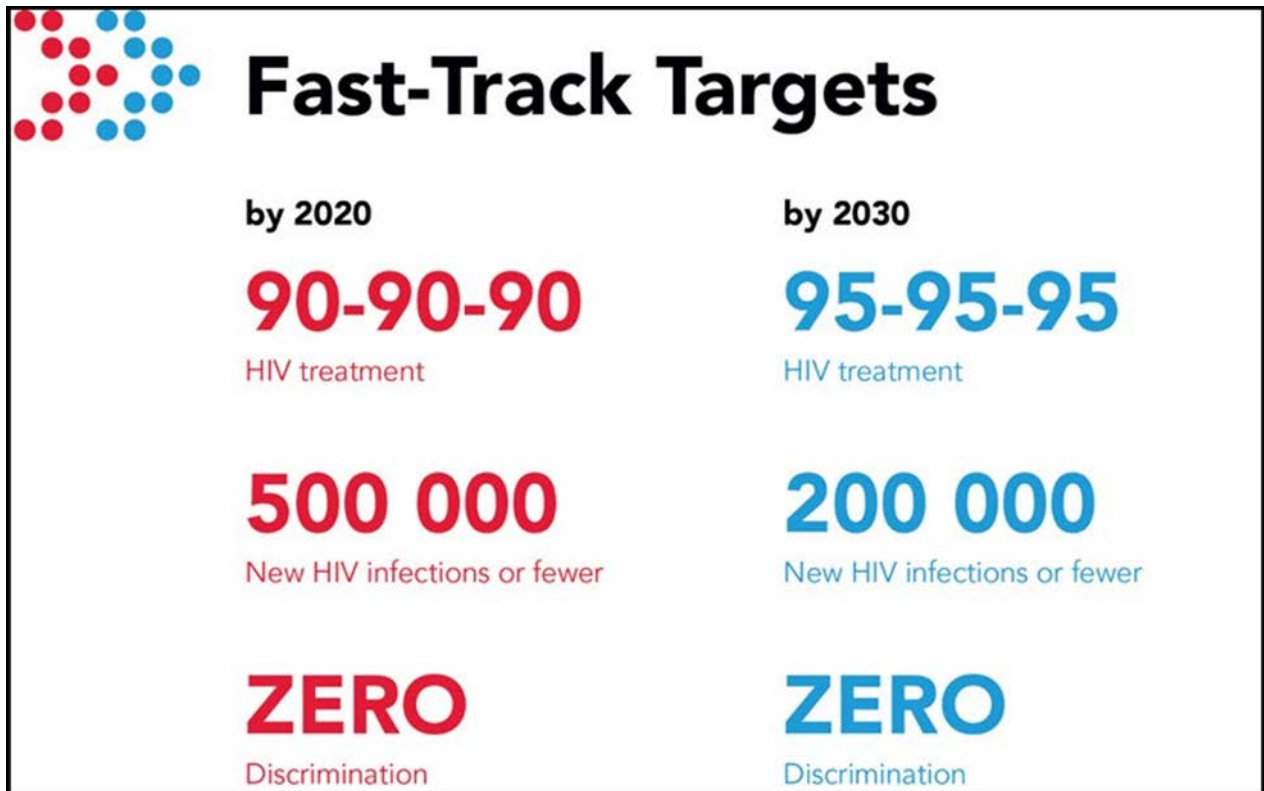
- John Hopkins Centre for Communication Programmes
- John Hopkins School of Public Health
- Microsoft Academic Search (Disciplines: Multidisciplinary, Arts and Humanities)
- OpenDOAR (Directory of Open Access Repositories)
- Routledge Books Open Access
- SAGE Open
- South African National ETD Portal
- Taylor and Francis Open (Subject areas: Communication studies, Behavioural Sciences, Development Studies, Education, Health and Social Care> 1 Jan 2010 to 12 Jan 2015)
- The UNISA Library: Oasis Catalogue; the Institutional Repository.
- UN Women
- UNAIDS
- UNFPA
- WHO
- World Bank Open Knowledge Repository

2.2 The HIV and AIDS epidemic

To better understand the dynamics of HIV and AIDS, and ultimately aim at improving communication for women in this area, we look at the epidemic in more detail. In all recorded history, AIDS is one of the most important global public health issues (Smith 2014).

2.2.1 Global outlook and targets

After attaining the '15 by 15' goal, the world embraced a new target of 90-90-90. The '15 by 15' target, according to the UNAIDS Executive Director, is the first time in the history of global health that a treatment target has been reached by the deadline. The report, that focuses on 2011-2015, details what happened to make the goal possible: political commitment to the '15 by 15' target; increased funding for HIV testing and treatment services; knowledge of HIV status substantively increased; the continued decline in the prices of antiretroviral regimens and key diagnostics; improved HIV treatment programmes' efficiency and quality; institution of innovative service delivery models which have enhanced the reach and impact of treatment; the decline of HIV-related stigma through mitigation. Going forward, the strategy is to leverage on the '15 by 15' success (UNAIDS 2015a).



(UNAIDS & the African Union 2015:7)

Figure 2.1: Fast-Track Targets for 2020 and 2030

Figure 2.1 states, for example, that the goal is no more than 500,000 new infections by 2020 and 200 000 new infections by 2030 (UNAIDS & AU 2015:7).

The new WHO guidelines to help attain the first of the three UNAIDS goals (90-90-90 by 2020), were launched on 19 July 2015, at the eighth International AIDS Society Conference (IASC) held in Vancouver in Canada (Kironde 2015). The following is the 90-90-90 strategy in detail:

- “By 2020, 90% of all PLHIV will know their HIV status.
- By 2020, 90% of all people with diagnosed HIV infection will receive sustained ART.
- By 2020, 90% of all people receiving ART will have viral suppression” (Kironde 2015).

As a way of mitigating unknown HIV statuses, the WHO recommended that countries should improve the effectiveness of their HIV-testing services to reach PLHIV who are undiagnosed. It was anticipated that this would link them to HIV-prevention, care and treatment (Kironde 2015). The WHO also planned to assist countries achieve the second and third UNAIDS 90-90-90 by 2020 targets. The WHO guidelines are anticipated to help in taking strides towards an AIDS-free generation (Kironde 2015). Currently, more than 66% of PLHIV globally know their status (UNAIDS 2017b:9). 77% are on ART while 82% of those on treatment have suppressed viral loads (UNAIDS 2017b:9).

Although there has been much gain in terms of the availability of antiretroviral medications in developing countries, the growing consensus is that unless prevention efforts are intensified, HIV and AIDS will not be defeated from just tens of millions of people being put on lifelong treatment. This may be unaffordable and unsustainable, especially with the possibility of drug resistance – second and third line medicines will become increasingly necessary but these are also expensive alternatives. Behaviour change is widely recognised as being central to prevention efforts (Halperin et al 2011: [1]).

While behaviour change takes care of the ‘what’ part, communication efforts can take care, to a substantial extent, of the ‘how’ part. Communication efforts need to have strong elements of behaviour change. The communication of messages plays a pivotal role in HIV and AIDS messages and is very key for prevention efforts.

2.2.2 *Champions of HIV and AIDS awareness*

The concept of champions, that is, of people who champion causes, is not new or unique to HIV and AIDS. This concept is seen in advertising whether at a national, continental or global level.

2.2.2.1 *Global champions*

On 10 July 2010, UNAIDS launched a new UNAIDS High-Level Commission on HIV Prevention. This commission included 15 world leaders who are renowned, for example: former presidents of Chile, France and Botswana namely Dr Michelle Bachelet, Mr. Jacques Chirac and H.E. Festus Mogae, former basketball star Mr. Magic Johnson, who was one of the first sports celebrities to announce his HIV-positive status. The co-chairs are Archbishop Desmond Tutu, Nobel Peace Prize Laureate, and Professor Françoise Barré-Sinoussi, Nobel Laureate in Medicine for her role in HIV discovery. The strategy was for the Commissioners to rally support, swaying public opinion for effective HIV prevention programmes by utilizing their unique authority and influence, and thus lead

social and political action. There is also a Scientific Advisory Panel to assist the High-Level Commission on scientific matters (UNAIDS 2010).

2.2.2.2 Regional champions

In 2011, Oliver Mtukudzi, a Zimbabwean Musician also known as 'Tuku', was appointed United Nations Children's Fund (UNICEF) Regional Goodwill Ambassador for Eastern and Southern Africa (UNICEF 2011). His focus is on young people's development and HIV and AIDS prevention. He is the first Zimbabwean personality to use his artistic gifts and work with UNICEF in advocating for children's rights. The criteria used by UNICEF in making such appointments is not only name recognition but also is a recognition of the respect artists command and their appeal as genuine humanitarians. Oliver Mtukudzi has used his lyrics to speak out against stigma, discrimination and abuse of children (UNICEF 2011).

2.2.2.3 Local champions

Chief Chiveso, a traditional leader in Zimbabwe, spoke during the visit of UNAIDS Executive Director Michel Sidibe's visit to Zimbabwe in June 2015 (UNAIDS 2015b). The chief denounced violence against women and asked men to actively fight GBV. He was hailed by Sidibe as a champion for gender equality as well as for promoting the cessation of GBV and HIV and AIDS. Chief Chiveso gave an illustration of how a champion for a cause does not have to officially be inducted as one, but how rather they assume the role because of their words, attitudes and actions, in short, their activism (UNAIDS 2015b). This notion of champions is something that should be promoted in the community.

Vulnerable populations and key populations are not the same, as might be assumed. In both key populations and vulnerable populations, we can identify women in general, as well as adolescent girls as having a high likelihood of being infected by HIV.

2.2.3 Key populations

Key populations are groups that have a disproportionate burden in many settings and who also usually have increased legal and social barriers that increase their vulnerability to HIV. Common examples of these groups include men who have sex with men, those injecting drugs, transgender people, sex workers and those in closed settings and prisons (WHO 2015f:7).

2.2.4 Key vulnerable populations

This group is vulnerable to HIV in certain contexts or situations. Examples include adolescents (especially adolescent girls in SSA), orphans, the disabled, migrant and

mobile workers. The WHO defines an adolescent as a person aged 10-19 (inclusive) years while an adult is a person aged more than 19 years. However, it does acknowledge that these definitions may differ for others (WHO 2015f:7). While these people may face social and legal challenges in accessing HIV prevention and in obtaining treatment, they are not affected in the same manner in all countries (WHO 2015f:7).

2.2.5 The young generation

Speaking in Johannesburg at the launch of the United Nations Educational, Scientific, and Cultural Organisation's (UNESCO's) regional report on comprehensive sexual education (CSE) and sexuality and reproductive health services for young people in eastern and southern Africa, the UNAIDS regional support director, Sheila Tlou, stated that the young people are the ones carrying the burden of the HIV pandemic (Global Network 2013). She explained that this was in more ways than one since they are particularly susceptible to HIV infection and they also largely have the responsibility of looking after family members who live with HIV and AIDS. She added, "Aids is shattering young people's opportunities for healthy adult lives" (Global Network 2013). The report, compiled by several UN organizations and bilateral partners, covered 21 countries and encouraged health and education ministers to respond to the persistent elevated levels of HIV, unintended pregnancies and low HIV prevention knowledge and the effect on the region's 158 million adolescents. Sheila Tlou stated that it was expected that the young people's population was going to double to 281 million by 2050 (Global Network 2013). A fact sheet states that 33% of the population in the ESA is made up of young people aged 10-24 years and that every hour 50 young people are infected with HIV; this culminates in to 430,000 infected annually (Global Network 2013).

There are numerous organizations that are part of the global movement aimed at addressing the issue of HIV and AIDS in adolescents. These include PEPFAR, UNICEF, UNAIDS, United Nations Population Fund (UNFPA), and the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria. There are also many other agencies active among adolescent girls and young women being empowered by addressing education, economic issues and GBV. "All In!" was launched in late 2014 to early 2015 as an initiative to end HIV in adolescents. It is comprised of many of the organizations just mentioned together with youth movements. Twenty-five countries that represent 90% of AIDS-related deaths and 85% of new infections among adolescents are expected to join (Fleischman & Peck 2015:12-13). Thus, there is global evidence of political will to do something to address HIV and AIDS in the younger generation.

2.2.6 Africa

Africa has come a long way and made much progress since the epidemic first appeared some decades ago. In the beginning denial was the order of the day, but the situation is different now. Increasingly, both HIV and AIDS are being openly acknowledged and many gains realized over the years.

2.2.6.1 Denial

One of Africa's challenges from the mid-1980s has been the refusal to acknowledge that HIV and AIDS existed, and initially there were reservations about putting a human face to HIV and AIDS. In many cases there was a fear emanating from the possible loss of revenue associated with how giving HIV and AIDS could adversely affect tourism and issues of protecting those with HIV and AIDS from stigmatization, because of government policy in the early 90's. The next transition saw the silence being broken but with focus mainly on the prevention for high-risk behaviour groups. In the late 1990s southern Africa experienced a fast increase in the infection rate with countries like Zimbabwe being amongst those with high HIV infection rates (UNAIDS/PennState 1999:50-51).

Success stories with the HIV and AIDS epidemic since that era have had communication efforts being central. However, from the mid-1990s, strategies for communication had been dominated by information dissemination on a large scale. The spread of HIV and AIDS pointed to behaviour change not being as expected. This was what led to a new framework for communication being needed (UNAIDS/PennState 1999:52-53). This is dealt with in greater detail when communication strategies are discussed later in this chapter.

2.2.6.2 Gains of HIV and AIDS

Some of the gains in the HIV epidemic in the last four decades are: a decline in the number of AIDS-related deaths; more PLHIV than ever before have access to life-saving treatment; fewer babies are becoming HIV positive; there are increasingly less new HIV infections (UNAIDS & AU 2015:2). New HIV infections among the young (15-24 years) are declining and more people know their status (UNAIDS & AU 2015:8). The commitment of African leaders, scientific innovation, global solidarity and civil society (including women's movements and networks of women living with HIV) are responsible for these accomplishments (UNAIDS & AU 2015:2). 'African leaders' includes commitment from those at the highest level of Heads of States. The opportunity is great in Africa to end the AIDS epidemic as a public health threat by 2030, given the successes of the AIDS response realized to date as well as the post 2015 SDGs (UNAIDS & AU

2015:5). Of relevance to this section is Goal Three 'Ensure healthy lives and promote well-being for all at all ages' (UNDESA [s.a.]).

A report released in Addis Ababa, Ethiopia, at the Third International Conference on Financing for development stated that new HIV infections had fallen by 35% and AIDS-related deaths by 41% (Bulawayo24news 2015). The report showed that 83 countries, accounting for 83% of PLHIV, have halted or reversed their epidemics. This figure includes countries with major epidemics, such as Mozambique, Kenya, India, South Africa and Zimbabwe. Michael Bartos, Country Director for UNAIDS Zimbabwe, explained that the declaration of HIV and AIDS as a national disaster was instrumental in the success experienced by the country (Bulawayo24news 2015).

2.2.6.3 Funding

To combat HIV in the ESA, the Global Fund granted approximately US\$17 million to two consortia of organizations focusing on key populations most affected or at risk of being infected by HIV. About US \$11.4 million of this amount was budgeted for southern Africa. The programme is called 'Key Populations – Representation, Evidence and Attitude, Change for Health Impact) and is to be implemented over three years in Botswana, Zimbabwe, Namibia, South Africa, Lesotho, Swaziland and Malawi. This partnership is historical, being the first time so many regional and national partners have come together in such a manner to put focus firmly on strengthening community and civil society organizations with the objective of supporting the HIV response among those most affected. The private sector and research institutions are also involved (Nyaka 2015).

2.2.6.4 Drivers of the epidemic

The Southern African Development Community commonly known as SADC (in Zimbabwe Economic Outlook 2014) highlighted several areas as the drivers of the HIV and AIDS epidemic. One driver was extreme poverty and inequalities in income. There was also high mobility whereby people move around a lot, for example migrant labour between rural and urban areas, intra and inter country within countries in the region. Civil conflict, war and displacement was another driver (this can also encourage mobility). Other drivers were: gender-related issues including GBV; illiteracy; stigma and discrimination; alcohol abuse; multiple sexual partners; low rates of male circumcision; cultural norms (MoHCC 2015:3).

2.2.7 Zimbabwe

As with many other countries, HIV has impacted badly on Zimbabwe. It has heavily affected many sectors including the health sector, the economy (labour and firms), education and food security (MoHCC 2015:5-8). Despite this, there is some good news of progress being made.

2.2.7.1 Progress

In southern and eastern Africa, the HIV and AIDS epidemic has reversed faster in Zimbabwe than in any other country (UNAIDS 2015c:2). A question that has come up is, “Why has HIV declined more in Zimbabwe than in other Southern African Countries?” (Halperin et al 2011: [4-5]). Eight countries in southern Africa were compared during an analysis. Zimbabwe stood out as having elevated levels of both secondary education and marriage, especially in urban men. This is one group where the greatest level of behaviour change occurred. Marriage and education could have helped with a clear understanding and acceptance of how HIV is sexually transmitted, and the greater ability to implement the ‘Be faithful’ message. Increased IPC about HIV and AIDS, the effect of seeing more people die at home because of home-based care and the huge economic decline (and therefore less disposable income), are possible factors that could have contributed to the decline in HIV prevalence in Zimbabwe. It appears that since no particularly effective approaches were identified, that perhaps the cumulative exposure to many programmes is what helped create a ‘tipping point’ to improved behaviour (Halperin et al 2011: [4-5]).

About 90% of adult HIV infections in Zimbabwe arise from heterosexual transmission. The transmissions arise largely from multiple (including concurrent) sexual relationships, low levels of circumcision and inconsistent condom use (UNPFA 2011:2). In the 2015 ZDHS, the mean number of lifetime sexual partners was lower for women (1,8) than for men (6,1); it increased with age, with being separated, divorced or widowed as compared to their never-married and married counterparts, for both men and women, and slightly with education and wealth (ZIMSTAT & ICF International 2016:38).

2.2.7.2 Hotspots

A Global AIDS country report revealed that HIV prevalence in Zimbabwe is slightly higher in urban areas than in rural areas. It stated that in the 15-24 age groups, prevalence is 1.5 times higher in women than in men. Hot spots were said to exist in border towns, mining areas, growth points and resettlement farms (Ndlovu 2015). WHO (2013) describes a hot spot as a geographical location where there is evidence of high prevalence of HIV, STIs or risky behaviours that can lead to HIV infection (MoHCC

2015:3). Hotspots are also defined as “a small area within a bigger province/city/country where there is high HIV prevalence or incidence” (UNAIDS 2015d). The hot spot indicators used for a study carried out in Zimbabwe were HIV prevalence, HIV incidence rate, risk factors and service coverage data (MoHCC 2015:9). Most of the HIV geographical hot spots are in Matabeleland South province (MoHCC 2015:50). Most of the country is rated as medium, but there are elevated risk factors in these medium zones (MoHCC 2015:47). The largest hot spot area is Beitbridge town, at the border with South Africa; it is the busiest border and is open 24 hours. There is a lot of mobility in terms of cross-border traders, truckers and sex workers with the result that the risk of getting infected with HIV increases.

2.2.7.3 International funding

Funding issues are relevant to communication efforts regarding HIV and AIDS. The UNAIDS Communication Framework for HIV and AIDS highlights the need for government policy to be a prominent feature in the HIV epidemic because this reflects the political will in a nation. The funding levels need to be shared with stakeholders, including those affected by HIV and AIDS, although the detail may not be necessary. International funding has been increasing over the years.

UNAIDS has been instrumental in supporting Zimbabwe with a human rights approach to HIV programming for key populations which are often marginalized. This has been a challenge in many countries. UNAIDS has been instrumental in giving prominence to the Zimbabwe HIV response by collaborating with national partners to publicize, through both domestic and international media, the successes in Zimbabwe. This has helped bring the country’s success stories to the attention of the donors (UNAIDS 2015c:3).

In terms of funding the HIV response, the Global Fund came up with a new funding model (NFM). This was introduced to focus on countries with a high burden but limited domestic resources. Zimbabwe was among the first countries to secure a grant for its HIV response under this NFM: Zimbabwe’s AIDS response was effective, people-centred and prioritised, but heavily under-funded. UNAIDS came in and assisted Zimbabwe in going to a higher level and securing a three-year US \$311 million grant from the Global Fund. This equals all the HIV assistance the country has received from the Global Fund in the past decade (UNAIDS 2015c:2). While the first period of ART scale-up reached 85% coverage under the 2010 guidelines, under the new WHO guidelines, in 2015 it was reported by UNAIDS that only 50% coverage of the new guidelines had been reached (UNAIDS 2015c:3). An additional US \$244 million from the Global Fund was requested

to expand HIV treatment in Zimbabwe. The additional funds were anticipated in going a long way in PLHIV having early access to treatment in line with the 2013 WHO recommendations (UNAIDS 2015c:4). In the past of note, is that according to a senior UNAIDS official, there was donor fatigue as well as concern about lack of transparency and accountability in the use of donor funds that threatened future HIV and AIDS projects being funded in Zimbabwe and many other African counties. This potential risk of losing donor funding was confirmed by Dr Lovemore Mbengeranwa, the chairperson of the Health Services Board. The Executive Director of UNAIDS, who visited Zimbabwe in early 2015, confirmed this potential risk for Africa (ZimSitRep_M 2015).

2.2.7.4 Biomedical research

Zimbabwe is doing its part as far as research is concerned, in the response to HIV and AIDS. From 2016 The University of Zimbabwe-University of California, San Francisco Collaborative Research Programme (UZ-UCSF) hosted and began the country's first ever HIV vaccine trial. From 2012 to 2015, the organization was also involved in an HIV study coined 'ASPIRE' (A Study to Prevent Infection with a Ring for External Use). ASPIRE looked at whether a woman's use of a vaginal ring containing dapirivine, an anti-retroviral, was a safe and effective method to prevent HIV infection. UZ_UCSF researcher, Dr Nyaradzo Mugodi said that most of the studies focused on women because they were the most affected by HIV and AIDS. The MoHCC Minister, Dr David Parirenyatwa, commented by saying that his ministry supports any research that wants to arrest the HIV and AIDS epidemic, if proper procedure is followed (Agere 2015:5).

2.3 Communication

2.3.1 Definition

To understand health communication, it is important to first focus on communication in general. Confusion usually arises on how communication influences health outcomes. Communication is a science and is diverse. It is described in multiple ways, and here we look at some: A fundamental human process which facilitates most individual, group, organizational and societal activities including how people think about and respond to certain issues; Dervin and Foreman-Wernet (2012) state that it enables people to be aware of and discover their surroundings and make sense of through creating dialogue; Smart and Marshall (2013) describe it as being of use to teachers for teaching while learners need communication for learning; marketers use it to advertise commodities and services while consumers need it in order to decide what to buy or use, according to Storey, Hess and Saffitz (2014); according to Kincaid (2009) it is used to build consensus

and enforce norms in communities (Storey, Seifert-Ahanda, Andaluz, Tsoi, Matsuki, & Cutler 2014:S241).

2.3.2 Functions of communication

Most communication scientists agree on the four major communication functions namely informing someone or seeking information about something, motivating people to think in a specific way and act accordingly, connecting with others and participating in interpersonal relationships, and maintaining culture and norms through which social identities and values are shared. An additional commonly accepted function of communication is diversion in that entertainment and/or escape occur (Storey et al 2014: S242).

2.3.3 Communication channels

The modes through which communication takes place can broadly include any combination of non/verbal/visual, oral/spoken, written forms with or without technological assistance. Some channels permit interactivity while others do not (for example, smart phones can be interactive) and some are portable whereas some are not (Storey et al 2014: S243).

2.3.4 Health communication

Health-wise, Roter and Larson (2002) state that communication is used by health professionals for providing care in a context in which patients can also be persuaded to make healthy or unhealthy choices (Storey et al 2014: S242). Health communication is therefore seen as something that is beneficial to all stakeholders.

Babrow and Mattson (2003) describe health communication as being “Fundamental to the human experience, integrating health and illness through body, mind and community”. The U.S. Department of Health and Human Services (2010) states that ‘Healthy People 2020’ defines health communication as “The art and technique of informing and influencing individuals, organizations and communities regarding a health issue” (Sundstrom 2016:92). Cline (2003) states that health communication includes formal, informal, intended and spontaneous messages, in mediated and interpersonal contexts (Sundstrom 2016:92).

Health communication disparities exist: a study was carried out in Japan, by Ishikawa, Nishiuchi, Hayashi & Viswanath, focusing on how health communication outcomes are influenced by socioeconomic status. The findings showed an association between health information, self-efficacy and education as well as income status (Ishikawa, Nishiuchi,

Hayashi & Viswanath 2012: [1]). The study found that health communication outcomes are patterned by socioeconomic status in Japan, showing health communication inequalities that could show an association between social determinants and health outcomes (Ishikawa et al 2012: [9]).

Little has been done research-wise with regard to health communication inequalities in SSA. A study by Jung, Arya and Viswanath examined socioeconomic status, the media and HIV and AIDS-related knowledge and behaviour. The study which was carried out in 13 African countries had the following hypothesis: Communication inequalities, differential media use among social classes, may be one plausible mechanism through which social inequalities in wealth and education lead to knowledge disparities of HIV and AIDS in sub-Saharan Africa” (Jung et al 2013: [2]). Overall, the results showed that social inequalities were linked to communication inequalities in SSA. At all socioeconomic levels, there was some awareness among individuals; however, more wealth and education were consistently associated with HIV and AIDS awareness, prevention and transmission knowledge and condom use, among both men and women. This was more so in the case of education level. In addition, these links or associations are diminished when media use is added. Media use is positively linked with wealth and education in a clear and convincing manner (Jung et al 2013: [8]).

2.3.5 HIV and AIDS communication

It is recognized that biomedical interventions need the support of communication strategies so that together they win the battle of HIV and AIDS. Health communication interventions need to use multiple coordinated communication elements and in variable forms. This needs to encompass the whole spectrum of HIV and AIDS starting from prevention (Storey et al 2014: S298).

The power of communication in HIV and AIDS issues lies in its effect on knowledge, attitudes, social norms, risk perceptions and behavioural decisions (Storey et al 2014: S243).

Primary prevention programmes for HIV target preventing new HIV infections while secondary prevention programmes aim at treating existing HIV infections; the two are intractably connected (Baelden, Van Audenhove & Vergani 2012 166-167).

2.3.5.1 Communication categories

IPC and media campaigns (used herein interchangeably with ‘mass communication’ or ‘mass media’) are complimentary for HIV and AIDS interventions.

- Interpersonal communication

IPC relies on face-to-face relationships and benefits from the trust of direct connection (Sundstrom 2016:92).

The importance of IPC is its focus in matters relating to primary HIV and AIDS interventions. The role of IPC is to mediate the effects of campaigns thereby creating a social learning environment. This results in the formulation of many HIV and AIDS strategies such as entertainment education programmes using mass media channels for conveying messages and encouraging IPC among target groups. However, tangible evidence of this has been hard to harness. At the same time, there was a rise of interest in the use of recent technologies for HIV prevention. Their interactivity and anonymity uniqueness may be more appropriate than traditional channels, to stimulate IPC (Baelden et al 2012:166). IPC is important because conversations are thought to enable the creation of social learning environments which in turn can enhance critical thinking skills (Baelden et al 2012:168).

During the mid-1990s and the early 2000s, Zimbabweans began to receive information about AIDS from friends, the churches and other people, as opposed to receiving information through the mass media (Halperin et al 2011: [5]). This increase in IPC appears to have been one reason why HIV declined in Zimbabwe (Halperin et al 2011: [6]). There were other contributing factors as well.

Communication between sexual partners is probably the most intimate type of IPC that takes place. It is important to have the ability to communicate and negotiate with a sexual partner. This is a vital skill in negotiating safer sexual behaviours. The communication could be verbal and/or non-verbal. However, social and interpersonal barriers exist that make this type of communication difficult (Communication Perspectives 2009:4).

Another study carried out in Florida, U.S.A had the purpose of testing associations among communication system message, self-efficacy, perceived risk, HIV and AIDS knowledge and sexual decision-making in older adolescent females (Chandler 2008:14). The study limited interpersonal relationships to peers, partners and parents (Chandler 2008:24). Media exposure looked at television, the internet, radio, newspaper and books (Chandler 2008:70). One of the key findings was that the preferred HIV and AIDS and sex education communication systems were interpersonal relationships rather than mass media and this is something that health care providers can maximize on. Parents can also be encouraged to make use of this insight (Chandler 2008:85).

- Mass communication/media campaigns

Kline (2003) states that the role of the mass media in communication is to serve a powerful socializing role, framing health concerns and agenda-setting by repeatedly covering specific health issues (Sundstrom 2016:92).

- Channels

Television (visual/seeing), radio (auditor/hearing) and print (reading) are the most popular and effective channels used in HIV and AIDS prevention, information, educational and communication (IEC) activities and interventions. It is important to note though that according to Singhal and Rogers (2003) and Bessager et al (2004), combinations of these channels, rather than using just one, tend to be more effective in HIV and AIDS campaign (Steele 2008:8).

Traditional campaigns make use of one or a combination of media channels: television, radio, print media – mainly newspapers and magazines. However, according to Noar (2006), a sizeable number of campaigns use non-media channels like community mobilization, peer education and school-based components (Noar, Palmgreen, Chabot, Dobransky and Zimmerman 2009:32). In a review of mass campaigns, most (79%) used multiple channels while the rest used one channel only. In this study, it was found that a new trend where internet websites were an additional campaign channel was emerging Futterman et al (2001), Geary et al (2007a), and Lombardo and Leger (2007) (Noar et al. 2009). Additional review findings related to channels and getting the message out are as follows: use of creative materials such as postcards and condom packs during mass campaigns; making use of interpersonal strategies such as provider support and hotlines. Some campaigns made attempts to engage the wider community and including community partners, community coalitions and community education/mobilization. Some campaigns have made use of 'small' media such as leaflets, brochures, billboards, and newsletters (Noar et al 2009:32).

Cynthia (2008) reports that radio is the key source of information in SSA, followed by television (Jung et al 2013:1[2]). This is not surprising given the ability of broadcast media to be shared by more people and their ability to reach more people. It is also a useful mass media channel for those who are illiterate as all they need to do is listen and/or look in the case of television.

- Audience segmentation

In the study that reviewed mass campaigns, 94% reported information related to targeting specific audiences. The study found audiences segmented according to gender, race/ethnicity, sexual orientation, age group, geographical location and sensation-seeking and impulsivity (Noar et al 2009:30-31).

In addition to others, the researcher's study employs three of these variables, to form a specific target of young urban women: gender (women), age group (20-29 years) and geographical location (Zimbabwe urban areas), based on the UNAIDS Communication Framework for HIV and AIDS. Therefore, the recommendations and guidelines are for this specific segment of the population.

- Message and theme/slogan

Regarding the message being promoted, the review found that 30% of the campaigns design used the entertainment education strategy. 82% of the campaigns reported a theme or slogan for the campaign (Noar et al 2009:31).

- Technology

New technologies are also referred to as e-health. Unlike traditional media channels, new technologies enable the customization of information, communication that is widespread and at the same time tailored, participatory, interactive, and possibly for users to access information on demand. According to Broom (2005) and Ziebland (2004), some advantages new technologies have over conventional media channels include: the internet provides tailored messages in a relatively cheap and time-saving manner; the high level of anonymity is relevant as HIV and AIDS still has stigma and discrimination associated with interactivity (Baelden et al 2012:169). An internet user becomes an active producer of health information as well as a passive one; the internet can be used for both mass and IPC (Baelden et al 2012:169).

A pilot project was launched in parts of Shurugwi district, Zimbabwe, by the Zimbabwe Women's Resource Centre and Network (ZWRCN) following the realization that information can be used with technology, more specifically with mobile phones. In this particular case, the information being mediated all related to sexual and reproductive health information. HIVOS gave support for the project. The launch of the project came against the background of a survey that revealed that young people in that area had no comprehensive knowledge of sexual reproductive health even though they were engaging in unprotected sexual intercourse from a young age, thus being exposed to HIV.

Social and cultural barriers were preventing the young women from accessing the needed information. The respondents were aged 15-25 and 88% of them suggested the use of mobile phones and computers as a platform of information sharing (Butaumocho 2014).

The above is an excellent example of how when a problem is 'thrown back' at the community, solutions can come from those who are most affected. Information is shared and the participants openly share information and ask questions on the mobile platform (Butaumocho 2014). When issues that are controversial arise or ones that are scientific or complicated, the different critical service providers are invited to assist, for example, community leaders, nurses and the police. Regular meetings are also held with community health service providers so that relevant queries can be addressed. Plans are underway to buy smart-phones for the young women although some have their own phones. Conversely, some other young women have had to borrow mobile phones from friends and parents. That behavioural change is starting to manifest itself is a positive development which, however, must be seen against the challenge of young impoverished women who continue to engage in risky sexual behaviour and argue that they can only desist from this kind of behaviour when income-generating projects are put in place as necessary incentives (Butaumocho 2014).

- Health communication disparities

According to Viswanath (2006), there is increasing evidence of disparities in health communication and these disparities are characterized by communication inequalities among various social groups and individuals from a lower socioeconomic status who have tended to be disadvantaged when compared to their counterparts (Jung et al 2013: [1-2]). Viswanath, Ramanadhan and Kontos (2007) argue that this is despite mass media channels such as radio, television and newspapers being crucial information sources (Jung et al 2013: [1-2]). Given this background, it becomes clear that it is essential to understand the inequalities in health communication to be able to influence mass media campaigns in population-based approaches for HIV and AIDS, especially in low-income countries (Jung et al 2013: [1-2]). At this stage, it should be put forth that those with a lower socioeconomic status might ultimately regard television and radio as luxuries if they become desperate and must sell property. Newspapers are also probably a luxury if poverty worsens. Nevertheless, it can still be argued that many of these channels can be shared and that to a considerable extent, they can be accessible from family, neighbours, friends and even areas where the community congregates such as at shopping centres.

- Research in mass communication

A systematic review of HIV and AIDS mass communication campaigns spanning over almost a decade, from mid-1998 to 2007 was carried out and thereafter compared with earlier campaigns explored by a study looking at the period from mid-1986 to mid-1998. Myhre and Flora (2009) carried out another study (Noar et al 2009:35). The findings of this study showed that campaigns have changed for the better over time and from several angles: audience segmentation procedures leading to targeting defined audiences; focusing on behaviour change instead of change in knowledge or attitude; campaign design based on behavioural theories for advancing higher message exposure to messages; strengthening outcome evaluation; and outcome assessments that include behaviour change. Many of these improvements symbolize campaigns moving from a simple goal of raising HIV and AIDS awareness to impacting safer sexual behaviours (Noar et al 2009:35).

Mass campaigns are known to be widely varied. The study that reviewed the mid-1998 to 2007 mass campaigns found that 21% of campaigns used a single channel for their campaigns, which was typical of media efforts (Noar et al 2009:35). The rest used diverse multiple channels, component and strategies to broadcast and reinforce the campaign message, for example peer education, skill-building workshop, small media and promotional materials. The discussion component of the study suggested that the shift towards behaviour change necessitates IPC integration to maximize mass media campaigns (Noar et al 2009:35).

A SWOT (Strengths, weaknesses, opportunities, threats) analysis of HIV and AIDS messages in women's magazines was carried out as part of a study carried out in South Africa that examined women's magazines and HIV and AIDS messages. The information that was consolidated can be used as a strategic decision on if, how and when women's magazines become part of HIV and AIDS health communication: strengths included creating a sense of 'female community' in which messages for women were custom-made; weaknesses were identified as the frequent presentation of women as passive and influenced by male perceptions; the currency of unrealistic elements of messages and exaggerated presentation of sexual activities, to name just two; there were several opportunities including reaching women in a relaxed mode and therefore increasing the likelihood of the reception of embedded messages; threats included that magazines are too expensive to reach a broad audience and also the embedded message gets lost within the entertaining context (Van den Berg 2013:77-78). The study found that these

magazines have a role to play in the health communication of HIV and AIDS. The respondents recommended focused, relevant and sense-full content to bring about motivation, stimulate reception, interpretation and an exchange of messages (Van den Berg 2013:80).

HIV-related stigma is a public health concern. The following study highlights the role of not only women, but of men too since men can also participate in programmes and activities aimed at addressing HIV-related stigma.

A study was carried out to evaluate the Malawi 'Radio Diaries' which was a programme that hosted HIV-positive people telling their life stories to those listening in. The evaluation focused on how the programme affected stigma and the additional effects of group discussions. The programme was one component of a wider HIV prevention communication campaign. The stories were told in local languages and lasted 10 minutes. Six radio stations participated and featured a weekly episode featuring two HIV-positive diarists, one female and one male (Creel, Rimal, Mkandawire, Bose & Brown 2011:456-457). The results indicated that there is a role that radio programmes that include HIV positive people can play in mitigating stigma in the general population. Examples of stigma that were effectively addressed in this manner are the fear of casual contact with PLHIV and AIDS and the shame associated with being HIV-positive. The idea of PLHIV and AIDS being included in addressing stigma stems from the Greater Involvement of PLHIV and AIDS (GIPA) strategy which is promoted by UNAIDS and other organisations (Creel et al 2011:462).

Involving people with HIV and AIDS in communication efforts, is important in that it also emphasizes that although HIV prevention is important and must be promoted, many are already living with the HIV virus, others will die if their infection progresses into full-blown AIDS. For that reason, a holistic approach needs to be formulated to address, through mass communication (together with IPC), prevention, treatment, care, stigma and discrimination. Radio diaries are a creative mass communication mode that can be explored in other settings, including in Zimbabwe.

2.3.5.2 Education

Education in terms of educational level indirectly helps in mitigating HIV and AIDS. Education attainment to a high enough literacy level is necessary to be able to understand and articulate health issues, in this case HIV and AIDS, as well as to improve socioeconomic status by eventually securing employment as this has been found to

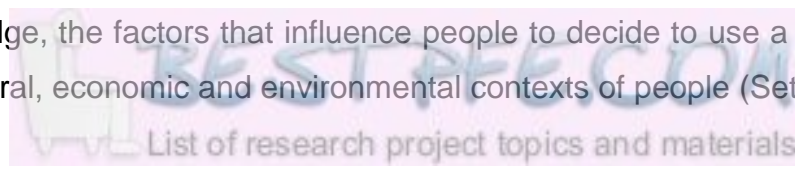
positively affect the spread of HIV and AIDS. This type of education or literacy is covered under 'Socioeconomic status' as it is deemed to be related to it in a linear fashion to a significant extent. However, there is a place for direct formal HIV and AIDS education that should go beyond describing it as a biological or health issue only, and encompass social aspects as well at school-going age, although the question is how early this should be done, not if it should be done at all. Sooner or later, the opportunity to educate the young diminishes over the years because they will no longer be in the school-age catchment as they will have selected their specialities and may no longer have the opportunity to be taught on HIV and AIDS. In Zimbabwe HIV and AIDS education could perhaps be done in the later years of primary school (which ends at 12 years of age) as well as in early high school years (after the first two years, students begin to drop certain subjects and to focus on what they are writing for their 'O' levels; in the last two years, they only do two to three subjects, sometimes four or five). At the tertiary level, the opportunity to teach HIV and AIDS issues may lessen, as students specialise and focus more on certain subjects.

Education has been used as a strategy for managing HIV and AIDS. Educational strategies are several, for example, through sex education, family life, population education (emphasizes consequences of sociology, environment, economy), science education (focuses on biology) and medical disease education (focus is on risk and medication information). Students have different learning styles so this would also need to be considered (Majaro 2007:55).

UNESCO (2003) highlights that informal education used for sexuality matters in a school setting, is very difficult. At times school authorities abdicate their role and leave the class teachers to take over the responsibility even though they have no guidance from policy makers (Majaro 2007:55).

2.3.6 Health communication strategies

Initially, to combat HIV and AIDS, a behavioural disease, the strategy was to target individuals in prevention efforts, by providing HIV and AIDS information, but it became clear that the behaviour change was not long lived. Over time it became apparent that for prevention efforts such as using condoms to be sustainable and successful, vulnerability, and not just risk, had to be addressed. This realistic model considers, in addition to HIV and AIDS knowledge, the factors that influence people to decide to use a condom, that is, the social, cultural, economic and environmental contexts of people (Setswe 2010).



Over the years there has been a shift in communication strategies from focusing on individual behaviour to focusing on social change, to a convergence of the two. According to Parker (2001), for HIV prevention programmes, the strategies have primarily been focusing on behaviour change (Baelden et al 2012:167). The assumption was that individuals make rational decisions about behaviour generally, including decisions of a sexual nature. Therefore, health promotion has leaned towards mass media channels being used to highlight risk-based expert information to the public to influence rational decision-making to lead to individual health patterns. The result has been success in awareness and public knowledge on HIV and AIDS but not large-scale behaviour change. This led to the evaluation of the determinant of health-related behaviour, which led to a more holistic view of health-related behaviours, which included social and cultural contexts in which behaviour occurs that is, social change. According to Campbell (2003), HIV and AIDS prevention interventions rely on participatory approaches was the result; the approach emphasizes the importance of the community in development projects (Baelden et al 2012:167).

2.4 Theoretical framework

The Communications Framework for HIV and AIDS was selected for this study by the researcher. After perusing various publications that cover a few decades of HIV and AIDS communication and health communication in general, it became apparent that this model was the one still being used and the most appropriate one for HIV and AIDS. The model was developed in 1999.

2.4.1 Inadequacy of former theories

As the new framework was being conceptualized, it became necessary to acknowledge that the approaches, theories or models that had up until that point in time been used to guide HIV and AIDS communication in Latin America, Asia, Africa and the Caribbean needed to be examined in terms of relevance. How well communication has fared as a factor in behaviour change was also a relevant topic (Airhihenbwa et al 2000:101).

In a study carried out in rural Zimbabwe, it was found that despite quite high knowledge levels of HIV and AIDS, gender, poverty and low literacy levels, may have undermined the advantage of knowledge (Nhamo et al 2010:1667). This emphasizes the need to use the UNAIDS Communications Framework when designing intervention strategies because other models emphasize knowledge while the UNAIDS model considers the context of individuals, rather than disregarding it.

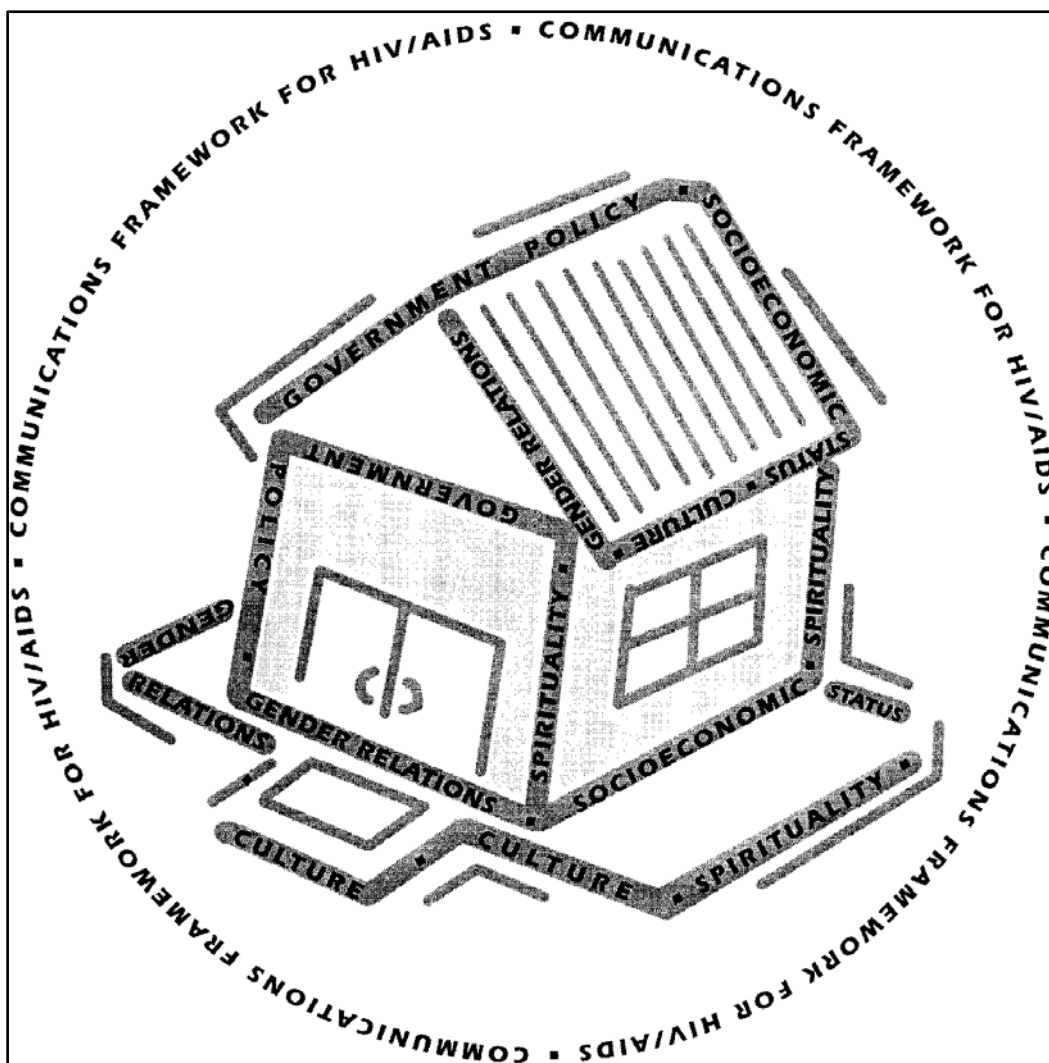
2.4.2 Background to a new framework

The main difference between the Communications Framework for HIV and AIDS and older frameworks is that the new one has its basis on social and environmental contexts as opposed to how individuals behave. Researchers and practitioners guided the process of the development of this framework, which was a consultative process involving African, Asian, Latin American and Caribbean regions experience in HIV and AIDS aspects. The framework is adaptable and the basic assumption made by UNAIDS was that the logic and theory of HIV and AIDS strategies should come from the meanings and values of the population that is affected. The developed regions of Europe and the United States also shared their experiences. This new framework was conceptualised in five workshops between 1997 and 1999. Many peers and specialists reviewed the reports, consensus and recommendations that were the outputs of the workshops (UNAIDS/PennState 1999:11).

The aim of the workshops was to develop an improved framework and strategy for HIV and AIDS communication in the African, Asian, Latin American and Caribbean regions (UNAIDS/PennState 1999:16).

2.4.3 “A new direction”

In Figure 2.2 we see that this new framework is symbolized by a house. The structure of the house, however, varies depending on the region and country. The things that transform the ‘house’ into a ‘home’ are the culture, gender, spirituality, economic resources and family relations as well as the policy rules governing the home. Explained differently, the specifics of the region, country, and community are what converts a house into a home. The contexts or conditions in the environment influence the way the house, comprised of a foundation, a body and a roof, responds. The five domains (spirituality, gender relations, culture, socioeconomic status, government policy) are represented in the foundation, the roof and the body of the house. However, they depend on the goals, objectives and strategies to be utilized in each communications intervention (UNAIDS/PennState 1999:85).



(UNAIDS/PennState 1999:86)

Figure 2.2: House-to-Home metaphor

The framework is intended to encourage debate regarding the relationship between the focus of a communications programme and each phase of an HIV and AIDS epidemic. At each stage, different approaches and messages may be relevant. In a house, there are doors to enter and leave through as well as several windows. Similarly, this framework has a double-door with two panels: one panel is for the key issues and processes for implementing a strategy; the second panel has the key steps and processes for evaluation. The windows represent opportunity for each of the regions and countries to address specific conditions consistent with the epidemic stage in their setting. An illustration of how this could be implemented is hereby described: To establish policy that would ensure 100% condom availability, the national government could be located on the roof of the communications framework, for a programme availing condoms to sex workers' clients. But it would be strategic to gender relations in the foundation so that the

societal expectations of women in the industry can be identified. This is what would optimize the programme. So, in addition to the roof and foundation, walls are required to be present. These would constitute the socioeconomic status, cultural and spiritual factors at community, institutional and individual levels. This would then complete the context (UNAIDS/PennState 1999:87).

2.4.4 Public health

It is important that issues surrounding HIV and AIDS take a public health approach since it is a public health problem, rather than just an individual problem. A public health approach addresses the health needs of a population instead of focusing primarily on individual case management (WHO 2015f:8). This is consistent with the framework being used for the study as not only the individual is considered, but other factors as well. At this stage, it should be noted that each of the five domains that frame the UNAIDS HIV and AIDS communication model can influence HIV and AIDS communication either positively or negatively through hindering or promoting good behavioural change, depending on which aspects are focused on. Many issues are overlapping, cross-cutting and belong to more than one domain.

2.4.5 Spirituality

Religion and spirituality are often used interchangeably but the latter is a wider and more encompassing and inclusive term than religion. Spirituality involves organised religion but also individual and collective values, the foundation being the existence of a supernatural being or force. In this construct, the supernatural being governs the interaction of humans with their visible and invisible surroundings. Positive health behaviours have been associated with spirituality in scientific literature. Spiritual beliefs need to be considered in HIV and AIDS communication. Leaders of religion have significant roles to play in the HIV and AIDS epidemic. The families of people with HIV and AIDS have the capacity to rally support and provide a caring environment (UNAIDS/PennState 1999:45-46).

2.4.5.1 Global spirituality

The faith-based approach has been used as a strategy to diminish HIV and AIDS in communities around the world to help reduce HIV transmission and assist those living with HIV and AIDS (Moore, Onsomu, Timmons, Abuya & Moore 2012:867).

When we examine the United States of America, the African-American church is the focal point or 'cornerstone' of the community. Over the years the church has played multiple roles in the community for African-Americans as a place for various activities: meeting to

discuss oppression during the days of slavery; learning to read and write during Sunday school; establishing finance institutions, housing and schools; coming together during the civil rights movement to impart social justice education; spiritual guidance. Another role has been added as a place for health information. Pastors are 'change agents' in health as they are trustworthy and credible – this is essential for communication. It is therefore befitting that HIV and AIDS should be part of the church's health information agenda. Having said this, the church in the African-American community, was slow to react to HIV and AIDS. This could possibly have been because of the challenge of discussing risky behaviours in relation to HIV and AIDS (Moore et al 2012:868-9).

It is essential that religious leaders and heads of churches openly speak about HIV and AIDS to champion the epidemic's cause and to destigmatize it. This influences public opinion. Pope Francis, Head of the Catholic Church, sent a message to the 2015 International AIDS Society's (IAS's) 8th Conference held in Vancouver, Canada and attended by 6 000 participants. In the message, he gave thanks for the anti-retroviral medicines being used, for their use as prevention and for treatment. Pope Francis encouraged unity in common purpose (Official Vatican Network 2015).

In both African countries and the United States, the clergy and officials from public health have begun uniting in a bid to implement faith-based programmes to reduce HIV and AIDS and associated disease (Moore et al 2012:869). It is clear that spirituality has a prominent role in HIV and AIDS and communication thereof.

2.4.5.2 African spirituality

The AIDS and Rights Alliance for Southern Africa (ARASA) announced that together with the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) and MANERAL+, it would be jointly hosting a regional workshop where the focus would be on the role of religious leaders in addressing human rights barriers to accessing HIV and TB services. The conference would seek to enhance the collaboration between religious leaders and civil society and promote rights-based responses. It is acknowledged that religious leaders are vital players in HIV, TB and SRHR and that they are legitimate and their presence in the local community is long-lasting (Michaela 2015).

2.4.5.3 Spirituality in Zimbabwe

Nyoni states that the three key religions in Zimbabwe (Christianity, African Traditional Religion and Islam) make women vulnerable to HIV and AIDS, for example, certain

religious groups' resistance of contraception and condoms, of which lack of use of condoms has heightened the risk of HIV and AIDS (Nyoni 2008:94).

During the Bishops Dialogue held in Harare (Zimbabwe) on 17 July 2015, the President of the Apostolic Christian Council of Zimbabwe (ACCZ), Johannes Ndanga, confirmed its commitment to ending prevalent child marriages (*Vapostori* condemn child marriages 2015:1). It was reported that the ACCZ has partnered with UNFPA in a campaign to fight child marriages. This news came among reports of widespread cases of forced child marriages among apostolic sect members (Maririmba & Majuta 2015). Further to this, a union of Apostolic and Zionist sects in Zimbabwe came up with a strategic plan that goes up to 2017, to fight child marriages. The president of the Union for the Development of Apostolic and Zionist Churches in Zimbabwe, Africa (UDACIZA), Reverend Edison Tsvakai, was reported as having said that the child marriages in their churches have promoted a low social status, unlike in mainstream churches such as the Pentecostal, Protestant and Catholic ones where education has been used as a tool for elevation. He added that the Union had partnered with Government and NGOs to make changes. The Union has since instructed all member churches to submit their constitution and has asked that each constitution contain a child policy framework. Other Christian-based organisations whose legal standing is similar to that of UDACIZA include the Zimbabwe Heads of Christian Denominations (ZHOCD), the Zimbabwe Catholic and Bishop Council (ZCBC), the Zimbabwe Council of Churches (ZCC) and the Evangelical Fellowship of Zimbabwe (EFZ) (*Vapostori* condemn child marriages 2015:1). The issue of ending child marriages, a rampant practice in Zimbabwe, will be far-reaching in not only achieving gender equality and empowerment, but also in addressing HIV and AIDS. Early marriages for young girls makes them vulnerable to being infected by HIV.

Religion has profound influence in Zimbabwe, especially upon the thinking and living of women albeit it being a key factor in exposing them to HIV and AIDS because of the teachings (Nyoni 2008:141).

2.4.5.4 Biblical teachings

According to Christian biblical teaching by the Apostle Paul (in Nyoni 2008:88-89) in the Holy Bible, women are to submit themselves to the husbands or the *heads* just as Christ is the head of the church. This is a teaching many Zimbabwean women subscribe to and follow by viewing themselves as inferior in all aspects including sexually (Nyoni 2008:88-89).

The researcher, herself a practising Christian, agrees with the thought that some women are of the view that the inferiority of women is a misinterpretation of the Holy Bible and that some Bible verses are taken out of context. There should rather be preaching about the distinct roles women and men play, since in God's eyes, all are equal. Several verses in the Holy Bible confirm this, for example, "There is neither Jew nor Greek, there is neither slave nor free, there is no male and female, for you are all one in Christ Jesus" (Bible Study Tools 2014).

The researcher finds herself uniquely placed, being a female Christian who is passionate about HIV and AIDS, to highlight the misconceptions used by some religious groupings to portray women as inferior and thus reinforce the existing cultural and gender setbacks for women. By contrast, the researcher can, instead, advocate for the correct representation of a woman in a way that is accurate and advantageous to addressing HIV/AIDS issues.

From the researcher's own observation over time, having lived in Zimbabwe for over 46 years, Pentecostal churches have become increasingly more wide-spread and popular in Zimbabwe. Of late, Pentecostals emphasizing deliverance and healing attract the biggest crowds and therefore their influence in life affairs, including public health, should not be underestimated, but rather it should be given due focus. The following is an example of positive influence regarding HIV and AIDS, from the spiritual domain:

Big churches particularly have a huge input on human behaviour by what their leaders say and promote, and this is of great significance for HIV and AIDS communication. The Prophetic Healing and Deliverance Ministries (PHD) is led by Walter Magaya (NewsDay 2015a). It is one of the largest congregations in Zimbabwe. Most of the congregants who attend this church seek healing for a variety of medical conditions and, HIV and AIDS, not surprisingly, is one of these. Magaya admitted to praying for HIV-positive persons and said that they get healed and that the healing is real. He however, emphasized that the beneficiary of healing should always continue with their medication, go for proof of healing to a doctor and then only stop when the doctor says they should. This was said in the presence of the Minister of Health and Child Care, Dr David Parirenyatwa, during a function in Harare. The Minister publicly endorsed the partnering between spiritual and physical health practitioners with the statement "Us as doctors we know that we can give you drugs, we can do surgery on you, but sometimes there is that spiritual lack and that is what Magaya is good at". Magaya's position on healing was against a background of reports of people stopping medication after the assurance of healing by traditional healers

and prophets. Because of this, some of those on ARVs have since developed drug resistance (NewsDay 2015a). Drug resistance is undesirable and is potentially life-threatening, depending on whether a suitable and sustainable alternative for a patient can be found.

2.4.5.5 Global spirituality research

A study was carried out in a metropolitan city and surrounding areas in North Carolina, in the United States of America. The study's specific objective was, "To explore HIV and AIDS communication strategies among church leaders at predominately African American churches who are members of an interfaith-based organization". The results indicated that both interpersonal communication and mass media have a role to play in HIV and AIDS information dissemination. It was important to undertake the study because of the enormous impact HIV and AIDS had on the Black (African American) Community (Moore et al 2012:865-6). The interfaith-based organization comprised 45 churches, who are partners with the network (Moore et al 2012:867). 57% of the church leaders were men while 45% were women. These are the four major themes that emerged from the study: dissemination information about HIV and AIDS through a combination of communication modes; responsibility and obligation to create more awareness about HIV and AIDS; reducing stigma by example; preaching and teaching compassion (Moore et al 2012:870-1).

Regarding communication modes, there were some traditional as well as innovative ones found during the study. One church leader highlighted that they also used professionals from the medical field and personal testimonies from PLHIV. Some used symbols of HIV and AIDS to initiate questions and discussion, for example the wearing of red ribbons on selected Sundays. The study showed that classes were conducted but that although congregants attended, the surrounding community was also welcome to come (Moore et al 2012:871-2). This is very important as this means that even people not part of a specific church or faith, or even those considered not 'spiritual' could also benefit from these faith-based HIV and AIDS outreaches.

It was evident from the study that the church should be an advocate for HIV and AIDS mitigation and that its role is very important (Moore et al 2012:872). This no doubt locates the place of spirituality in HIV and AIDS communication. The church was seen in the study to be a culturally significant institution, able to assist in meeting the physical, social and emotional needs of the community, together with its role as a collaborator with other organizations in the elimination of HIV and AIDS. Key recommendations included church

leaders being assessed for their preferred mode(s) of HIV and AIDS communication and capacity building of the church leaders, by universities/colleges, to be skilled peer educators (Moore et al 2012:876).

2.4.5.6 Research in Zimbabwe

A study was carried out in East Zimbabwe. One of the objectives was to compare HIV prevalence change between major religions. The selected review period was 1998 – 2005, a period of significant HIV risk reduction (Manzou, Schumacher and Gregson 2014: [1]). Of note also is that the study period occurred before the introduction of antiretroviral medicines in Zimbabwe (Manzou et al 2014: [10]). The most prevalent religion was Christianity followed by spiritualists (different Apostolic sects); the remaining groups were comprised of traditionalists and others who subscribed to no religion. The results show that religion is a determinant of responses to the HIV epidemic in Zimbabwe. The Christian churches especially, may have been instrumental in facilitating the HIV-risk reduction during the period covered in the study (Manzou et al 2014: [10]). This is attributable to the Christian churches beliefs and teachings as well as their participation in national HIV programmes (Manzou et al 2014: [7 - 8]). Results also imply that the religious leaders can be engaged further and cultural norms can be addressed to reduce risky behaviours Manzou et al 2014: [10]).

2.4.6 Gender relations

According to WHO, gender relations “refers to social relations between and among women and men that are based on gender norms and roles. Gender relations often create to hierarchies between and among groups of men and women that can lead to unequal power relations, disadvantaging one group over another” (WHO 2017a).

To be able to design informed, meaningful and relevant guidelines for improving HIV and AIDS communication for women, the plight of women comes into play and gender relations must be under scrutiny. The focus will mostly be on women, though gender does refer to both sexes, since gender equality and empowerment issues normally target women. However, men’s roles will be highlighted.

2.4.6.1 Biology of women

Before looking at gender, a look at the biology of women will show how they are already disadvantaged, through no fault of their own when it comes to the spread of HIV and AIDS. While the social aspects of women do render them more vulnerable to HIV and AIDS than men, biology already ‘feminizes’ the epidemic. When we look at heterosexual

vaginal intercourse, male-to-female HIV transmission is double that of female-to-male. According to Hankins (2008) and Cohen (2007) this is because of the more receptive contact surface of the vagina, a higher concentration of HIV in semen compared to vaginal fluid, and cervical ectopy (Carter, Bourgeois, O'Brien, Abelsohn, Tharao & Greene 2013: [1-2]).

2.4.6.2 Gender definition

Gender is defined as the “Roles of women and men that are determined by economic, social and cultural factors rather than by biology” (UNECOSO 2012:11). According to WHO, “Gender refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and work places” (WHO 2017a).

Promoting responsible and respectful sexual behaviour for both women and men is the foundation of HIV and AIDS prevention. From an early age, in most societies, gender plays the key role in how and what men and women are expected to know and what attitudes to adopt in sexual matters. These inputs need to be weighed and addressed in communications programmes to promote health ideals that discourage inequalities.

2.4.6.3 Equality and empowerment

For gender equality to be achieved, women need empowerment to manage their own lives (UNFPA 2015). The issue of gender equality is a human rights issue, based on the right for women, to live indignity and with freedom from want and fear. Women who are empowered can contribute to the health and productivity of whole families and communities, improving prospects for the next generation and by so doing advancing development and reducing poverty. Even though there is overwhelming evidence of how women’s empowerment can address the world’s most urgent challenges, this ideal has not yet been achieved (UNFPA 2015). As with the MDGs, the SDGs have prioritised women’s’ empowerment by dedicating a stand-alone goal to them. This is Goal Five ‘Achieve gender equality and empower all women and girls’ (UNDESA [s.a.]). Hence ultimately, the envisaged guidelines for the young urban Zimbabwean women, are for communication for empowerment and development. The guidelines have a sizable portion that talks about gender equality.



Despite the achievements pertaining to the AIDS epidemic, adolescent girls and young women are still being left behind and denied their rights in full. Often, their risk of contracting HIV is increased together with their vulnerability because of several factors: low likelihood of secondary education and employment; the threat of violence including in conflict or post-conflict situations; being married whilst they are still children. These issues hugely contribute to gender inequalities and these are part of the sociocultural, economic and political make-up of the society (UNAIDS & AU 2015:2).

2.4.6.4 Transmission

There is a need to talk of not only young women but also of adolescent girls because tomorrow these will grow up to be the young women, and in any case, the way the epidemic is manifesting today, they are already greatly affected. While some of these infected girls and young women are infected prenatally (at birth from their HIV-infected mothers), for many more, it is through sexual transmission (Fleishman & Peck 2015:3).

2.4.6.5 HIV and AIDS information

The basic ABC (Abstinence, Be faithful, Condom use) message for HIV prevention is many times difficult for a girl to implement because these factors are often not within a girl's power to control. To prevent HIV in adolescent girls and young women in high-prevalence areas, they need to be informed about social protection and safe spaces, education and economic skills, access to family planning and reproductive health (Fleischman & Peck 2015:2-3). Therefore, empowering girls is what will make them responsive to the HIV and AIDS information so that they make use of the information needed to protect themselves (Fleischman & Peck 2015:3-4).

2.4.6.6 Poverty

Women who live in poverty are economically and emotionally dependent on men. This makes them vulnerable to being coerced by men. As a result, they usually have limited choices with regards to relationships and living circumstances than women in the middle class. For the dependent women, what prevails more for them are other matters usually, such as shelter, food and care for their children, more than the threat of HIV and AIDS (PennState 1999:43). This implies that those women who are poor, find themselves trapped in their vulnerability to getting HIV and AIDS, and that they are more focused on short term survival rather than on the 'luxury' of long term planning (such as HIV prevention).

2.4.6.7 Vulnerability

Young women and adolescent girls are amongst the most vulnerable to HIV and this is not only because of their physical make-up or biology, but because of gender inequality, power imbalances and higher intimate partner violence as well as discrimination. This becomes even worse for marginalized women, for example, those with disabilities, migrants, sex workers and those who are transgender (UNAIDS & AU 2015:13). Other factors that make young women and adolescent girls vulnerable to HIV infection include: transactional and unprotected age-disparate sex (emanating from poverty, lack of opportunity and lack of material goods); conflict and post-conflict settings (UNAIDS & AU 2015:13).

2.4.6.8 Violence

Violence can be of a non-sexual and/or sexual nature either outside of or inside a marriage setting. There is compelling evidence that has emerged in the last decade that shows a relationship between intimate partner violence and HIV. In settings of high prevalence, women exposed to intimate partner violence are 50% more likely to be infected by HIV than those not exposed to violence (UNAIDS & AU 2015:11). The UNAIDS 2014 Gap report states that young women and adolescent girls have the highest incidence of intimate partner violence (UNAIDS & AU 2015:11). Zimbabwe exemplifies this well in that the prevalence of intimate partner violence among 15-24-year-old women is 35%; in those aged 25-49 it is 24%, and is therefore lower for older women. Fortunately, there is also strong corresponding evidence that there are successful community strategies to prevent intimate partner violence and therefore HIV vulnerability - this is concluded from a report by Start Awareness Support Action (SASA) entitled 'Raising Voices', and diverse studies: by Jewkes, Dunkle, Nduna and Shai (2010); Wagman, Gray, Campbell, Thoma, Ndyanabo, Ssekasanvu et al (2015); Leclerc-Madlala (2008) (UNAIDS & AU 2015:11).

The unique risks women and girls face are found during conflict and post-conflict, and emergencies; again, these heighten HIV vulnerability (UNAIDS & AU 2015:12). Violence under these types of situations also needs addressing.

Creativity has found an outlet in the promotion of non-violence towards women and girls:

Yuwei Lee is a jewellery designer and is the founder of Yuwei Designs, based in the United States (UN Women 2015a). She has a desire to engage the fashion world in a bid

to prevent and end violence against women and girls. She launched an exclusive range in 2014 specifically to promote and render support to the United Nations Trust Fund to End Violence against Women (UN Trust Fund). She herself was a victim of physical, verbal and psychological abuse in the home as she was growing up and this is a driving force to what she does. She saw jewellery designs as an avenue to help other women. As an advocate, her goal is to see women and girls respected and to promote life chances for them (UN Women 2015a).

The Australian Woman Minister, Michaelia Cash, announced that she would recommend that Immigration minister, Peter Dutton, bar American singer and hip-hop artist, Chris Brown from entering Australia. Chris Brown is known for domestic violence. Cash spoke at an event where new government efforts to fight domestic violence were being highlighted. The Prime Minister, Malcolm Turnbull, pledged \$100 million to combat domestic and family violence (Henderson & Keany 2015). This clearly shows that no one should be above the law, especially a celebrity, because they have the ability to influence and the potential to shape behaviour, in a good or bad way. The move by the Australian Woman minister is commendable, despite Chris Brown's probable popularity, and stresses the unacceptability of violence towards women as well as the possible repercussions and dire consequences.

2.4.6.9 Stigma and discrimination

HIV-positive women have been found to be imposing stigma on themselves, because of their economic dependence on men, as daughters, partners and spouses, according to one study. Women may not disclose their HIV status because of fear of separation, divorce or violence (DeCapua 2015).

2.4.6.10 Sex workers

Sex workers are one of those groups classified under key affected populations (KAPs) and are usually considered as being at risk of getting HIV infection. UNAIDS defines sex workers as, "Female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally" (Avert [s.a.]). The type of sex work varies within communities and countries. Several reasons make sex workers more vulnerable to HIV transmission, even if they are from diverse backgrounds: comparatively high numbers of sexual partners as compared to the general population; inconsistent condom use; they are often stigmatized, marginalised and criminalized and these social and legal factors can increase vulnerability to HIV. In sub-Saharan homosexuality is criminalized; some inject drugs and share needles which in itself is a

vulnerability factor because of the efficient route for HIV transmission; migration can play a role as some migrants may fail to find any work other than sex work; mobility plays a role through for example, sex tourism which is travelling between countries in search of paid sex. Despite sex workers being hugely affected by HIV, it has been shown that this group is one of those most likely to respond to HIV campaigns. Examples of this are found in India, the Dominican Republic, India, Cambodia and Thailand. In these countries, initiatives targeting sex workers and their clients have contributed to reducing national HIV prevalence (Avert [s.a.]).

In Zimbabwe, homosexuality is illegal and therefore even if it exists, the visible sex workers are females. This therefore means that advocating for HIV prevention, treatment, care and support, and the related communications, must be done in a manner that considers human rights.

2.4.6.11 Africa

According to the Executive Director of UNAIDS, Michel Sidibe, and the Chair of the African Union (AU) Commission at the time, Nkosazana Dlamini-Zuma, it is a moral obligation to guarantee the rights and empowerment of women and girls in Africa in this generation (UNAIDS & AU 2015:2). A 2015 report called 'No ceilings', by the Clinton Foundation and Bill & Melinda Gates Foundation, and another one in 2012, 'World development report: gender equality and development', shows that the manifestation of how young women and adolescent girls are disadvantaged can be seen in an array of ways: less than a third of girls in SSA go to secondary school; women have unequal access to economic opportunities; women lack decision-making power in the home and in society in general; these decisions can range from choosing what age to marry, when to have sex, how to protect themselves, to how many children to have (UNAIDS & AU 2015:5). This poor ability to total lack thereof to make choices and act on women's health and well-being culminates in low personal agency or empowerment; harmful gender norms are generated (UNAIDS & AU 2015:13).

Young women and adolescent girls account for one in five new infections in Africa. They are three times as likely as their male peers to be living with HIV in SSA (UNAIDS & AU 2015:2). More specifically, a recent report states that girls account for 80% of all new HIV infections among adolescents in the ESA. HIV and AIDS is the leading cause of death for girls aged 15-19. Seven thousand girls and young women aged 15-24 are infected every week and therefore some drastic and innovative approach must be undertaken if an AIDS-free generation is to be in sight for this age-group (Fleischman & Peck 2015:1).

A 2013 WHO Women's health Fact sheet (Number 334) states that even though ARVs are available, the leading cause of death among girls and women of reproductive age in Africa are AIDS-related illnesses (UNAIDS & AU 2015:5). A factor that inhibits young women and adolescent girls from protecting themselves from HIV is 'inadequate access to good quality sexual and reproductive health information, commodities and services, in some measure due to age of consent to access services' (UNAIDS & AU 2015:13). In Africa HIV and AIDS is to a considerable extent classifiable as a sexual disease due to it being spread largely heterosexually, as mentioned in the first chapter of the study.

The 2015 AU theme was 'Year of women's empowerment and development towards Africa's agenda 2063'. This requires a contribution partly in the form of advancing rights of women and gender equality, in a bid to accelerate the end of AIDS among adolescent girls and young women (UNAIDS & AU 2015:3).

There are three pivotal changes on the African continent that are particularly relevant for the fast-tracking of the end of AIDS among girls and young women (UNAIDS & AU 2015:15). They are described in the following three paragraphs.

- Growing economy

SSA is among the zones with the fastest growing economies. This can be a key factor for reducing poverty which potentially would benefit girls and young women. The participation of women in the economy has the effect of decreasing poverty and growing the GDP. A Raising Voices report by SASA shows that when girls' secondary education increases by 1%, 0.3% is added to the GDP of a country; we can see that this is a positive cycle (UNAIDS & AU 2015:15). It is therefore worthy of mention that the fourth SDG is "Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all" (UNDESA [s.a.]). From this goal, we see that while formal education is a must, the learning process is a lifelong journey and goes beyond the classroom. This is what is desirable equally for women, that they too are availed such opportunities.

- Population growth

Africa has a population that is young and growing rapidly and this will provide enormous opportunity for growth. More than 30% of the African population is aged 10-24 years and half of it is under 18 years in 15 countries in SSA, according to a 2014 UNFPA report called 'The power of 1.8 billion'. Another 2014 UNFPA report, 'Motherhood in Childhood' states that by 2030, about a quarter of adolescent girls will live in SSA if the current trends continue. This growth may indeed seem like a challenge for healthcare but if viewed

differently it is also an opportunity to reach more girls and women and empower them (UNAIDS & AU 2015:15-16).

- Urbanization

UN Habitat/UNAIDS DHS meta-analysis in 2014 highlighted that by 2050, Africa, which is fast urbanizing, is expected to be 56% more urban - when we refer to service outreach, 52% of the PLHIV in SSA will be in urban areas by 2020, 62% of PLHIV will be in slums. Although urbanization should be improving accessibility of services, those in slums/informal settlements may experience inferior quality of services. Urban poverty, of which slums are one aspect, together with the increased likelihood of violence in urban areas, increases further the HIV risk for women and adolescent girls. Add to these, transactional sex, as mentioned before, and insecurity and we have women in slums being 25% more likely than other young urban women, to be living with HIV, as well as 3.4 times more likely than young men of the same age, to be living with HIV. These vulnerabilities and specific needs of young women in increasingly urbanized and crowded settings will need to be addressed (UNAIDS & AU 2015:16-17).

2.4.6.12 Global picture

Dr Flavia Bustreo, Assistant Director General for Family, Women's and Children's Health through the Life-course, WHO, states ten key issues for women's health are as follows: cancer, reproductive health, maternal health, HIV, STIs, violence against women, mental health, non-communicable diseases, being young, and getting older. She highlighted an important aspect, with regards to HIV, that it leaves the women particularly vulnerable to TB. TB is one of the leading causes of death in women aged 20-59 years in low-income countries (WHO 2015b).

2.4.6.13 Global initiatives supporting women

- HeForShe

HeForShe, is an initiative of UN Women and relies on how high-profile people impact those around them. Key decision-makers in governments, universities and corporations are engaged and relied on to push for change from the top. The IMPACT champions must prioritize gender equality where they are with a view of eventually influencing other organizations. Some of the Heads of State Impact Champions are: Sauli Niinistö from Finland; Shinzo Abe from Japan; Paul Kagame from Rwanda. Corporate Impact Champions include: Antony Jenkins, Chief Executive Officer (CEO) Barclays; Paul Polman, CEO Unilever. University IMPACT Champions are several, for example Adam

Habib, Principal and Vice Chancellor University of Witwatersrand in South Africa; Mario Antonio Zago, President University of Sao Paulo, Brazil (UN Women 2014).

- Beijing Declaration and Platform for Action

“The Beijing Declaration and Platform for Action of 1995 is a visionary agenda for the empowerment of women. It still remains today the most comprehensive global policy framework and blueprint for action, and is a current source of guidance and inspiration to realize gender equality and the human rights of women and girls, everywhere” (UN Women 2015b:3). The declaration was formulated in Beijing, China in September 1995 over a period of two weeks. There were representatives from 189 countries present (UN Women 2015b:3).

In 2015, the Beijing Platform for Action turned 20. The goal is ‘Planet 50-50 by 2030’ and the motto was ‘Step it up for Gender Equality’ (UN Women 2015c). Table 2.1 shows the most recent update on the Beijing Platform indicators.

Table 2.1: Beijing Platform indicators

Indicator	Progress	Challenge
1. Maternal deaths	44% less than in 1990 globally	830 women still die daily from preventable pregnancy-related causes (99% of these are in developing countries)
2. Access to clean water	11% of the global population now uses an improved source	Women still spend 16 million hours daily collecting water in 25 Sub-Saharan countries
3. Wages	At least 50% of world's women obtain pay through employment compared to over 75% of working-age men	Women earn 24% less than men
4. Politics	Since 1995, percentage of women has doubled in parliament	This only translates to 23% of women currently in parliament
5. Senior management	21 women CEO's lead Fortune 500 companies in 2016. In 1998 only one did.	This only translates to 4% of all CEO's on the list
6. Education	In primary education, all developing regions have almost achieved gender parity	All the secondary and tertiary school levels the gender disparity widens; In Sub-Saharan Africa, this was true for tertiary level in 2014
7. Literacy	Since 1990 adult literacy has gone up from 76% to 85% in 2014	60% of the world's illiterate were women in 2014.
8. Conflict	The impact of war on women is different and the UN Security Council resolved to increase women's participation in peace talks	Between 1992 and 2011 only 9% of negotiators, at peace tables, were women
9. Violence against women	In 1993, a framework for action was formed after a declaration to eliminate violence against women	It has now been more than 20 years and yet a third of women still experience physical or sexual violence (mostly from an intimate partner)
10. Media	Of women's presence as news subjects in print, radio and television, the increase has been from 17% to 24%(1995 to 2015) only	9% of news evoke gender (in)equality issues while only 4% challenge them

(UN Women 2015c)

- Gender Action Plan (GAP)

GAP was a commitment by the European Union (EU), to gender equality and women's empowerment and it was applauded in 2010. However, since then it has been disgraced because it was slow in being implemented and it did not encourage change. The updated version for 2016 – 2020 has been regarded with scepticism. Generally, there is agreement that a face lift is urgently needed for the EU's equality strategies and actions. The European Commissioner for International Cooperation and Development, Neven Mimica, has stated that the latest action plan will be more results-orientated. This has given hope that the EU will at last move from ideas to implementation. There was heavy criticism in the new GAP being reduced to a 'staff working document', which is not broad, as compared to it being an official commission 'communication'. In the latter, there's accountability for the EU's programmes and institutions. There are efforts to reverse this decision and to have a strategy policy document formulated. Jessica Poh-Janrell, a representative of Concord (Europe's Gender Working Group) said that an official communication would show full support for the new GAP and it would reflect to all stakeholders the commitment to gender equality (De Vos 2015).

The context of adolescent girls and young women in Africa that has just been described in this section, one that describes elevated risk and vulnerability, underscores the need to ensure that HIV and AIDS information is accessible to them by the most appropriate communication modes (both interpersonal and mass) – this needs considerable attention during information design and dissemination.

Having looked at the context of the African adolescent girl or young woman in general, one aspect that the study will explore is the specific context of the Zimbabwean urban woman and how the structural impediments can be incorporated into HIV and AIDS communication efforts. HIV and AIDS information available needs to be of a nature that is not only accessible but accurate, easily understood, calls for action and that empowers the women.

2.4.6.14 *Zimbabwe*

According to NAC, in Zimbabwe at least 80,000 women (aged 15-24 years) were living with HIV as compared to 36,000 men of the same age (AllAfrica 2015). In 2016, 86,000 women and 42,000 men of the same age range were living with HIV (UNAIDS 2017a). A quick comparison in both years shows that just over double the number of the men, make-up the number of women infected. This is a large disparity.

- Political will of national leaders

In 2015, the newly appointed Women's Affairs, Gender and Community Development Minister in Zimbabwe, Nyasha Chikwinya, stated in an interview with a leading newspaper that she plans to tackle issues affecting women and girls, for example child marriages, alignment of family laws and quota systems in diamond mining. This would be with a view of empowering women and girls economically in various sectors. She added that the Ministry's programmes and projects cover women empowerment, gender mainstreaming and economic development. According to the minister at the time, child marriages were one major challenge in Zimbabwe. Her ministry therefore planned to partner with civil organizations and development partners to implement several programmes to raise awareness on child marriages. She also revealed detailed plans for Zimbabwe to empower women economically. This was in response to being asked how Zimbabwe, currently the custodian of the chairmanship, would be setting an example to Africa, against the background Africa's 2063 agenda, which incidentally has chosen a theme aligned to women empowerment, for 2015 (Butaumocho 2015).

There is acknowledgement by men in Zimbabwe that some affluent men take advantage of the socioeconomic status of some women and that this propagates the spread of HIV and AIDS. This was said by a government minister. A meeting on HIV interventions in the workplace had been organised by NAC in Mutare, one of the larger towns in Zimbabwe. The Minister of State for Manicaland (a province in Zimbabwe) Provincial Affairs at the time, Mandiitawepi Chimene castigated businessmen who she said were rich and were the chief culprits in spreading HIV. She said that sex workers exist because these men are there to take up their services and that government needed to initiate income-generating projects to empower sex workers. She added, "The best way is to stop these men from paying for sex first. From there on we will work with the sex workers by empowering them through various initiatives that stop them from visiting beer outlets. More often we have seen these men misbehaving, some of them sleeping with three different women per day, and spreading the [HIV] virus. Why?" Manicaland has a prevalence rate of 14%, one of the highest in Zimbabwe (Masekesa 2015). It is also important to highlight that Manicaland is a border province. Country borders, by their definition are where people cross over from one country to another, hence there is a lot of mobility and an opportunity for HIV infected persons to move from one place to another.

The Provincial Coordinator of NAC, Sinatra Nyathi, talked of the woes of sexual relationships between young women and much older men. She was addressing

journalists on the 16-days of Activism Against Gender-based Violence. She highlighted that risk-perception of HIV and sexually transmitted infections (STIs) in cross-generational relationships is low since young women perceive older men as being faithful while the older men in turn believe that younger women are sexually inexperienced (Harris 2013). The aforementioned statements by the NAC Provincial Coordinator and two ministers, underline the role of high-ranking officials and national leaders to speak out on harmful cultural and gender norms that contribute to the spread of the HIV and AIDS epidemic.

- Collaboration with regional bodies

In September 2015, SAfAIDS, Sonke Gender Justice and the Swedish International Development Cooperation Agency (SIDA) scheduled the signing of an agreement to address gender equality in Zimbabwe. SIDA was represented by the Swedish Embassy in Zimbabwe. Sonke Gender Justice carries out HIV and AIDS related work. The team of three organizations have put forward a proposal for a two-year programme with the overall goal that seeks to change gender roles and promote more gender-equitable relationships between young men and women to reduce HIV, GBV and promote sexual reproductive health and rights. The target population is those in hard to reach areas such as mining communities and farms (SAfAIDS 2015a).

- Child marriages

Forced early marriage and rape are a violation of human rights. A global organization, 'Girls not Brides', works to address child marriage. It estimates that 31% of girls are married before their eighteenth birthday (Majaha 2015).

- Sex work

The terminology has changed from the degrading 'prostitute' to 'sex worker', acknowledging not only the prevalence of this type of work but possibly also its persistence in being formalised. Many have ventured into this type of work mainly not out of choice or as a first option of type of work, but out of desperation for survival. In Zimbabwe sex work has manifested often at the borders and surrounding towns.

In a bid to prolong their work and maximise on opportunities, some at Ngundu (a rest place for cross-border truckers going to and from Beitbridge) have gone as far as to formulate new strategies: they have become versatile with some being travel sex workers, bar sex workers, retired bar sex workers or indoor sex workers. Some sex workers charge as much as ten times the normal amount for unprotected sex, depending on their need

for money. NAC reports that Ngundu is one of the HIV and STI hot spots in Masvingo, a province in Zimbabwe (Kavhu 2015:4). Sex work increases risk and promotes the spread of HIV and AIDS because condoms are not always used.

It becomes pertinent to ask how exactly gender inequality contributes to the spread of HIV. Much of what we have discussed in terms of gender relations can be summarized in the last paragraph:

Gender inequality can promote the increase of HIV transmission in these ways: coping strategies of women and girls can be reduced; less information about HIV may be available to them, as may also be the case with resources for preventative measures. In addition, there are barriers for safer sex negotiation, sexual violence exacerbates the risk of contracting HIV, and there is also evidence suggesting that marriage can be a major risk factor particularly for young women and girls (UN Women 2015d). Besides the general increased risk of HIV spreading that gender inequality brings, HIV and AIDS also disproportionately affects women in several ways. Women's lack of rights magnifies stigma and exclusion in women living with HIV. Those living with HIV, or even without it, usually end up caring for others who are sick or dying of AIDS and the resulting orphans; some may be widowed by AIDS. These negative effects of HIV and AIDS reduce the prospects for education and employment (UN Women 2015d). Ironically, the lack of education and employment fuels poverty, creates dependency on men, making women even more vulnerable again to the direct or indirect effects of HIV and AIDS, and the vicious cycle begins again.

2.4.6.15 Research on gender and HIV and AIDS

African women living with HIV still face a lot of stigma and discrimination, despite the HIV and AIDS epidemic being more than 30 years old, according to research (DeCapua 2015). The research was community-led, commissioned by the WHO and carried out in Nigeria, Namibia and Kenya. It was conducted by the International Community of Women Living with HIV (ICW) and the global network of PLHIV. One of the ICW advocacy officers, Margaret Happy, stated that stigma, in part, exists because of limited or lack of information for some service providers, and for the community of PLHIV, particularly women. She added that many health providers and employees in Africa do not acknowledge current HIV prevention efforts. In addition, some of the health workers have negative attitudes. She went on further to say that the legal environment is not an enabling one but rather one that criminalizes HIV, for example in Kenya, Uganda and Tanzania. The report from the research called for women living with HIV to be provided with

information about testing options so that they have time to make an informed choice about when to get tested and that whatever choice they make must be respected and the human rights of the mother protected (DeCapua 2015).

Many gender and HIV and AIDS issues are closely associated to the negative sociocultural and socioeconomic status of women, as these are the very elements that make them vulnerable. A study was carried out in Zimbabwe entitled “Socio-Cultural Factors and Practices that Impede Upon Behavioural Change of Zimbabwean Women in an Era of HIV and AIDS”. The study attempted to answer the following questions:

- “How do specific socio-cultural factors hinder and disempower women from changing sexual behaviour relating to HIV and AIDS? Are women inherently unable to change their sexual behaviour?”
- What are the specific socio-cultural practices preventing women from attaining safe sexual behaviour in an era of the menacing HIV and AIDS pandemic?
- Why have the “safe sex messages” being propagated every time on the country’s communication lines (radios, newspapers and televisions) been unable to result in sexual behavioural change of women?” (Nyoni 2008:120).

The study highlighted the difficulties women face in attaining safe sexual behaviour. The age-group that was part of the study was 18-59 years and both rural and urban settings were included in the scope of the research (Nyoni 2008:121). Although this study included rural and urban areas in Zimbabwe, some valuable insights can be drawn and will be important background for the researcher’s study that focuses on women in an urban setting. The results of the study confirmed that almost all Zimbabwean women value marriage. A common theme of fear of rejection by their husbands and ultimately the societal stigma emerged as an emotive topic in relation to violence. Accepting or living in fear of violence handicapped the women from demanding safe sexual behaviour. The respondents also largely agreed with the notion that they are viewed as perpetual minors. One woman pointed out that testimony to this is the existence of widely accepted derogatory idioms such as *vakadzi ipwere* (in Shona) and *abafazi ngabesintwana* (in Ndebele) meaning ‘women are minors’. Fertility is revered among Zimbabweans. Different ethnicities agreed during the study that the value attached to fertility was the reason they were exposed to HIV and AIDS. In this study, the ethnic groups that participated were Venda, Ndaou, Manyika, Shona and Ndebele (Nyoni 2008:123-137). In

addition to the harmful cultural practices such as dry sex, wife inheritance and ritual cleansing, additional practices that are detrimental to women's health were identified during the study. These are female genital mutilation and virginity testing (Nyoni 2008:146).

A key finding of the study was that among Zimbabwe's ethnic groups, sexual relation and activities occur in the context of power relations that favour men. Also of key importance was the finding that socio-cultural factors and practices present the greatest challenge to HIV and AIDS intervention strategies (Nyoni 2008:185-187).

2.4.7 Socioeconomic status

To mitigate HIV risk for adolescent girls and young women, there is a concerted global effort to address the urgency of social and economic factors in addition to biomedical interventions (Fleischman & Peck 2015:1).

2.4.7.1 Poverty

When we talk of socioeconomic status, poverty must be one of the topics that are included because this affects individuals and communities' wellbeing, ability to access healthcare and quality of life which no doubt, among other negative effects, have a part in vulnerability and risk of HIV and AIDS.

- **Definition**

Poverty can be defined in terms of a figure, quantitatively or qualitatively by a description. After two decades, the World Bank has redefined its global definition of poverty. However, by so doing tens of millions are now considered poor since the poverty line is indeed likely to cause shifts in the estimated size and distribution of the planet's poor. The measure was moved from US \$1, 25 to about US\$1,90 a day. In 2015 World Bank set up a commission to examine how to measure poverty and how to update the poverty line (Shawn 2015:1). This is significant, given the global thrust to alleviate poverty as it now seems that the number of people that would need assistance in one form or another have hugely increased.

Extreme poverty can be defined as, "The inability to meet basic consumption needs on a sustainable basis" (USAID 2017). Extreme poverty includes such indicators as "the lack of sufficient resources for a family to survive and thrive at the most basic level of human dignity" (Thier 2015). The resources cover clean water, nutritious food, income-generating work, education and participation in a free and open society. In 1990, 43% of the world lived in extreme poverty. By 2011 the number had fallen to 17%. The first MDG

had pledged for this to be halved by 2015. However, in 2015, one billion people still lived in extreme poverty (Thier 2015). The World population as of July 1, 2015 was 7,3 billion; 15.5 % of this is in Africa, second only to Asia; SSA had three countries listed in the top 20 largest countries by population: Nigeria, Ethiopia and Congo (Worldometers 2015). This therefore means that as of 2015 about one out of every seven people lived in extreme poverty. Since 2015, the figures have changed. As of December 8, 2017, the world population is 7,6 billion, 16.6% of the people are in Africa, still second only to Asia, with the same three countries in 2015 from SSA. within the top 20 of largest countries (Worldometers 2017). In November 2017, 767 million people lived in extreme poverty, which is one out of every 10 people globally, with half of these in SSA (Hunger Project 2017). Although the statistics have improved, SSA has the highest burden of people living in extreme poverty. There are on-going global initiatives to address poverty. Poverty makes people vulnerable to HIV.

- Priority

The first Sustainable Development Goal is, “End poverty in all its forms everywhere” (UNDESA [s.a.]). The goal is like the first MDG, an acknowledgement of the seriousness and far-reaching consequences of poverty.

World Bank has made poverty eradication a priority by enshrining it as well as giving it timelines in its mission, “End extreme poverty within a generation and boost shared prosperity” (World Bank 2015b).

- Global efforts to eradicate poverty

There is an international effort to end extreme poverty, which the United States is helping to lead. United States Agency for International Development (USAID) is acting as partner and catalyst for this goal to be accomplished (USAID 2017).

There is a link between poverty and HIV and avenues to address this for women include cash transfers, food support and child grants. With conditional cash transfers, there may be the requirement of improving social services uptake like attending school. HIV risk is high in women because of their economic and social situation especially lack of education and economic dependence on men. Economic dependence on men drives several HIV-related risk behaviours such as transactional sex, age-disparate and intergenerational relationships and the inability to negotiate for safer sex (Fleischman & Peck 2015:10).

- Poorest people

The world's poorest people are women, making up six tenths of all poor people. Women often absorb most of the unpaid work within families and communities, and they also face discrimination in the economic sphere. Also, two out of three of illiterate people in the world are women, which then leads to less access to information and opportunities (UNFPA 2015).

- Poverty alleviation

As mentioned earlier, poverty negatively affects the socioeconomic status of the people and inevitably it also helps the spread of HIV and AIDS. Poverty alleviation or eradication in Zimbabwe has been put on the economic agenda. The Minister of Women's Affairs, Gender and Community Development is on record as saying that meaningful poverty eradication can only be achieved after women are equally economically empowered. The Constitution of Zimbabwe states that women and men have the right to equal treatment and that this covers political, economic, cultural and social dimensions (Butaumocho 2015).

Poverty alleviation is high on the agenda in Zimbabwe. In recent years there have been high unemployment rates, retrenchments and job losses. The economy is in a state of crisis. Job creation is an immediate solution that comes to mind, as a way of fighting poverty be it at the household, community or national level. The question that immediately comes to mind is 'Jobs doing what?' since many industries in Zimbabwe have closed and are closing. This calls for innovation. An article written by the most widely read Sunday newspaper in the country featured an article about one way that can contribute to poverty alleviation.

It has been proven that promoting solar energy can contribute to poverty alleviation, transform economies and create jobs for millions (Denhere 2015). The majority of developing countries have an abundance of renewable energy sources from the wind, sun as well as geothermal. After sunset, in mostly rural areas where there is no electricity, many school-going children have restricted opportunity to read because of limited light sources. What is mostly used are the non-renewable, expensive, not easily accessible, and harmful (their fumes) energy sources such as paraffin and candles; incidentally these also emit poor light. Research has shown that solar lamps increase the average learning time per day as well as school performance. When quality of learning is improved, ultimately the lives of poor families also improve. In addition to this, the harmful household

pollution caused by fossil fuels is harmful to those in the surroundings and this can cause poor health and premature death, further contributing to poverty in the family. Solar energy would have a role to play in such a scenario. Solar energy also eliminates the risk of a fire outbreak, which is a possibility when using firewood, candles and flammable sources of energy. Spending many hours looking for water has become a norm for children and women in Zimbabwe, and this can be mitigated by using solar water pumps, though this would require fund-raising by communities' investment because of initial start-up costs. The manufacturing of solar components and generation of energy on a large scale would also create jobs on the market, further assisting in reducing poverty at a household and eventually national level (Denhere 2015:9).

2.4.7.2 Literacy

Generally, women have less access to property ownership, credit, training and employment culminating in them having the inclination to be poor and illiterate as compared to men (UNFPA 2015). This comes as no surprise as we would expect that the two, illiteracy and poverty to be linked. Ironically though Zimbabwe has a high literacy, as will be seen later in the discussion, its economy is struggling and in part this is manifesting in high poverty levels. Perhaps what remains to be done now is to harness the literacy further to turnaround the economy.

The UN says that in addition to meeting the MDG related to access to primary education, Zimbabwe remains Africa's education flagship. The UN resident coordinator, Bisho Parajulu, said that Zimbabwe has about 95% enrolment. This is attributable to increased government budget allocation to education in the early years combined with development aid after that. The data available to UN shows Zimbabwe has the highest, and possibly the best ratio of school books per student (SABC 2015:2).

One challenge that has arisen in Zimbabwe, to continue the legacy of high literacy, is the affordability of education. Ignorance is said to be more expensive than school fees meaning that by all means necessary, children should not stay at home but be in school. The economic woes and school fees payments have called for innovation in the form of payment plans being devised as a way of paying the fees in instalments rather than all at once. One key recommendation for policy makers has been for government to channel more resources towards the Basic Education Assistance Module to assist those who cannot pay school fees. In addition, grants and loans should be introduced for tertiary learning institutions in particular (Mubvumbi 2015:21).

In all spheres whether it is in the community, public sector, parliament, development, private sector or other, in addition to acquiring education, women need to get involved in leadership at the highest level, not only because this is a human right but also because it is plausible that they do add value and make a positive difference. The education needs to translate to something tangible in terms of work and for some in terms of taking up leadership roles. Getting education is the first hurdle, then getting a job to improve economic-status is the next step, but more women need to go to the third step beyond getting a job, that is, becoming leaders in the marketplace, in the community, in politics and in the nation. These efforts will not only empower women and work towards equality, but they will ultimately impact everyone positively.

A popular saying, by Mahatma Gandhi is “Educate a man and you educate one person; educate a woman and you educate a whole nation” (Education Times 2011). This emphasizes the power for good that a woman has. This extends to non-executive roles such as board representation in the corporate world; gender balance on boards is something that is regarded as important.

2.4.7.3 Women in the marketplace

- International outlook

Former banker and UK trade minister, Evan Mervyn Davies, compiled a report in 2011 that questioned under representation of women on boards despite the history of women achieving the highest qualifications and leadership positions in several domains. Another report by the Equality and Human Rights Commission in 2008 explained that at current rates of change, it will be seven decades before gender-balanced boardrooms are present in the UK’s 100 largest companies. Catalyst, an international non-profit promoting development of women in business, echoes the sentiments adding that women add shareholder value. Studies show that women contribute more effectively than their counterparts by being better prepared for the meetings, asking awkward questions and challenging strategy, in addition to other positive traits in board meetings. However, some dismiss them as activists and ‘typical’ women and some say that board appointments should disregard gender and purely be on merit (Changwa 2015:6).

- Regional outlook

Research shows that a good portion of companies with a relatively high percentage of women in power perform better compared to the male-dominated ones. However, one argument is there that states that it may be too simplistic to view things in this manner.

The reason is that women being in top roles does not necessarily reflect how companies treat all employees that are female. Others have said that gender diversity may signal a well-managed company but causation is hard to prove: “Is a company diverse because it’s well run, or well run because it’s diverse?” (Bloomberg 2015:6). The researcher believes it is probably both, being a vicious cycle of one continuously reinforcing the other.

- Zimbabwe situation

“Women hold up half the sky” is an old Chinese proverb that Mao Zedong made famous during his campaign for women’s rights to be used and for them to participate in the economy. In Zimbabwe, as of 2015, there were only two licensed female stockbrokers out of 36; there are no women heading any asset management companies; the four largest accounting firms have never been female led; the last female who led a Zimbabwe Stock Exchange (ZSE) company left in 2001, and as of 2015, all 61 ZSE companies are male led and the corresponding boards are male-dominated (Mavolwane 2015:27). This cuts across colour because even before 2000, female white representation was also low on boardroom, contrary to popular perception. Of the ZSE companies, female CEOs had never exceeded five; no company on the ZSE had a female chair and few had female executives - positions such as Chief Finance Officer, human resources positions, company secretaries and executive secretaries were women’s favoured positions. Being averse to risk-taking and lacking confidence have been raised as reasons why few Zimbabwean women have led the listed companies, though they are competent (Mavolwane 2015:27). It is interesting to note how the corporate environment in Zimbabwe has been skewed in favour of men.

Vital Voices Global Partnership believes that investing in women leaders is the most efficient way for change to take place and transform lives as well as accelerate peace and prosperity for everyone. The organization believes that meeting the gender-related targets of the global goals (SDGs) will act as the foundation of progress of all goals. Requirements that go beyond financing are required and include a collective solution (Nelson 2015). Placing women in sight or preferably at the forefront as leaders is highly desirable as they make significant and undeniable contributions towards society such as policy and strategic insight, peace and prosperity, all which impact HIV and AIDS directly and/or indirectly, be it at the micro or macro level.

2.4.7.4 *The Zimbabwean economy*

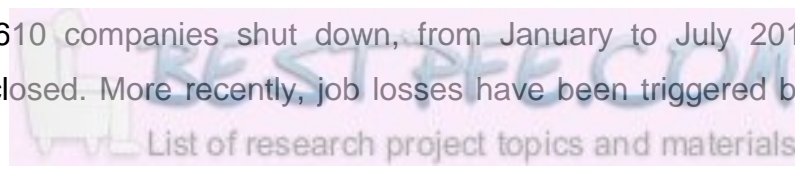
- Background

The environment in Zimbabwe has been of a challenging nature as already mentioned in Chapter 1. Between 2000 and 2008 there was hyperinflation, a complex political and humanitarian situation as well as a breakdown of social services' delivery. In July 2008, the inflation peaked to a record 231 million percent. The percentage of the population living below the national poverty line went from 55 percent in 1995 to 72% in 2003, a figure believed to have increased further because of adverse economic conditions that persisted (UNFPA 2011:2). The World Bank stated that the Zimbabwe poverty line was 72,3 in 2011 (Trading Economics 2015 [s.a.]). Another source, the Zimbabwe Country Brief report stated that social indicators have remained below international baselines. Poverty has remained high mainly because of the weak growth of the economy (as indicated earlier by UNFPA). However, persons in extreme poverty have lessened, going from 47,2% (1995) to 41,5% (2001) to 22,5% in (2011). The drop has been in part due to remittances from the diaspora, gifts and transfers (African Development Bank 2013).

In Zimbabwe, economic growth slowed down to about 3% in 2014, with only minor improvement expected in the following two years, 2015 and 2016, and the informal economy expected to expand. The economic recovery in recent years was due to the mining and agriculture sectors, which accounted for over 90% of exports from 2009 – 2013. Implementation of structural reforms needs to continue so that the business environment improves together with other progressive activities (Monyau & Bandara 2015).

Elsewhere it was reported that Zimbabwe's fragile economy has been adversely affected by a slowdown in recovery witnessed after the 2009 dollarization. This has the potential to "trigger an unprecedented humanitarian, economic and social crisis" which would translate into more job losses and further erode disposable incomes. The unofficial unemployment rate already stood at 80% in 2015 (Ndlela 2015:1). As a result, most are informally employed; many are vendors although off late their trade has been compromised since their expulsion from central business districts across the country (Ndlela 2015:1). In May 2017, the unemployment rate in Zimbabwe was 95% (Forbes 2017). It is apparent that the economy has gone from bad to worse over recent years.

While in 2014 4,610 companies shut down, from January to July 2015, additional companies have closed. More recently, job losses have been triggered by a Supreme



Court ruling that reaffirmed employers' rights to fire workers on notice, with over 20,000 losing their jobs within weeks (Ndlela 2015:17).

- Economic recovery

The plan for economic recovery in Zimbabwe, the Zimbabwe Agenda for Sustainable Socioeconomic Transformation (Zim Asset), is covered in detail under Government Policy. Before delving into the plan, itself, the policy document gives the situational analysis of the economy in 2013, when the plan was launched. According to Zim Asset, there are still many challenges to overcome despite the economy having shown some degree of stabilization such as a decrease in inflation (GoZ 2013:18).

- Potential

World Bank states that there is immense potential for sustained growth and poverty reduction in Zimbabwe given that there are many natural resources, existing public infrastructure and skilled human resources. These can be tapped into in addition to additional renewal of institutional and operational capacity in the public sector, further improvements in basic service delivery and much needed reforms in investment climate and economic policies (World Bank 2015a).

The backbone of the Zimbabwe economy is the agricultural sector and this affects economic growth, food security and poverty eradication. In 2013 this sector still had severe challenges because of reasons ranging from lack of agricultural financing to lack of affordable input and prolonged drought brought about by climate change (GoZ 2013:20).

Besides its natural resources, Zimbabwe's comparative advantage even at a global level, is that it has a strong human resource base, which emanates from the educational policy implemented at Independence in 1980. However, a key challenge has turned out to be significant skills flight (GoZ 2013:18). In addition, although literacy rate stands at 92%, more schools still need to be built and equipped especially in new resettlement areas. There is also a need to develop a curriculum that matches the development needs of the country (GoZ 2013:21-22).

- Social and health sector successes

Success in the social sector has manifested itself through the sixth MDG of combating HIV and AIDS, Malaria and other disease, the second MDG of universal primary education and others. Challenges in the health delivery system are related to sporadic

outbreaks of epidemics. For example, typhoid and dysentery, increased maternal mortality, shortage of funds to procure essential drugs and equipment and to rehabilitate dilapidated infrastructure (GoZ 2013:20-21). When the health system is not fully capacitated then the very well-being of individuals in the society is compromised.

A UN official stated that Zimbabwe has made good progress towards achieving the MDGs even though climate change has had a negative impact. Sirak Gebrehiwot, Communications Specialist in the UN Zimbabwe Residents Coordinator's Office, highlighted that government alone should not be responsible for attaining the goals. He acknowledged some progress towards gender equality, reducing child mortality and maternal mortality as well as increased internet penetration rate that made Zimbabwe now the third ranking country in Africa (Radio Dialogue 2015).

- Challenges

Energy is listed in Zim Asset as a key enabler to productivity and socioeconomic development in Zimbabwe. The challenges have been related to infrastructure and funding issues. Social protection programmes have been adversely affected and this has negatively impacted on orphans, vulnerable children and the poor. Poor water and sewerage reticulation systems are present in urban areas (GoZ 2013:22-23).

Other economic challenges can be summarized and being associated with the manufacturing sector, tourism sector, transport sector, housing demand, high unemployment, utilities and infrastructure sector, environmental issues, growing debt and therefore inability to access international capital and investments (GoZ 2013:19-24).

When reviewing the situation in Zimbabwe, one thought is that Zimbabweans will have to work hard to overcome all these challenges and improve their living conditions, thus making the environment conducive to true empowerment. Health and food security are threatened and without these being adequately addressed, the very existence of people is threatened.

The National Health Strategy (NHS) refers to this vital issue of socioeconomic status. One of the goals contained therein, under Determinants of Health and more specifically Socioeconomic Dynamics, is to increase awareness in the nation, of socioeconomic factors on the public's health and quality of life. Such factors include but are not limited to resources allocation, income, poverty, adult literacy, housing, food security, working conditions, water, sanitation, hygiene and gender (MoHCC 2013a:13).

The NAC Chief Operations Officer, Mr. Tapuwa Magure, registered his concern on the increasing new HIV infections in the 15-24 age-group, especially for women, to the HIV and AIDS Thematic Committee in Parliament. He highlighted that current poverty and social challenges were the cause. He added that most educational facilities did not have clinics and that they were not capacitated to administer ART. This was despite at least 400 focal persons at educational facilities being trained to equip students with HIV knowledge (AllAfrica 2015).

2.4.8 Government policy

So much rests on this domain as it determines political will. It is central to the other four domains of socioeconomic status, culture, gender and spirituality. Government policy is all encompassing and has the potential to create an environment conducive to mitigating HIV and AIDS. Government policy can be related to laws and policies affecting HIV and AIDS directly or ones affecting the environment and thus have an indirect effect. Civil Society has a role to play here, as is it is often with many issues. It holds governments accountable and ensure HIV and AIDS issues are addressed for all population groups. Government policy is influenced by international policies, as well as guidance from NGOs, donors and other partners.

2.4.8.1 Global initiatives

- World AIDS Day

So, important and key is the issue of HIV and AIDS that there is a day used to commemorate it. The day is 1 December – World AIDS Day. It is used to raise awareness of HIV and AIDS. Each year has a different theme; the 2014 AIDS Day theme was ‘Focus, Partner, Achieve: An AIDS-free generation!’ In 1987, two public information officers for the Global Programme on AIDS (at WHO), now UNAIDS, conceived the idea of World AIDS Day. Former UNAIDS head, Dr Jonathan Mann, agreed to hold the day on 1 December. This was deliberate as this date was after U.S. elections but before Christmas Holidays to maximize coverage by western media (Smith 2014). AIDS Day has been held since 1988 (Rothman 2014).

- International AIDS Society

There are also some global entities that are dedicated to the HIV and AIDS epidemic and by so doing endorse it as a global public health issue. This inevitably gives it the global attention it deserves.

IAS has more than 16,000 members from 196 countries (IAS 2013:1). The members work at all levels of the global response to AIDS. These members include clinicians, researchers from all disciplines, public health practitioners, community practitioners, policy planners and programme planners. IAS is the world's leading independent association of HIV professionals. It is the custodian of the biennial International AIDS Conference as well as the main organiser of the IAS Conference on HIV Pathogenesis, Treatment and Prevention. IAS announced on 29 November 2013 in Geneva, Switzerland, that Durban will host the 21st International AIDS Conference 2016 dubbed AIDS 2016. The 13th International AIDS Conference was also held in Durban and is worthy of special mention for several reasons. This was the first time it was held in a developing country. The conference was a watershed one as it was instrumental in influencing a new direction for global public health: some South African Government leaders had presented controversial views and the conference was a land mark in that the 'Durban Declaration' was signed by over 5,000 scientists confirming the overwhelming scientific evidence that HIV causes AIDS (IAS 2013:1-3).

These types of forums underscore their importance and ability to be game changers. Various strategies and policies that are relevant to the HIV epidemic, are in place.

- Sustainable Development Goals

Unlike the MDGs, for the first time the global goals include climate change, Goal 16, recognizing that peace, justice and inclusive governance are the foundation for all development success (Thier 2015).

Zimbabwe's Head of State at the time, Robert Mugabe, together with 150 others, attended the 70th Session of the UN General Assembly in New York. On 25 September 2015, the 193-member states of the UN adopted the 17 SDGs, which are the Post-2015 Development agenda and targets for guiding the global socioeconomic transformation until 2030 (Sasa 2015:2). Although adopted, they are not without criticism from some people. It has been said that three critical indicators are missing from the new global goal which would focus attention on the action needed to achieve the participation target, SDG 5:5 (SDG 5 is concerned with gender equality and empowering women). These are: representation of women at national or local government level; metrics to measure women's levels of influence or power; the tools, skills and capacity to be effective in their leadership. The indicators are essential as they go beyond implementation and would hold communities and the world accountable for SDG 5 (Pepera 2015).

“Success without democracy is improbable. Democracy without women is impossible” is a statement by Madeline Albright, chair of National Democratic Institute’s board of directors (Pepera 2015). The statement points to the success of the SDGs being heavily dependent on women’s involvement and advancement as well as issues of democracy, which is a human rights issue.

- Global Health Sector Strategy on HIV and AIDS

In 2015 the WHO has announced that it would be developing three global strategies, one for HIV and AIDS, viral hepatitis and one for HIV and AIDS, for the period 2016 – 2021. The strategies were to be finalized for consideration in 2016 by the 69th World Health Assembly. The strategies were informed by wide consultation in 2015 and involved all key partners such as the UN family, member states, multilateral agencies, donor and development agencies, civil society, NGOs, scientific and technical entities and the private sector. The previous HIV and AIDS strategy covered 2011 – 2015 (WHO 2015c). The proposed new HIV and AIDS strategy which started in 2016, has four strategic directions: essential quality services and interventions; achieving equity and input; innovation for acceleration; financing for sustainability (WHO 2015d:31).

- Human rights

Under the fourth strategic direction (financing for sustainability), securing an enabling environment for delivery and impact has several related issues (WHO 2015d:31). One of these is promoting healthy policies and laws. Laws and policies that promote and protect human rights have the potential to decrease vulnerability and HIV infection risk, increase access to health services and their reach, quality and effectiveness. This is the case particularly for higher risk populations. It is a priority to remove legal, regulatory, policy and other structural barriers that hinder equitable access to HIV and supportive services. Public health evidence should be used to influence pro-health laws and actions (WHO 2015d:32).

A recent example of this scenario where human rights laws is promoted, exists: one law that was anti human rights was removed in Zimbabwe: The entire Constitutional Court bench struck down one section of the Criminal procedure and Evidence Act. In the past, the law was infamous for being used by prosecutors to counter bail orders which would have been granted by courts. The judges declared that the law was in direct violation of the constitution. Lawyers from the Zimbabwe Lawyers for Human Rights represented the applicant (Financial Gazette 2015:11).

- Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS)

In December 2014, on World AIDS Day, there was a major shift in policy by the PEPFAR (Fleischman & Peck 2015:1). PEPFAR launched a new initiative to significantly reduce new HIV infections in adolescent girls and young women. This was in partnership with the Bill and Melinda Gates Foundation and the Nike Foundation. The initiative is called DREAMS. The strategy entailed addressing HIV risks for adolescent girls and young women in high burden 'hot spots' in 10 countries in the ESA by identifying where these women are being infected and what is putting them at risk, with a view of creating relevant programmes (Fleischman & Peck 2015:1). Public support from civil society and government leaders globally has also generated new determination to address the needs of women and girls. However, the success of DREAMS ultimately rests on changing social and cultural norms, legal practices and economic realities. These are all very slow and difficult to shift (Fleischman & Peck 2015:2).

Issues identified in the DREAMS initiative as needing to be addressed were lack of education, child marriage, GBV, economic and financial literacy for orphans and vulnerable children (OVCs), reproductive health, family planning and poverty. Interventions must address these socioeconomic drivers because, whether directly or indirectly, they need to be woven into any new approaches, going beyond the health sector (Fleischman & Peck 2015:1-2).

The widespread recognition that an entirely biomedical approach for HIV prevention has shortcomings has led to some of the following multi-sectoral programming approaches in the DREAMS design: conditional and non-conditional cash transfers (an example of addressing the link of HIV and AIDS with poverty); empowerment programmes; GBV reduction; pre-exposure prophylaxis or PrEP (Fleischman & Peck 2015:8).

- Start Free, Stay Free, AIDS free

The Start Free, Stay Free, AIDS Free framework was designed to super-fast-track the ending of AIDS among children, adolescents and young women by 2020 (UNAIDS 2016b). This is a targeted approach that looks at selected vulnerable populations.

- United Nations Population Fund

UNFPA advocates for women and girls, promoting legal and policy reforms as well as collecting gender-sensitive data, supporting initiatives that improve the health of women and expand their life choices. They have done this for more than 30 years. They focus their responses on the most vulnerable and marginalized women. This includes

adolescent girls, those with disabilities, indigenous peoples, migrants, refugees, female heads of households and those living in extreme poverty. Key strategic issues for women include reproductive health, economic empowerment, educational empowerment and political empowerment (UNFPA 2015).

- UN Women

UN Women has focus areas which they see as priority and fundamental to women's equality. These are the ones they deem necessary to accelerate progress. The areas are: leadership and political participation, economic empowerment, ending violence against women, peace and security, humanitarian action, governance and national planning, Post-2015 development agenda and SDGs, and HIV and AIDS (UN Women 2015e).

When we look at the HIV and AIDS component of women, one of the things UN Women seeks to do is to make sure that the voices of women living with HIV are heard. UN Women seeks to integrate gender equality and women's rights into strategies, policies, budgets, institutions and accountability frameworks. The programmes are guided by various agreements such as the 2011 Political Declaration on HIV and AIDS, the Beijing Platform for Action, Intensifying our Efforts to Eliminate HIV and AIDS, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Millennium Declaration. To begin guaranteeing that gender equality is pivotal in global action on HIV and AIDS, in June 2012 UN Women became the 11th cosponsoring agency of UNAIDS (UN Women 2015d). There have since been other agreements, such as the Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 (UN General Assembly 2016).

Despite many international human rights agreements, gender equality has not yet been achieved (UNFPA 2015).

- International Women's Day

International Women's Day (8th of March) is celebrated globally. It celebrates the social, economic, cultural and political achievements of women. It also symbolizes a call to action for accelerating gender parity. This day has been present since 1911. The campaign theme for 2017 was #BeBoldfor Change, while the one for 2018 is #PressforProgress. (International [s.a.]). It is commendable to have a day set aside globally, to celebrate women and show their importance.

- Joint United Nations Programme on HIV and AIDS

The most recent UNAIDS Strategy covers the period 2016-2021. The strategy outlines the key vision of ending AIDS epidemic in 2030, several goals, and ten specific targets. The goal of direct relevance to women is the seventh goal, “90% of women and girls live free from gender inequality and GBV to mitigate the risk and impact of HIV” (UNAIDS [Sa]:7-8).

- Antiretroviral treatment affordability

ART is the treatment used for HIV infections. Standard treatment uses of a combination of at least three medicines and is often called highly active ART or highly active antiretroviral therapy (HAART). The treatment potentially reduces mortality and morbidity and it improves the quality of life in HIV-infected people (WHO 2015e).

UNAIDS reminded countries, amid celebration of reaching 15 million people with HIV treatment and committing to ending AIDS by 2030, that it is paramount that new trade agreements under negotiation do not interfere with access to medicines for HIV, thus protecting public health. This was with reference to the Doha Declaration and the Trade-related Aspects of Intellectual Property Rights (TRIPS) Agreement. UNAIDS Executive Director, said that “The right to health must not be negotiated away for trade gains” (UNAIDS 2015e). The whole strategy is in having accessibility and affordability of HIV treatment scale-up. This comes against a background of generic competition in the pharmaceutical industry and use of flexible intellectual property being the foundation. However, threats of less generic competition and higher drug prices loom (UNAIDS 2015e).

In a development in September 2015, a U.S. pharmaceutical company defended its 5,000% price increase. A 62-year old medicine, Daraprim, used by patients with AIDS, had its price raised from \$13,50 to \$750. Martin Shkreli, CEO of Turing Pharmaceuticals, that acquired the rights to the medicine in August 2015, is reported as saying that the new price is the correct market price. He added that the company needs to make a profit and that the medicine is under-priced; he highlighted the cost of some cancer drugs that can go as high as \$1000,000. The company was asked to reconsider this hike (Roberts 2015). By August 2017, Daraprim still cost \$750; there was still no generic equivalent, although studies have shown that there is an alternative that however might not work as well (Johnson 2017).

- Investment Framework

In 2011 an innovative approach in the form of an Investment Framework, was published to guide global response to HIV. International experts met and worked with UNAIDS and formulated a mathematical model demonstrating that investments that are targeted on HIV programmes and services will lead to a reduction in HIV rates. The need for additional funding was also highlighted (MoHCC 2013b:3).

2.4.8.2 *Regional leadership*

Although overall, opinion leaders and those of national standing are expected to speak out and make a stand to take measures against HIV and AIDS and promote efforts to end it, there have been instances whereby Heads of States have unfortunately made misleading statements concerning HIV and AIDS, based on their personal beliefs, and this is not something that is expected or desirable at that level, because of the influence and potential for such leaders to sway public opinion:

- The Gambia

In January 2007, the Gambian president, Yahya Jammeh, announced that he had a cure for HIV and AIDS and that the treatment had been given to him by ancestors in a dream. The announcement was made before a group of foreign diplomats. His announcement caused a lot of controversy and anger as health officials branded the claim as false hope for those with HIV and AIDS and there was fear that those on therapy would stop taking their anti-retroviral medicines. The WHO was critical of his claims and the UN envoy, Fadzai Gwaradzimba, one of the critics, was immediately expelled. This was in response to her making a statement soon after the claims, and instructing patients to continue with their normal treatment and calling on the concoction to be “assessed by an international team of experts”. One professor from the University of Kwazulu Natal, Professor Jerry Coovadia, stated that it was irresponsible and dangerous for a country leader to make such claims and that he needed to be reprimanded and stopped (Koinange 2007).

- South Africa

According to Harvard researchers, the result of South Africa President at the time, Thabo Mbeki’s refusal to accept medical evidence of a virus, was a major hurdle to providing medicine (Guardian 2008). Harvard University quantified the impact by stating that the former president of South Africa’s government AIDS policies directly caused avoidable deaths of more than 300,000 people in the society (South Africa had and still has one of the severest HIV and AIDS epidemics globally). There were 900 people dying of AIDS

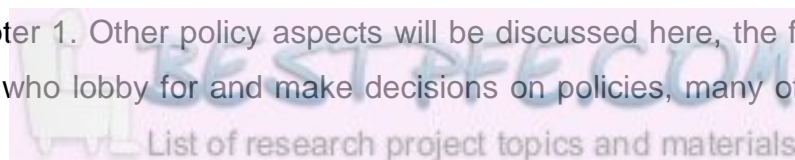
daily in 2005. From the 1990's, Thabo Mbeki rejected scientific consensus that AIDS was caused by a virus and that the virus, though it could not be cured, could be fought by sophisticated expensive medicines. Mbeki was influenced by a group of maverick scientists called AIDS denialists. The most well-known of these was Peter Duesberg from Berkeley in California. In 2000, a meeting was convened by Mbeki, including those supporting him as well as those opposing them. The goal was to discuss the cause of AIDS. The International AIDS Conference was held in Durban later in 2000 and Mbeki took a public stance of rejecting scientific evidence. He did admit that AIDS came about by the immune system collapsing, but he denied the role of a virus. He attributed the cause to poverty, bad nourishment and general ill-health and said that therefore poverty alleviation was the solution. He discarded expensive western medicines and rejected offers of free drugs and grants and procrastinated the introduction of a treatment programme. A national adult treatment programme was introduced in 2004 after international pressure, with PMTCT having been introduced in 2003. "Access to appropriate public health practice is often determined by a small number of political leaders..." (Guardian 2008). The scenario just described in South Africa exemplifies this.

In March 2016, Thabo Mbeki sought to clarify his position on HIV and AIDS by stating that, "I never said 'HIV does not cause AIDS'". He elaborated that what he had said was that one virus cannot cause a syndrome but that that HIV might contribute to immune deficiency (Gqirana 2016).

After being appointed president in 2009, Jacob Zuma gave a speech acknowledging HIV and AIDS as one of the most the most important challenges South Africa faced. To many South Africans his appointment signified the end of state-endorsed HIV and AIDS denialism. However there has been controversy. He was accused of rape in 2010, acquitted and it was later said to have been consensual sex. He then made a questionable statement about having showered after having sex to prevent HIV infection (Avert 2014). The acknowledgement of HIV and AIDS as a challenge, from the highest level in the country, is good start to effectively communicating HIV and AIDS issues to the public, as it shows that indeed the political will to address the issue is there.

2.4.8.3 Zimbabwe

Some of the relevant strategies and policies related to HIV and AIDS have already been discussed in Chapter 1. Other policy aspects will be discussed here, the first being the make-up of those who lobby for and make decisions on policies, many of which affect girls and women.



- Women leaders in politics

The Minister responsible for Women's Affairs, Gender and Community Development in Zimbabwe stated in an interview that there are challenges for women as they attempted to occupy decision-making positions. In the political domain, she said that lack of financial resources was a deterrent as well as the fact that society was predisposed to seeing men in such positions (Butaumocho 2015). One cited cause for child marriages, is the policies that are weakly formulated, leaving women and young girls vulnerable. Many of these policies are endorsed by male politicians (Majaha 2015). This suggests that if more women had prominent decision-making ability in politics, they could be able to challenge such laws that are passed by largely their counterparts. It is ironical that few women are in these politically powerful positions. This position is not unique to Zimbabwe. What further supports this is the fact that in 2015, 22% of parliamentarians globally were women (UNFPA 2015). As of January 1, 2017, 23.3% of all parliamentarians globally were women; in SSA the percentage is 23.6% (UN Women 2017). SSA has female representation above the global figure, which is a step in the right direction, although the percentage is still low. After Zimbabwe's general elections in July 2013, the representation of women in Zimbabwe's Eight Parliament improved: 85 women out of 270 legislators (Zhangazha 2014). The representation of women in Parliament more than doubled, from 17% following the 2008 General Elections, to 35% in the 2013 elections (UN Women 2013).

- Sexual crimes and child marriages

In addition to policies that are weakly formulated, child predators have been getting away with community service sentences and other non-prohibitive sentences. This is despite the Constitution stating that every child has rights and defining a child as every boy and girl under the age of 18 years (Majaha 2015). The rights are listed as: to be protected from economic and social exploitation, from child labour and from maltreatment, neglect or any form of abuse. However, with the age of consent in Zimbabwe having been effectively made 12 years, children, particularly girls, are further exposed to rape, sexual abuse and early marriage. These increase the risk of being infected by HIV and related diseases. The Zimbabwe Human Rights NGO Forum was quoted as saying, "Married girls are more likely to contract sexually transmitted diseases including HIV and AIDS than in married girls and are often powerless to demand the use of contraception during sex" (Majaha 2015). A UNFPA report entitled, "Marrying too young: end child marriage", strongly highlights that the girls themselves need to get involved and empowered in

seeking solutions to these issues. Civil society will need to be very active in resolving such issues and involve the community; together these two groups can raise awareness and push for legal reforms (Majaha 2015). Many examples exist whereby the sentencing of crimes related to engaging in sex with underage girls is a mockery. This is the case especially when compared to penalties handed out for other crimes.

In Gweru, a city in Zimbabwe, a celebrity disc jockey was sentenced to six months in jail or US\$600, with three additional years of the sentence wholly suspended on condition of good behaviour. He had been charged for having sex with a 14-year old school girl. The judge deemed the penalty severe for such a serious crime (Gweru DJ fined 2015). Although sex was said to have been consensual, the case is riddled with contradictions, on reading the story. The DJ's arrest is proof enough that he had done something wrong. In Zimbabwe, girls and boys under 18 years of age are considered minors. To worsen the issue, the offender is a well-known personality and therefore should be a role model to many especially young boys and men; this should have been highlighted to him and he should have received a stiffer sentence.

In Zimbabwe, in crimes involving the theft of stock, one cow attracts a mandatory sentence of nine years which can be lengthened to 25 years. The stiffer penalties were introduced to curb rampant stock theft. As a result, there is indeed a very big decrease in stock theft (Mpofu 2014).

When we make a comparison with stock theft sentencing, we see that the sentences for sexual crimes against female minors are not deterrent despite the likelihood of the victims suffering physical and emotional trauma. The disparity and logic is something that needs to be addressed by law makers.

- Policies and strategies
 - National Health Strategy

In lieu of developing a new health sector strategy, a decision to extend the 2009-2013 NHS to 2015 was made, based on gaps in addressing various issues in the strategy (MoHCC 2013a:3). It remains to be seen how much impact this extension will have.

The NHS is what currently guides the health sector. Its primary aim was to improve the health status of Zimbabweans and to put the country back on track towards achieving the MDGs (MoHCC 2013a:3) Major achievements include the HIV prevalence having declined from over 29.5 to 13.7% in adults and 3.2% in children, by 2013. One challenge,

at the time of extension of the strategy, was high morbidity and mortality due to HIV and AIDS and malaria (MoHCC 2013a:7).

The MoHCC, in drafting the NHS, identified areas that go beyond the health sector and are the government's responsibility – these are essential to success. One such area is socioeconomic and environmental risk factors as well as health promotion. These are all seen as playing a role in decreasing disease burden (MoHCC 2013a:12).

A new NHS has superseded the old one: in the NHS for Zimbabwe, 2016 – 2020, HIV and AIDS is highlighted as a continued public health problem in Zimbabwe. It is explained in the new strategy that the HIV epidemic is threatening the socioeconomic fibre of the country and placing a massive strain on the health sector capacity to respond to the nation's health needs (GoZ & MoHCC [Sa]:15). "To prevent new HIV infections and to reduce deaths due to HIV by 50%", is listed as one of the five objectives of the NHS, under the 'First Priority' of 'Communicable Diseases' and 'First Goal' of 'To Strengthen Priority Health Programmes' (GoZ & MoHCC [Sa]:40). To prevent new HIV infections would mean there are zero incidences.

- International collaboration

UNAIDS has been dedicated to assisting Zimbabwe strengthen its national capacity to respond to effectively to HIV and AIDS. UNAIDS entered dialogue with NAC, the Health Ministry, Parliament, representatives of PLHIV and key populations, development partners including the Global Fund (UNAIDS 2015c:3).

- AIDS levy

The NAC Chief Operations Officer raised his concerns on the shrinking of the AIDS Levy; effectively the domestic funding's contribution to HIV and AIDS. Official statistics released in 2014 state that approximately 140,000 people's treatment depends on domestic resources. The remainder comes from donors, with approximately 160,000 PLHIV covered by USAID and the remainder (the majority) covered by Global Fund (AllAfrica 2015).

It was reported during a NAC sensitization meeting in Bulawayo, Zimbabwe, that the AIDS levy collection, due to massive job losses, and therefore significantly less employees contributing to the levy via tax, had been compromised. This was said to undoubtedly widen an already existing funding gap for PLHIV. 50% of the total funds collected are for antiretroviral medicines, 10% for prevention programmes, 6% for monitoring, evaluation

and coordination, 5% enabling environment, 5% goes to programme logistics support and 4% to assets (Harris 2015).

The GoZ has said that it will adopt a strategy to extend the AIDS Levy to the informal sector, as it realizes that at least 75% of the working population constitute informal workers (ZimSitRep_M 2015). It remains to be seen how exactly they will implement this.

- HIV impact assessment

The GoZ has been proactive in its attempt to take measures against HIV and AIDS epidemic as evidenced by a move it took in 2015. The government has embarked on a project to determine the HIV burden and to assess the impact of interventions implemented to date. The project came in the form of a door-to-door national HIV and AIDS survey which will also offer HIV-testing and counselling, CD4 count, syphilis testing and referrals to health care facilities for further management. This was revealed by Dr Owen Mugurungi, the Director of the AIDS and TB Unit in the MoHCC. He added that the study was to be the first of its kind in Africa and would be called the Zimbabwe Population-based HIV Impact Assessment (ZIMPHIA). It was planned to take six months to carry out, cover 15,000 randomly picked households in all 10 provinces. The survey's uniqueness was in that it was specific to the epidemic unlike previous surveys, and it had a larger sample. It was to provide a better understanding of the epidemic in Zimbabwe and inform social services planning in line with Zim Asset. PEPFAR was a key funder for the groundbreaking survey (Chipunza & Nyamukondiwa 2015:1). The survey was since completed and the objectives were met (MoHCC 2016a). It is very encouraging that with this survey, we see a concerted effort for policy and activities to be in alignment as evidenced by the survey informing Zim Asset, the national economic recovery plan for Zimbabwe.

- ZNASP

ZNASP II follows on from the first one that ran from 2006 – 2010, and runs from 2011-2015. It is informed by the 2011 Global Political Declaration on HIV and AIDS. ZNASP II articulates the key policy issues, strategic orientation, and priority targets and interventions for the national response. National priorities for the plan are prevention of new adult and child HIV infections and reduction of mortality amongst those living with HIV. It had set expected impacts by way of three key indicators: reduction of HIV incidence for adults by 50%, virtual elimination of mother-to-child-transmission to less than 5% and HIV-related mortality reduced by 38% for children, all by 2015 (MoHCC 2013b:3).

According to a Global AIDS country report, by 2015, Zimbabwe's HIV and AIDS-related deaths had dropped by a record 38% since 2010, together with a 25% reduction in mother-to-child-transmission rates. Credit for this goes to the country's ZNASP 2011-2015 together with awareness campaigns and ART. The GoZ was hailed as demonstrating great commitment and leadership in addressing HIV and AIDS. ZNASP was aligned with international commitments and its review was facilitated by government. The report used data collected by NAC, MoHCC and the health partners (Ndlovu 2015).

ZNASP III covers the period 2015-2018. It adopted and maintained ZNASP II's vision, "Towards zero new infections, zero stigma and discrimination and zero AIDS-related deaths with an aspiration goal of 'Ending AIDS by 2030' (GoZ 2015a:14). This vision is in line with global goals.

- Combination HIV Prevention Approach

Combination prevention is a systematic approach to implementing a range of HIV prevention interventions such as behavioural (for example communication to promote reduction in sexual partners' number), biomedical (for example male circumcision) together with structural interventions such as increasing girls' access to education (MoHCC 2013b:1).

Structural interventions would be addressing the five domains that emanate from the HIV and AIDS Communications Framework, which is being used in the study by the researcher: culture, gender relations, religion, government policy and socioeconomic status (UNAIDS/PennState 1999:29-30).

The principles of the Investment Framework, mentioned earlier, gave guidance to the Combination HIV Prevention Approach development, especially with regards to targeting resources toward HIV programme activities that will lead to the greatest impact on HIV and AIDS in Zimbabwe while at the same time delivering those activities as efficiently as possible. This prevention approach prioritizes and further articulates the prevention interventions from ZNASP II, the focus being on building synergies between interventions and strengthening linkages with other sector development goals (MoHCC 2013b:3).

MoHCC and NAC are the custodians of the combination HIV prevention services. MoHCC implements health service delivery at all levels and is responsible for capacity building. The two organizations will also advocate for resources mobilisation and budget allocation. Of significant importance will be for MoHCC to monitor mainstreaming of combination HIV prevention into existing intervention programmes. NAC has the mandate to coordinate

the multisector response to HIV in Zimbabwe together with advocating for and mobilizing resources from both government and funding partners (MoHCC 2013b:31)

SBCC is listed as one of the core service delivery areas that will make the biggest difference in prevention (MoHCC 2013b:11). This is in collaboration with the other five service delivery areas of PMTCT, male circumcision, condom promotion, prevention with positives and HIV testing and counselling (HTC). Young women are listed as one of the groups for who needs should be tailored and who should be involved and part of the process (MoHCC 2013b:14). The current study is therefore in line with the national priorities in Zimbabwe.

SBCC is essential to influencing behaviour that will reduce HIV transmission and it can be targeted to the general population or tailored for specific groups (MoHCC 2013b:11). The researcher is attempting to do this for young urban women by conducting this study and considering their context in Zimbabwe.

- The National Girls' and Young Women's Empowerment Framework

The National Girls' and Young Women's Empowerment Framework was launched in October 2014 ((MoWAGCD 2014a). The empowerment framework, is the first of its kind in Zimbabwe. It was the culmination of extensive consultations of stakeholders, not least the girls and young women (MoWAGCD 2014b:5).

During an interview, the Minister of Women's Affairs, Gender and Community Development stated that there was an existing women empowerment framework developed by the ministry, designed with strategies for protecting and empowering girls and young women in Zimbabwe (Butaumocho 2015). The framework acts as a guide to all stakeholders involved in empowerment programmes for girls and young women. The main categories of the framework are education, economic empowerment, reproductive health rights, safety and protection and leadership development. Further, in response to a question about the Prosecutor General, Johannes Tomana, and his controversial remarks earlier in 2015 about how there was inconsistency between Section 70 of the Criminal Code and the Constitution in terms of the legal age of consent, the Minister acknowledged this. She elaborated by saying that the Zimbabwean laws relating to age of marriage and the definition of a child are in conflict in that according to the Constitution, the minimum age of marriage is 18 years for both girls and boys. In the Marriage Act the age is set at 16 years for girls and 18 years for boys while in the Customary Marriage Act,

no minimum age is stipulated. She said that the relevant leaders would be engaged as a way of initiating amendment to the laws (Butaumocho 2015).

The empowerment framework can be linked to the UNAIDS Communication Framework in several ways, though it primarily speaks to gender; it also is of great relevance to the other five key components of the UNAIDS Framework, namely: spirituality; gender; government policy, socioeconomic status; culture (UNAIDS/PennState 1999:29-30). The fact that the empowerment framework exists, covers government policy. The five main categories of the framework (safety and protection, leadership, reproductive health rights and economic empowerment), highlighted earlier, can all in some way be linked to socioeconomic status.

The participatory empowerment approach within the framework, refers to collaborating with faiths, in addition to other areas (MoWAGCD 2014b:11) This caters for the spirituality component of the UNAIDS Communication Framework. Reference to religion and culture is made throughout the empowerment framework, for example the fact that for education for girls and young women, barriers exist in that there is existence of discriminatory cultural and patriarchal belief and practices that favour males at the expense of females (MoWAGCD 2014b:13). It is gratifying to note that within the framework is enshrined campaigns against negative harmful religious and traditional practices affecting girls and young women (MoWAGCD 2014b:28)

- Zim Asset

In 2013, soon after elections were held, the GoZ introduced a new economy. It runs under the vision “Towards an Empowered Society and Growing Economy” and the mission “To provide an enabling environment for sustainable economic empowerment and social transformation to the people of Zimbabwe”. Zim Asset comprises four clusters namely Food Security and Nutrition, Social Services and Poverty Eradication, Infrastructure and Utilities, and Value Addition and Beneficiation. It also has two sub-clusters – Fiscal Reform Measures and Public Administration, and Governance and Performance Management. The ‘Quick Wins’ concept prioritizes immediately implementing results in the shortest possible time frame (October 2013 – December 2015) in each cluster. The responsibility to implement, monitor and evaluate Zim Asset lies with the President and the Cabinet (GoZ 2013:8-11).

The acronym ‘Zim Asset’ suggests that Zimbabwe is endowed with assets, which are its natural resources – these should attract foreign capital by being leveraged on. Zim Asset

can be divided into two phases: the quick fix (2013 – 2015) and the long-term solution which deals with economic woes. Analysts are sceptical that this model will work. The reason they give is that the State wants to control rather than encourage a favourable business environment. According to Zhangazha, a Zimbabwean political analyst, the model used is a State Capitalist one focusing on empowering the State to become a profit-driven corporate. Zim Asset is modelled along China's development program. Professor Masunungwe highlighted that NGOs and the private sector are some of the stakeholders excluded and their buy-in is therefore a challenge. Zim Asset has been criticized for not having been a consultative product (Mpofu 2013).

Government policy is pivotal in that it covers the governance of everything in the country: while this may directly include health laws, many times it has to do with the issues that are related to the context domains discussed, such as gender and socioeconomic status to create an environment conducive to mitigating HIV and AIDS, for example, job creation.

It has emerged that there is the issue of the law and policies that influence HIV and AIDS in some way whether directly or indirectly, and then there is also the issue of who makes or endorses those laws. It has become apparent, after looking at these issues that the law-making processing does not involve women enough due to their low representative in parliaments, the world over. Arguably increasing women's numbers will empower them to make significant contribution and admittedly in the right direction including in their interest.

2.4.9 Culture

2.4.9.1 Role of culture explained

At the 16th International Conference on AIDS and STIs in Africa (ICASA), a task force was launched with the objective of focusing on ways to impact the HIV and AIDS epidemic and address the vulnerability of women and girls. 21 countries would be targeted. The task force came out of the 2010 Global Task Force's Agenda for Accelerated Country Action on Women, Girls and HIV. A key goal of the taskforce was to engage traditional leaders as the custodians of culture. The task force was to engage education and health ministries (Fleischman & Peck 2015:14).

Empowerment of women needs to consider culture, so that the culture is respected while women's rights are also upheld. Women and men have roles they play in society that are not biologically determined. Society determines them and they are liable to change although they may be justified as being required by culture or religion, they are very

variable depending on locality, changing with time. Therefore, diversity needs to be considered, as the empowerment agenda is pushed forward since women play distinct roles. They have different ages, social status, locations and educational attainment (UNFPA 2015). One example of a biologically determined role is that of breast-feeding, which is for women. An example of one that is not biologically determined is being a leader in the community.

2.4.9.2 Women and culture in Zimbabwe

The cultural context in which Zimbabwean women in general live in is important for us to more deeply understand their circumstances, though it is a given that some of the issues are not particular to Zimbabwe or even Africa.

The Chairperson of the Women's Coalition of Zimbabwe has stated that in the taking measures against HIV, it is vital for women to be able to make their own choices (Majaha 2015). She added that the hurdle for accomplishing this goal is that culturally, decision-making is rendered to men and women therefore must be subordinate. The editor of Priority Projects Publishing is Patience Ziramba. Her organization has produced some books on women and gender development. She believes that the first step in protecting women against HIV is empowering them and appreciating that they can make decisions that are firm, for themselves (Majaha 2015). This of course calls for a shift in the cultural stereotyping of women's role in society that exists and does not promote this.

In Zimbabwe, the Ministry of Women's Affairs, Gender and Community Development (MoWAGCD) is promoting campaigns, together with non-governmental partners, as one strategy to end child marriages. These campaigns have reached 150 traditional leaders who have been sensitized on the Constitution and legal provisions prohibiting child marriages and describing the resulting health and economic consequences (Butaumocho 2015).

- Perpetual minors

Zimbabwe is predominantly a patriarchal and patrilineal society. Nyoni examined the sociocultural factors that inhibit behavioural change of Zimbabwean in the era of AIDS. The factors were in the form of several discourses. Some of the key ones will be examined here, whilst others will be highlighted elsewhere. The first discourse that negatively affects women is that of 'perpetual minors'. Reid, in Nyoni (2008), describes how women through the eyes of customary law have been viewed as perpetual minors - they are either under the authority of their father or under that of their husbands when they marry. The ability

to negotiate and make decisions (for her sexuality and other things) is not developed. “The social environment in Zimbabwe is one, which degrades and devalues women’s social worth making her unable to seek and enjoy good health” (Nyoni 2008:76). According to Nyoni, so deep-rooted is the teaching of perpetual minors that men have difficulty in acknowledging female individuals as equal to them. This attitude limits females in reaching out for safe sexual reproductive health which in turn makes them susceptible to HIV and AIDS (Nyoni 2008:78).

- Marriage: a norm

The second discourse is that of marriage as the norm. Marriage is highly esteemed in Zimbabwe; it is greatly anticipated and accepted as a norm. It is the legitimate means of procreation, a priority in life. This then gives pressure to women who end up wanting to get married no matter the cost lest they become social outcasts. Getting married early is encouraged traditionally and this exposes young women to HIV and AIDS (Nyoni 2008:79-84).

- Violence

Violence is a factor that is covered extensively under the ‘Gender’ section. In some cultures, violence towards women is normal or expected. It is also seen in Zimbabwean culture and basically works to disempower women in that they become unable to take steps towards good reproductive health. Fear of violence influences women negatively in that they become unable to demand safe and satisfactory sex (Nyoni 2008:91-92). There is no doubt that the socio-cultural context of women in Zimbabwe was a pivotal factor that was explored during the researcher’s study, with a view of not only better understanding it, but of somehow incorporating this aspect into the guidelines so that HIV and AIDS communication for women in Zimbabwe improves.

2.4.10 Frameworks from different regions

At the time of designing the new communications frameworks, the regions participating in the workshops (Africa, Asia, Latin America and the Caribbean) constituted 90% of new cases where HIV was manifesting. While all regions endorsed the five domains, each region had to identify two additional key areas specific and critical to their region. It did not matter if they were common to other regions as well as which region had first identified it (UNAIDS/PennState 1999:49).

The Asian region added to the five domains in its framework, ‘Communications context’ and ‘Epidemic situation’ (UNAIDS/PennState 1999:58). The Latin American and



Caribbean regions added 'Advocacy' and 'Involving HIV-positive persons in programmes' (UNAIDS/PennState 1999:63-64). The African region added 'Community-based approach' and 'Regional cooperation' and these elements will be looked at closely now (UNAIDS/PennState 1999:53).

2.4.11 African framework

2.4.11.1 Community-based approach

The community approach focuses on the provision of needs of communities while simultaneously zeroing in on empowerment and the participation of people. 'Community' has a broad meaning but essentially it involves solidarity, mutuality and inter-relatedness as well as common interest. Interest is one thing that determines whether solidarity and emotions are shared with each other; it is an ideal worked towards or developed; it must be a process and a strategy. Even if there are differences between stakeholders, people can form a community as it only exists when there is an identified need. Therefore, in development issues, the concept of community can be a strategy whereby people are pulled together to solve problems. The family is the smallest unit of a community. A family unit is significant and can support individual members, can stay together and can be connected under a strong emotional bond of oneness. Traditionally, communities in Africa lived together and helped each other financially and health-wise. According to the UN (2005), many issues have arisen to threaten the family unit - these include culture, political and economic problems. HIV and AIDS has also been added to the list of threats (Majaro 2007:52).

In the context being discussed here, a strategy targeting to assist those infected by HIV, and members of their families, by re-uniting or being one in solidarity to support those infected by HIV and mitigate the spread of the epidemic, is seen as a community approach for HIV and AIDS prevention (Majaro 2007:53).

The involvement of communities in supporting outreaches and peer education activities to promote culturally appropriate strategies, is important. The same applies to the evaluation of communications programmes, both qualitatively and quantitatively, at the community-based level. This identifies successes and weaknesses and addresses communications gaps, refines messages, selects appropriate channels, develops more acceptable IEC materials and addresses training needs, as well as closes knowledge and skill gaps. Workplace HIV and AIDS education programmes should be set up, as these assist in mitigating the impact of the epidemic in industry and agriculture – ownership by

the community and their sustainability depends on its continual involvement at all stages (UNAIDS/PennState 1999:54).

In Zimbabwe's economic recovery plan, Zim Asset, under the key result area of "Policy and Legislation" which is part of the Social Services and Poverty Eradication Cluster, under the outcome of "Improved collaboration and coordination", one strategy mentioned is "Strengthen meaningful community participation in health" (GoZ 2013:74).

It is widely acknowledged that community mobilization is pivotal in addressing HIV in Africa, although more needs to be done in understanding which mechanisms can be used and how they can be facilitated within communities (Nhamo, Scott, Madanhire, Nyamukapa, Skovdal & Gregson 2015: [1]). As the name suggests, communities may not naturally group together to carry out an activity, but they need to be rallied or mobilized.

WHO established and publicized Community Based Health Care (CBHC) and this is key in the search for a sustainable approach that uses the community to address HIV and AIDS (Majaro 2007:56).

- Community involvement

A study was carried out that looked at community involvement in managing HIV and AIDS in rural areas [Campbell, Nhamo, Scott, Madanhire, Nyamukapa, Skovdal & Gregson 2013: [1]]. The number of community conversations conducted in Zimbabwe were 18, with 77 participants. This was carried out in rural settings and directed by experienced facilitators. Community conversations are defined as "An intervention method through which local people work with a facilitator to collectively identify local strengths and challenges and brainstorm potential strategies for solving local problems." Results showed that community conversations contributed to local HIV competence in more than one way. However, it was identified that support from outside the community was necessary, and in this case it was making anti-retroviral medicines available. Other issues may also need addressing to optimize the ideas that are put forward from the community conversations, so that they are fruitful and able to be implemented, for example poverty and political instability [Campbell et al: [1]]. These community conversations can be adapted for urban settings.

- Male dominance

In a study also set in rural Zimbabwe, the dominance of men had an adverse effect on the community in that it hindered the initiative and energy of young people and women

and yet these two groups are a big resource for an effective community response (Nhamo, Campbell & Gregson 2010:1668).

It is noted that in Zimbabwe, at a national level, 'community development' has been put under the women's ministry, which perhaps is an indirect acknowledgment that women do play a pivotal role in the community progressing. It is evident when looking at the community-based approach, just from the two studies examined, that the members of communities often have very good ideas and that they do see opportunities to be involved in managing HIV and AIDS but they are often constrained by elements outside of their control, for example, male dominance which leads to intimidation and withdrawal by females; these are threats for full community involvement. Although the studies were set in rural settings, we find that in Zimbabwe, the threats are also found in urban areas as well to some extent, for example gender issues, cultural issues, political instability even poverty.

2.4.11.2 Regional cooperation

With a view of creating synergy and widening the scope for negotiating and prioritizing African interests, multilateral organizations and forums should come together. Countries in the region should research into success stories in Africa and examine case studies for lessons learnt and best practices. Focus should be toward institutionalizing action and achieving sustainability. Governments should be at the centre through policy and agreements concerning migration, inter-country border crossing etc. SADC, for example, can be a platform for addressing HIV and AIDS related regional issues (UNAIDS/PennState 1999:40-55).

- Southern African Development Community

SADC, with fifteen-member states, has acknowledged HIV and AIDS as one of the greatest challenges facing member states and that globally it is the region with the highest HIV prevalence. SADC has enshrined its response to HIV and AIDS in several documents including the SADC HIV and AIDS Strategic Framework and SADC HIV and AIDS Business Plan for 2005 – 2009 (SADC 2012). The SADC HIV and AIDS Strategic Framework ran from 2010 – 2015, builds on the previous one's achievements, which ran from 2003 -2009 (USAID [s.a.]).

- African Union

- The AU has 54 members (AU Commission [s.a.]). Africa has been engaged in regional cooperation in many areas including HIV and AIDS. Here are several

examples of regional documents in the form of AU declarations that have been formulated, pertaining to HIV and AIDS:

- March 2006: Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS prevention, treatment, care and support in Africa by 2010
- May 2006: Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, TB and Malaria Services in Africa
- October 2005: Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care
- July 2003: Maputo Declaration on HIV and AIDS, TB, Malaria and other Related Infectious Diseases
- 1994: Tunis Declaration on AIDS and the Child in Africa (Centre for Human Rights 2008).

In July 2013 in Abuja, the AU convened the AU Special Summit in Abuja. The summit ended with a call for strong commitment of the “Abuja actions toward the elimination of HIV and AIDS, TB and malaria in Africa by 2030”. The theme was “Ownership, Accountability and Sustainability of HIV and AIDS, TB and Malaria response in Africa: Past, Present and the Future” (AU 2013). In 2017, African Union Heads of State and Government adopted the AIDS Watch Africa Strategic Framework, to accelerate efforts to end AIDS, TB and malaria by 2030 (AU 2017).

From the various AU and SADC policies spanning several decades, Africa is committed to solving the HIV and AIDS threat together and in unison. Zimbabwe is a member of both the AU and SADC and therefore stands to benefit from these policies once they are implemented.

- Southern Africa HIV and AIDS Information Dissemination Service. (SAfAIDS)
SAfAIDS covers ten countries in the region, and its mission is “To promote effective and ethical development responses to the epidemic and its impact through HIV and AIDS knowledge management, capacity development, advocacy, policy analysis and documentation” (Visser, 2011).

The research unit of SAfAIDS further illustrates regional efforts to manage HIV and AIDS, by facilitating evidence-informed action across the region. Its main activities centre on HIV and sexual reproductive health related research, policy and research data analysis,

as well as dissemination, operation research for organizations, and formulating policy materials for publication (SAfAIDS [s.a.]).

Among several programmes at SAfAIDS, communication for change is one of them. This is composed of behaviour change communication using mass media, as well as using community outreach. SAfAIDS makes use of formative research then determines appropriate and effective messages, format and communication channels for individuals within a proposed target population. SAfAIDS has a lot of experience in design as well as implementation of communication that utilizes a combination of mass media: social media, print, radio and television, short message service (SMS) and web-based media (SAfAIDS 2015b). SAfAIDS Zimbabwe was one of the key informants for the current study.

- Society for AIDS in Africa (SAA)

SAA was founded in 1989 by a group of African scientist, activists and advocates in response to the epidemic, and the cause was supported by Unedited mission of SAA is promoting research and policies so that government national response to HIV and AIDS is supported. The goal is to reduce transmission and mitigate the impact of HIV and AIDS, STI's, TB and malaria in Africa. Various activities are undertaken to progress towards this goal (SAA [s.a.]). Research is high on the agenda since interventions need to be evidence-informed. The ICASA is organised by SAA (SAA [s.a.]).

Zimbabwe had the opportunity to engage in regional dialogues in a big way towards the end of 2015. Several countries put in their bids, but Zimbabwe won the bid to host the largest AIDS conference in Africa, the 18th edition of the ICASA. It was held from end of November to early December 2015, and the researcher had the opportunity to attend. It is held every two years and approximately 7,000 delegates are expected from all continents. The winning bid comes against a background of Zimbabwe's impressive programmes in mitigating HIV and AIDS, according to ICASA president, Ihab Ahmed. In addition, Zimbabwe was assessed and found to have the capacity to host a conference of this magnitude (Bulawayo24news 2015). The 19th ICASA event was held in Cote d'Ivoire in December 2017 (SAA 2017).

2.4.12 The future

Mthuli Ncube, a Senior Research Fellow and project Leader at Oxford University and Principal Investigator of RethinkHIV, has said that defeating HIV will take decades and that more resources are required from the affected countries and donors. He

acknowledged that in addition to biomedical preventions, structural and social drivers need to be addressed through interventions and more focus should be put in in this area. RethinkHIV is a consortium of senior researchers created by RUSH Foundation. The consortium evaluates new evidence related to benefits, costs, effects, fiscal implication and development impacts of HIV interventions in SSA in a bid to maximize contribution against HIV and AIDS (Ncube 2014). RUSH is a registered charity in the United Kingdom, cofounded by Kimbell Duncan and Marina Galanti. Founded in 2010, it seeks to encourage innovation with regards to HIV policy and grass root level interventions inSSA. RUSH encourages thinking out-side-the-box rather than sticking to traditional ways as they believe that these ideas will be the game changers. In fact, the motto for RUSH is 'Funding disruptive ideas against HIV' (RUSH 2015).

The researcher believes that the study is line with the recommended focus area of addressing structural and social aspects that drive the epidemic.

2.5 Conclusion

The chapter began by focusing on the key element of the study which is HIV and AIDS communication. The literature reviewed covered a comprehensive look at the HIV and AIDS epidemic from a global and African perspective, as well as giving details of its outlook in Zimbabwe. Communication was reviewed including defining communication in broad terms and introducing health communication followed by HIV and AIDS communication. The various health communication strategies were described and this lead to the introduction of the UNAIDS HIV and AIDS Communications Framework which was the chosen theoretical framework for the study. Most of the literature review centred on the five contextual domains of this framework. These are gender relations, culture, government policy, spirituality and socioeconomic status. Community-based approach and regional cooperation are specific interventions recommended for Africa, when operationalizing the framework and these were also covered. The study variables comprise the five contextual domains, the community, knowledge, perceptions, IPC and mass communication.

The researcher has been unable to find studies that have the objective of developing guidelines for improving HIV and AIDS communication and therefore the approach is to review studies which cover the study variables.

CHAPTER 3

3 RESEARCH METHODOLOGY

3.1 Introduction

This chapter covers the method that was used to carry out the study. The overall viewpoint of the researcher in terms of the philosophy that informed the study is explained herein. A brief discussion in which the pros and cons of the qualitative paradigm compared to the quantitative paradigm is executed. After that, the research design is elaborated on. In the section following the research design, there is a description wherein the research population as well as the sampling methods are outlined. Thereafter the literature review proceeds to look at the actual procedure itself. The study was anchored on two data collection methods namely the FGDs and in-depth interviews, which are defined in terms of their characteristics, strengths and weaknesses. After the brief discussion on the procedures, there is an explanation of how the research tools of the study were developed and a description of the pre-fieldwork preparations, followed by a section on going into the field. Data analysis, trustworthiness and ethical considerations from the last part of the methodology before concluding.

3.2 Philosophy

The overall philosophical approach that was adopted by the researcher and that guides the study is stated after looking at two other philosophies.

Positivism believes that the world is unaffected by and is independent of the researcher (Snape, Spencer, Ritchie, Lewis, Elam, Arthur, Nazroo, Legard, Keegan, Ward, Finch, O'Connor, White, & Woodfield 2003:16). It endorses the methods of the natural sciences as being appropriate for social enquiry (Snape et al 2003:23).

Interpretivist and constructivist stances tend to underpin some qualitative methods while positivist stances tend to be supported by quantitative methods (Snape et al 2003:18). The aim of the researcher in the interpretivist-constructivist viewpoint (which started in the 1980s) is not to predict social phenomena but instead to understand it. Lather (2006) states that though both fall well within the 'understand paradigm of inquiry', they seek understanding in diverse ways. The interpretivist researcher has the goal to understand social phenomena by attempting to access the meanings that people assign to social phenomena. Constructivists understand meanings as something that through experience is constructed. The research is thus focused on understanding and identifying the

processes of how people acquire or construct different meanings over time (Stinson & Bullock 2013:1257).

Constructivism has its origins in sociology and its aim is to display 'multiple constructed realities'. This is achieved through the shared investigation of meanings and explanations, by both respondents and researchers (Snape et al 2003:12).

Interpretivism holds the view that the researcher and the social world impact on each other. The researcher focuses on exploring and understanding the social world using both the researcher's own understanding as well as the respondents' understanding (Snape et al 2003:17). In considering the input of respondents and researchers, interpretivism and constructivism thus have a commonality.

In interpretivism, facts and figures are not distinct and it is inevitable that the findings are influenced by the researcher. This can be mitigated by the researcher being transparent about their assumptions. It is recognized that the natural sciences' methods are inappropriate since the social world is not governed by law-like regularities but rather, it is mediated through meaning and human agency (Snape et al 2003:17). Qualitative research is largely associated with interpretivism (Snape et al 2003:23).

The positivist view-point was inappropriate for the qualitative study being undertaken by the researcher. After some consideration, the researcher selected interpretivism as the philosophical stance of her study. As with any school of thought, there are pros and cons. While interpretivism is responsive to respondents, it nevertheless lends itself to some criticism. In this regard, two issues that are normally raised are concerned with identifying the aspects in a researcher's findings and interpretation that should be accepted, as well as with the possibility of the findings not being generalizable (Eslami, 2013:193). To mitigate these problems, the researcher depended on the trustworthiness of the study, as discussed towards the end of this chapter where the researcher ensures that there is reflexivity while at the same time focusing on the respondent's views when discussing the findings. The researcher also ensured the transferability of the results by engaging in thick description. Authenticity ensured that a range of realities were described.

3.3 Research paradigm

3.3.1 Qualitative paradigm

Qualitative research was selected for the study.

In choosing qualitative research in terms of its appropriateness for the study, the researcher took several things into consideration including the following: what exactly the researcher was trying to find out; the level of detail of the phenomenon required; how other researchers have dealt with a similar topic and the extent to which alignment with this literature is wanted; practical considerations including the duration of study; if quantitative or qualitative methods assist in learning more about the subject; and commitment to a particular research model and the implication of a particular approach (Silverman 2013:13).

The research was not as much concerned with numbers and statistics (questions that lean to 'how many') as it was with exploring and attempting to understand the information that was gathered, collected and analysed in relation to the phenomenon of HIV and AIDS communication for urban Zimbabwean women (questions that are inclined towards 'what', 'how', 'why').

Qualitative research has the goal of refining information from samples to understand and interpret phenomena. Quantitative research differs in that it uses representative sampling to find out a generalizable law (Eslami 2013:192).

- Definition

Qualitative research is defined as "A research study based on non-numerical data". Non-numerical data covers "pictures, words, statements, clothing, written records or documents, or a description of situations and behaviour" (Christensen et al 2011:29).

- Describing qualitative research

Qualitative research is interpretive research that relies on many types of subjective data and investigates people in specific situations in their natural environment. In this type of research, the researcher examines the data before and after collection the course of the study and continually attempts to understand it from the subjective perspectives of the respondents, which is pivotal. Thereafter, the research becomes an 'objective outsider' and relates the interpretive-subjective data to the research purpose and questions. Qualitative research is, by comparison, more flexible than quantitative research in that the research questions are permitted to evolve, and even change during the study since the focus is on exploration of phenomena. Therefore, qualitative research can generate theories. Quantitative research is more rigid as usually the focus is on testing a hypothesis (Christensen et al 2011:52-53).

Qualitative research employs multiple data collection methods and this assists the process of obtaining the best description of a phenomenon and the interpretation of how respondents best understand it. This is evidence for triangulation in the study, and will be elaborated on later. This research type does not rely on numerical data interpretation (Christensen et al 2011:53-54).

Qualitative research is also described as a type of social enquiry whose focus is the way in which people make sense of their experiences and the world they live in. The different approaches in qualitative research have the same goal which is “to understand, describe and interpret social phenomena as perceived by individuals, groups and cultures”. Qualitative approaches find use in the exploration of change or conflict (Holloway & Wheeler 2010:3). Some of the features of qualitative research are:

- The data have priority or primacy; the framework is not predetermined but is derived from the data directly.
- It is context-bound and therefore context sensitivity is important.
- Immersion into the natural setting by the researcher is necessary.
- Focus is on the views of the respondents and their perceptions, meanings and interpretations.
- Thick description is used: describing, analysing and interpreting as well as going beyond the respondents’ constructions.
- There is the basis of equality in human beings applied: between the researcher and the respondent, and the relationship is close.
- Reflexivity (explained later in detail) is required whereby the researcher is the main tool and their stance is made explicit (Holloway & Wheeler 2010:3-4).

3.3.2 Key characteristics

Table 3.1 compares some of the differences between qualitative and quantitative research.

Table 3.1: Some of the differences between qualitative and quantitative research

	Qualitative research	Quantitative research
Aim	Exploration understanding and description of respondents' experience and life world Generation of theory from data	Search for casual explanation Testing hypothesis, prediction, control
Approach	Initially broadly focus Process- oriented Context-bound, mostly natural setting getting close to data	Narrow focus Product-oriented Context-free, often in laboratory settings
Sampling	Respondents, informants Sampling limits such as place, time, concepts Purposive and theoretical sampling Flexible sampling that can develop during the research	Respondents, respondents Randomized sampling Sample frame filled before the research starts
Data collection	In-depth non-standardized interviews Respondent observation, fieldwork Documents, diaries, photographs, videos	Questionnaire, standardized interviews Tightly structured observation Randomized controlled trials
Analysis	Thematic or constant comparative analysis, latent content analysis ethnographic, narrative analysis etc.	Statistical analysis
Outcome relationships	A story, ethnography, a theory Researcher relationship: close	Measurable and testable results Limited involvement of researcher with respondent Researcher relationship: distant
Rigour	Trustworthiness, authenticity Typicality and transferability Validity	Internal/external validity, reliability Generalizability

(Holloway & Wheeler 2010:10)

Table 3.1's characteristics of qualitative study can be applied to this study as follows: the researcher's aim was to explore, understand and also describe the respondents' life world using an approach that is context-based; the sampling was purposive and limited to the cities of Harare and Bulawayo in Zimbabwe; the data collection was in the form of in-depth interviews as well as FGDs; the data analysis used the Colaizzi method; the research team had a close relationship with the respondents; the researcher used various strategies to ensure rigour in the study, as explained later under the section on trustworthiness.

3.4 Research design

Two research designs were selected for the study for the purposes of triangulation: phenomenology and qualitative case study.

3.4.1 Phenomenology design

The aim of phenomenology is to understand the 'constructs' people use in daily life to make sense of their world. Meanings that are embodied within conversation or text are uncovered. It has its origin in both sociology and philosophy. It has also been used synonymously with the term 'ethnomethodology' (Snape et al 2003:12). It is described more concisely as a "Qualitative research method where the researcher attempts to understand and describe how one or more respondents experience a phenomenon". The aim is for the researcher to gain access to the life world of the respondent or respondents. The life world is described as the inner world of subjective experience or 'phenomenal space', where the 'lived experiences' are; where the immediate consciousness of a person exists; where the person can feel, sense and have 'inner' talk (Christensen et al 2011:368). Lived experiences refers to how respondents are making sense of their personal and social world. Of most importance are the meanings that specific experiences, events and states hold for the respondents (Smith 2015:25). The researcher attempted to understand and describe the experiences of the respondents from the perspective of the respondents, by making use of various variables of the study. How the respondents made sense of or understood their experiences, was important.

There are two types of phenomenology, namely Husserl (descriptive) and Heidegger (interpretive) phenomenology (Reiner 2012: [1]). The researcher applied descriptive rather than interpretive phenomenology. This was because the researcher decided to bracket any biases (Reiner, 2012: [2]). This agrees with Colaizzi's method, which instructs the researcher to validate the findings by returning to the study respondents (Reiner 2012:

[2]). Colaizzi's method of analysis, which the researcher used in the study, is one of the methods of analyses used in descriptive phenomenology (Reiner 2012: [2]).

3.4.2 Case study design

In case study, the research centres on a question and not on a method. Case study is a method that subsumes a variety of methods depending on what is desired. It is a means to an end; the end being answering a question; it is not an end. It is a design frame within which a wide range of research methods can be used (Thomas 2016:92). The case study design is good for obtaining a rich picture and gaining analytical insights (Thomas 2016:22). Case study is designed for exploration in a 'real life' context (Thomas 2016:10).

Case study research is a major approach to qualitative research. In this method, the researcher gives a detailed description and account of at least one case. A case is a bounded system such as a person, group, organization, activity, process or event (Christensen et al 2011:374). In the current study, the researcher takes the meaning of a case to be that of a group, consisting of young urban women aged 20-29 living in and have lived in either Harare or Bulawayo for at least the past 12 months. To achieve this the women undertook in-depth interviews. In this context, the unit of analysis is the group.

Case study is greatly associated with qualitative research, albeit it is used in a variety of ways. It may even seem as though it is a synonym for qualitative research although this is not the case (Snape et al 2003:51).

The fundamental question in case study research is, "What are the characteristics of this single case or of these comparison cases?" Differing sources and methods of data collection can be used for case study research: in-depth interviews, documents, test results, and archival records (Christensen et al 2011:375). The researcher selected in-depth interviews for the case study, together with FGDs. Life history and context are also important to capture for case studies, and this was done. An instrumental case study is different from an intrinsic case study. The latter is only interested in understanding the individual case. The researcher made use of the instrumental case design as what is important for the study was to understand the phenomenon and not one specific case. A template was designed for this purpose. This design gives insight into an issue or it can be used to develop, refine, or alter some theoretical explanation (Christensen et al 2011:375). The researcher's study sought insights into HIV and AIDS communication among young urban Zimbabwean women as this will assist in drawing up guidelines for the target population.

3.5 Sampling

3.5.1 Sampling

Sampling involves selecting a set of people from a population; it is drawing a sample (Christensen et al 2011:163).

3.5.2 Sample

A sample is the set of elements that is selected from a population (Christensen et al 2011:150).

3.6 Population

3.6.1 Definition

A population is the complete set of elements (basic unit selected) from which the sample is selected (Christensen et al 2011:150).

3.6.2 Defining study population

The population that was selected for the study, was that of women aged 20-29, are Zimbabwean, and have been living in either Harare or Bulawayo for at least the last 12 months. The figures from the last census in Zimbabwe indicate that 9.2% of the population were females aged 20-24 for females, while 8.7% made up females aged 25-29 (ZIMSTAT 2013: 18). This translates to 17.9% females for the age group 20-29, or just over 2.3 million females, since the population of Zimbabwe at the time of the census was just over 13 million, as indicated in Chapter 1.

3.7 Sampling method

3.7.1 Approach

Qualitative research is different from quantitative research as it does not aim to estimate the incidence of phenomena in the wider population: it does not focus on statistical representation or scale. Priority in sample design is given to the ability to represent salient characteristics. Therein lies the precision and qualitative rigour (Snape et al 2003:81-82). Qualitative research focuses on in-depth understanding rather than on the breadth of the study of many cases. Information-rich cases are sought. People who the researcher believes to be information-rich are continually selected (Christensen et al 2011:162). In short, the emphasis is on 'quality' of data rather than on 'quantity' of data.

3.7.2 Non-probability sampling

In non-probability sampling, deliberate selection with specific features in mind is carried out: the goal is not to have a statistically representative sample but rather the

characteristics of the population are used as the basis of selection and the chances of selection for each element remain unknown. The searching out of specific features is what makes for suitability for small-scale in-depth studies. Although probability sampling is generally considered to be the most rigorous type of sampling for statistical research, it is not considered appropriate for qualitative sampling (Snape et al 2003:78).

Non-probability sampling was used during the study as part of a combination of sampling techniques: for the FGDs and the individual interviews, convenience, purposive, cluster and snowballing sampling were used; for the key informant interviews, purposive and snowball sampling were used. The key informants were those selected from organizations that work in HIV and AIDS communication, deemed to be experts in this area, namely government entities and their partners (NGOs).

3.7.3 Purposive sampling

In purposive sampling, sample members are selected with a 'purpose' to represent a location or type in relation to a key criterion. It is also known as criterion-based sampling (Snape et al 2003:79). After specifying the characteristics of the population of interest, the researcher locates individuals matching the needed characteristics (Christensen et al 2011:159). Purposive sampling was carried out for the FGDs as well as for the in-depth interviews for both the sub-population and the key informants, as specific characteristics were required for the selection criteria for the respondents to be met.

3.7.4 Convenience sampling

In convenience sampling, the researcher chooses the sample according to ease of access (Snape et al 2003:81). It makes use of people who are easily or readily available, are easily recruited or who volunteer for sample inclusion (Christensen et al 2011:158). This was done for sub-population in-depth interviews and FGDs, as ease of access to the respondents and their availability for data collection, had to be at their convenience.

3.7.5 Snowball sampling

This method makes use of sampled people who are asked to identify other potential respondents with the inclusion characteristics (Christensen et al 2011:159). This proved very effective for the duration of the study. This sampling type was selected as it was easier for the initial respondents (the young urban women and key informants), than it was for the researcher, to identify and refer for possible inclusion, potential respondents who met the study inclusion criteria.

3.7.6 Cluster sampling

This is when clusters are randomly selected rather than individual type units (such as individual people) in the first stage of sampling. A cluster is a collective type of unit that includes multiple elements. Examples of a cluster are neighbourhoods, families, schools, classrooms and work teams (Christensen et al 2011:157). The researcher adapted this type of sampling and ‘purposively’ selected clusters for the study. The researcher purposively selected clusters in the form of residential areas to ensure that high, medium and low-density suburbs were all represented in the sampling for both interviews and FGDs, in both the cities of Harare and Bulawayo.

3.8 Sampling procedure

3.8.1 Inclusion and exclusion criteria

Key informants were eligible for interviews if their organization worked directly in HIV communication (implementing partners/NGOs), and were not, for example, donors. The eligibility criteria used for the sub-population in the study are shown in Table 3.2.

Table 3.2: Inclusion and exclusion criteria for the study

	Inclusion criteria	Exclusion criteria
Willingness to participate	Yes	No
Mental status	Stable	Unstable or questionable
City of residence, for at least past year	Harare/Bulawayo	Other cities/towns/rural areas
Age/years	20 -29, inclusive	19 or less, 30 or over
Sex	Female	Male

3.8.2 Sample size

In qualitative studies, the samples are usually small for three key reasons:

- There is a point of diminishing return where even if the sample size is increased, no new evidence is realized.
- Incidence and prevalence statements are not of concern as no statistical inference is required.
- The findings are rich in detail and so the size must be kept reasonably small for it to be practical to analyse them. It would otherwise become unmanageable to conduct and analyse, groups and observations in a reasonable time frame (Snape et al 2003:83-84).

The sample size for the FGDs was 62 (eight FGDs), 25 for the interviews of the women, and five for the key informant interviews.

3.9 Data collection

3.9.1 Approach

Collecting qualitative data can be divided into two broad groups: one approach focuses on naturally occurring data while another focus on generated data through the research interventions. The researcher chose to use generated data for the study (Snape et al 2003:34). According to Bryman (2001), generated data involve 'reconstruction' which is reprocessing and retelling of attitudes, beliefs, behaviour or other phenomena. In the final analysis, this type of data offers understanding of the meaning that people attach to their own perspective on and interpretation of their beliefs and behaviours (Snape et al 2003:36).

Of the various methods available for qualitative research, the researcher used a combination of in-depth individual interviews together with FGDs. During pretesting, the researcher established that the two should be implemented and completed for a specific location/suburb to avoid going back for the other. By using FGDs and in-depth interviews, triangulation was achieved.

3.9.2 Data collection methods

3.9.2.1 Focus group discussions (FGDs)

- Definition

FGDs are more than collective individual interviews. Group respondents interact and in this manner data is generated. Group respondents listen to what others say and in this way their continued contributions are refined. The group works together and can be described as synergistic (Snape et al 2003:197).

- Main characteristics

One to three hours is the general duration of focus group sessions and audio or video tapes are used. The emphasis is on small group interactions and in-depth discussion about the issues that are under study (Christensen et al 2011:56). The researcher used audio tapes, with the consent of the respondents. The study's FGDs did not last more than two hours.

The researcher/moderator guides the interaction between respondents and probes individuals as well as the group. Specifically, the researcher aims at ensuring that everyone participates and is heard, that the discussion is not derailed and that the research issues are covered. Body language or non-verbal communication in respondents needs to be taken note of throughout the sessions. It offers insight into

possible feelings of individual respondents and it can inform the researcher on how to manage the discussion and group. The researcher needs to be able to harness the discussion to enrich it: reflection and refinement of views is important and the ability to encourage more depth on emerging issues. For the group to be successful, practical arrangements need attention, for example time, the venue and layout. Group dynamics need to be handled well by the researcher. Group dynamics is a reference to the relationships between group members, relationships which change as time progresses and which influence the energy and direction of the group. The composition of the group, subject matter, broader environment and the researcher's behaviour all play significant roles (Snape et al 2003:197-198).

All the focus groups for the study were composed of 6-12 respondents. The respondents were females who had been living in either Harare or Bulawayo for at least the past year, and aged 20-29. For practical reasons (limited number of research assistants and moderators), the FGDs were selected and discussions carried out one at a time (not simultaneously) through the cluster method of locations, ensuring that low, medium and high-density suburbs were all included. The researcher secured the services of an experienced researcher cum moderator who has conducted similar research work for several decades. The researcher and one experienced research assistant simultaneously took notes while the moderator facilitated the FGD, during the pilot. In the main study the moderator and research assistant collected data generated in the focus groups and individual interviews while the researcher simultaneously interviewed the key informants. The researcher decided on using a moderator and research assistant who were both female because of the research title, which would have made the respondents less open and more reserved, had males participated.

- Strengths
 - Useful for exploration of concepts and ideas
 - In-depth information is obtainable
 - Researcher has window into internal thinking of respondents
 - Respondents reaction to each other can be observed
 - Probing is possible
 - Most content can be taped
 - Quick turnaround is possible (Christensen et al 2011:59).

- Weaknesses
 - Expense can be an issue
 - Locating a focus group moderator with good facilitative and rapport-building skills
 - Reactive and investigator effects are possible if respondents are conscious of being watched and studied
 - One or two respondents may dominate the group
 - If small, unrepresentative samples of respondents are used, it may be difficult to generalize findings
 - More information than is required may be provided
 - Measurement of validity may be low
 - Another method in addition to the focus groups should usually be used
 - Data is open-ended and therefore data analysis may be time consuming (Christensen et al 2011:59).

- Mitigation of weaknesses

To mitigate some of the focus group weaknesses, the researcher implemented several strategies as follows: the research budget had already factored in focus group expenses; a suitable moderator was identified in good time and participated in the sessions; training was undertaken so that the moderator and research assistant for the discussions understood that they should make the respondents comfortable. There was an agreement with the researcher on how to handle domineering personalities. Individual in-depth interviews were the second data collection method used to obtain information from the target population; the discussion tool was semi-structured and this gave a degree of control over the scope of the data collection. Accordingly, the researcher was confident that the data analysis would be manageable and had also budgeted adequate time for this phase; the sampling continued until data saturation reached, and this was deemed to be sufficient for the study as it was a qualitative one and not a quantitative one that depends on representative samples; trustworthiness was sought as a way of validation, through audio-recording of all the sessions. Furthermore, notes were taken during all sessions by the research assistant so that they could be compared later with the audio recordings. Four different people were assigned the task of data analysis namely the researcher, the research assistant, the translator cum transcriber, and a qualitative data analyst who assisted with the electronic qualitative analysis using NVivo software.

3.9.2.2 *In-depth interviews*

Phenomenology is a complex philosophy which is multi-faceted. No single approach to interviewing research can be labelled phenomenological. Different researchers that study phenomenology might develop a variety of approaches to inquire the 'phenomenological' (Seidman 2013:15). The researcher views interviewing for the study as a method that is necessary since "When people tell stories, they select details of their experience from the stream of the consciousness" and useful information is obtained (Seidman 2013:7).

The researcher selected individual in-depth interviews of the target population as this was a way to triangulate information obtained from the FGDs. The respondents who took part in the FGDs did not participate in the individual interviews. The researcher also chose to interview key informants who are well-informed about the study topic. All interviewees were purposively selected.

In-depth interviews do not test hypothesis and they are not usually for evaluation. Their focus is an interest in understanding the lived experience of the interviewee and their interpretation of that experience. This type of data collection requires that acknowledgement is accorded to those being interviewed and that it is valuable (Seidman 2013:9).

- Main characteristics

Interviews may be over the phone, face-to-face or electronically. Interviews can be asynchronous (interaction occurs over time) or synchronous where interaction happens in real time (Christensen et al 2011:56). The researcher held face-to-face interviews in real time. The interviews for the sub-population lasted no more than one and a half hours while those for key informants were less than two hours. The interviews all occurred in real time.

- Definition

In-depth interviewing involves the interviewers using mainly, not exclusively, open-ended questions to build on and explore the responses of the respondents to those questions. In this manner, the respondent reconstructs their experience within the topic under study (Seidman 2013:14). Interviewing is a data collection method consistent with people's ability to make meaning through language. It is a powerful way to gain insight into important social issues through understanding the experience of the individuals whose lives reflect those issues (Seidman 2013:13). The questions designed by the researcher

were open-ended, and it was therefore possible to probe and ask the respondent to expound on certain aspects of their responses.

- Strengths
 - Attitudes and most other content of interest can be captured
 - Probing and posing of follow-up questions is possible
 - In-depth information is obtainable
 - Provision of respondents' subjective perspectives and ways of thinking
 - Close-ended interviews provide exact information required
 - Email and telephone interviews usually provide a very quick turnaround
 - For well-constructed and tested interview protocols, the reliability and validity is high
 - Probability sampling can be used
 - The respondent rates that are attainable are relatively high
 - Useful for exploration and for hypothesis-testing (Christensen et al 2011:58).

- Weaknesses
 - In-person interviews are usually expensive and time-consuming
 - Reactive effects (such as the interviewee only trying to exhibit what is socially acceptable)
 - Investigative effect such as data distortion
 - The possibility of the interviewee forgetting crucial information and lacking self-awareness
 - Respondents' perceived anonymity might be low
 - For open-ended questions, data analysis might be time-consuming
 - Measuring of need validation
 - Mitigation of weaknesses (Christensen et al 2011:58).

To mitigate some of the interview weaknesses, the researcher planned several strategies as follows: as with the focus groups, the research budget had already factored in the interview expenses; training was undertaken so that the researcher and research assistant understand how to handle interview dynamics; debriefs with the researcher were held after each interview; the tool was semi-structured and this gave a degree of control over the data collection. In addition, adequate time was set aside for this phase with trustworthiness sought as a way of validation. Through audio-recording in all

sessions, for the sub-population, interviews took place with the help of a research assistant, and member-checking after each interview and, two experienced people were involved in the data analysis, that is, the researcher and research assistant.

3.9.3 *Development of tools*

Annexes E, F & G were the tools used to guide the FGDs and in-depth interviews (young urban women and key informants). In the case of all three data collection tools, the researcher did not use pre-designed data collection tools. The researcher designed each of the three data collection instruments or interview guides in a semi-structured format that comprised open-ended questions. The data collection instrument questions in each case, were guided by the research questions. The theoretical framework that was selected, was used to generate variables and these guided the various themes (in the form of sections) in the instruments - the reason for the semi-structure was to allow for all the variables generated from the theoretical framework, the UNAIDS Communications Framework, together with some of the issues that emerged from the literature review, to be included. At the same time, the semi-structure ensured that there was an element of comparability of information from different respondents. In each of the tools, open-ended questions allowed for additional information probing, depending on the answers given by the respondents. The variables covered the context (which has several components as elaborated in Chapter 1), both interpersonal and mass communication, knowledge and perceptions.

3.9.4 *Pre-fieldwork preparations*

3.9.4.1 *Translation of instruments*

After the finalization of the instruments for data collection, all the instruments, except for the key informants' tool, were professionally translated from English into the main vernacular languages in Zimbabwe. These are Shona and Ndebele. Together with English, Shona and Ndebele are the dominant languages of Zimbabwe. Shona is dominant in the northern part, including in Harare while Ndebele is dominant in Bulawayo and other southern areas of the country because of the different concentrations of ethnic groups. For the key informants, the English tool was appropriate because Zimbabwe's business language is English and the in-depth interviews were carried out in a business/working environment. The tools for the study population were made available throughout the study in all three languages in both Bulawayo and Harare, and respondents could speak in the language(s) they felt most comfortable. The consent

forms were also translated and available in the three languages, as were the demographic data forms.

3.9.4.2 Approvals

On completion of the translations, the researcher applied to the MRCZ for the study to go ahead in Zimbabwe. Only after written permission from this institute had been obtained did the researcher proceed with the data collection phase of the study, including pretesting. Prior to the MRCZ application, UNISA had given the go ahead to proceed with the study.

3.9.4.3 Recruitments

The researcher used the services of an experienced social scientist and researcher who was the moderator during all the focus-group discussions. This moderator had led FGDs several times before over the years. The same person was also the study manager (a requirement by MRCZ) in terms of mobilization of the interviewees and coordination of all aspects of data collection. The manager recruited the respondents by visiting locations and making enquiries as to where potential respondents could be found, including going door to door, and networking with those she knew or had been referred to. One research assistant, a researcher in her own right, was also recruited. The researcher carried out all the key informant interviews while the in-depth interviews and FGDs were carried out simultaneously by the moderator and the research assistant.

3.9.5 Going into the field

3.9.5.1 Preparatory phase

- Training of moderator and assistant

On obtaining approval to proceed with the study from the MRCZ, the researcher arranged for familiarization and the researcher's expectations during data collection, together with training in the FGDs instrument and the individual interview instrument with both the moderator and the research assistant. This included explaining the purpose of the study, clarifications and ultimately ensuring that all members of the research team understood the same processes and were ready to go into the field.

- Pre-testing

The researcher, moderator and research assistant all participated in the pilot for the study. Two tools were pretested (individual interview and FGD guides; not the key informant interview guide) under a similar environment as the intended study. One individual interview was held and one FGD comprising four respondents. This enabled the checking

of several issues, including that the questions were comprehensible, non-ambiguous, appropriate, that the questions enabled capturing of the desired information, that the questions were in a logical order that enabled the session to flow, and to determine the length it would take to go through each tool. The tools were not intended to be very long. Adjustments were made by the researcher accordingly before proceeding with the data collection. The key informant interview was deemed to be credible as it had been reviewed by the MRCZ. The sub-population interview guide and FGD guide were also reviewed by the MRCZ but, unlike the one for key informants which was designed for organizations, these were designed for the sub-population and required pretesting.

3.9.5.2 Interview phase

This involved carrying out the actual study and although this was planned to start latest by 13 August 2016 and to be completed by 15 October 2016, ultimately this was done from early December till mid-February 2016. The FGDs and the individual interviews were carried out in one location at a time, before moving to another location; Harare locations were first completed before moving onto Bulawayo city. This was carried out while the key informant in-depth interviews were being done in Harare. In each case, the interview area within a location was secluded to ensure privacy and confidentiality.

3.9.5.3 Post interview

After each FGD and individual interviews for a specific location, the moderator and research assistant debriefed the researcher who then made sure that all the information was completed and consolidated and that all notes were typed out and submitted. The researcher worked with the research assistant in a comparable manner, for the individual interviews. The key informant interviews and corresponding analyses were carried out by the researcher – the analyses were done manually for both the young urban women and key informant interviews. For each of the individual interviews for the young urban women, key informant interviews and FGDs, the information was in each case stored separately, and under lock and key, by the researcher. A professional transcriber cum translator was recruited one month after the data collection. Credibility of the translated data was ensured as the researcher referred to the notes taken by the research assistant during each FGD and interview.

3.10 Data analysis

Colaizzi's method of data analysis was used (Morrow et al 2015: [7]). This method has seven distinct steps. Ultimately, a description that is concise and all-encompassing for

the phenomenon was attained. This method largely relies on a first-person account of experiences. These experiences can be captured through such ways as face-to-face interviews, written narratives and research diaries, to name a few. These are the steps for this method:

- Familiarization: the researcher must become well versed with the data before analysing it. This involves rereading the respondents' account.
- Identifying significant statements: from the respondents; they should be relevant to the phenomenon.
- Formulating meanings: by identifying relevant meanings after carefully considering the statements. The researcher must 'bracket' any previous assumptions and rather focus on the phenomenon as experienced by the respondents, as much as possible.
- Clustering themes: identified meanings are grouped by commonalities
- Developing an exhaustive description: a full inclusive description is developed; it should be exhaustive of the phenomenon and include all the resultant themes.
- Producing the fundamental structure: summarizing the descriptions into short dense statements, ensuring it captures the aspects that are essential to the phenomenon.
- Seeking verification of the fundamental structure: the researcher returns to the respondents (or sub-samples, for larger studies) to confirm that the experiences were captured accurately. Modification of the earlier steps may then be required.

The last step has attracted controversy. Giorgi, in 2006, stated that the perspectives of researcher and respondent will differ (Morrow et al 2015: [7]).

The researcher had proposed that the seventh step, 'member-checking' or 'respondent validation' be done immediately after collecting the data, before parting ways with the respondents, while the respondents still remembered their responses, and for practical reasons. The researcher believed that it would be difficult to later trace the respondents and that it would also add extra expenses to the study because of travel. This is the proposal that the researcher implemented.

The bracketing being referred to, means that the researcher's knowledge and experience, minimise the influence of the researcher on the study (Chan, Fung & Chien 2013: [7]). "The inherent human factors and the ability to be aware of the researcher's pre-conceptions are the key attributes that can affect bracketing" (Chan et al 2013: [3]). This meant that the researcher had to consciously set aside their own beliefs, values, interests, perceptions and thoughts and not allow them to affect the study (Chan et al 2013: [3]).

The analysis for both the key informant and individual interviews was done manually, while for the FGDs the analysis was initially done electronically (using NVivo software), and results put into themes and sub-themes, and thereafter manually, by reading, extracting, refining and selecting the relevant information. Transcription and translation (for parts that had Shona and Ndebele) were done professionally and simultaneously between January and April 2017, for the audio recordings taped during the FGDs and the individual in-depth interviews.

Being a qualitative study that relies on data saturation as an indicator of having collected information from an adequate sample, data analysis, to some extent, occurred simultaneously with data collection.

Data analysis will be described in greater detail in Chapter 4.

3.11 Trustworthiness

Not much has been availed in relation to trustworthiness of qualitative content analysis in nursing science studies. The terms confirmability, dependability, credibility, transferability and authenticity are often used to present the trustworthiness of qualitative content analysis (Elo et al 2014: [1]). The main phases covered are from data collection up to reporting of results. Reporting of results can further be divided into preparation, organization, leading to reporting of results. By so doing, the overall trustworthiness of the study is covered. Content analysis needs to be reported in a valid and understandable manner and this is to especially benefit reviewers of scientific articles. What often leads to difficulty in evaluating the trustworthiness of qualitative content analysis is defective data collection method and/or analysis description (Elo et al 2014: [1]).

Koch and Harrington (1998) state that the issue of the most appropriate terms (rigour, reliability, validity, trustworthiness) for assessing qualitative research validity have been greatly debated (Elo et al 2014: [2]). Lincoln and Gupta (1985) developed the most widely used criteria for evaluating qualitative content analysis (Elo et al 2014: [2]). The term that they used was 'trustworthiness', which in a qualitative study had the goal of supporting the argument that the study's findings are 'worth paying attention' (Elo et al 2014: [2]).

There is general consensus among known researchers with regard to the techniques for establishing trustworthiness: Amongst eight researchers, between 1985 and 2011, all agreed that triangulation (sources, methods and investigators) and member checks were required; seven agreed on prolonged engagement, negative case analysis, thick

description and reflexive journal; five agreed concerning need for peer debriefing and dependability audit; two on overlap methods; one researcher only proposed the need for persistent observation, referential adequacy (archiving of data) and confirmability audit (Loh 2013:[8]).

Credibility, transferability, confirmability and dependability, all four trustworthiness criteria use the technique of reflexive journal which is about self and method (Loh 2013: [5]).

The researcher pretested the tools, a process which adds to the trustworthiness of the data collection aspect of the study.

3.11.1 Credibility

According to Lincoln and Guba (1985), credibility or internal validity is the criterion that has the following techniques: prolonged engagement, persistent observation, triangulation (sources, methods, and investigators), peer debriefing, negative case analysis, referential adequacy (archiving of data), and member checks (Loh, 2013: [5]). The researcher ensured credibility by engaging in the following: triangulation; member checks; peer debriefing. In addition, the researcher ensured that respondents were identified and described with accuracy (Elo et al 2014: [2]).

Despite doing a thorough literature review prior to data collection, the researcher did not experience bias in terms of preconceived idea, as they deliberately set aside any prior knowledge and information. This ensured credibility in the study. Instead, the researcher only used the UNAIDS framework to guide the generation of some of the study variables.

3.11.1.1 Triangulation

Triangulation is when more than one data source, research method, investigator, perspective and/or theory are used to cross-check and corroborate research data and conclusions (Christensen et al 2011:53).

This was achieved through the different data collection methods. Firstly, the information was collected from the target group using two methods namely FGDs which are a type of group interview, then secondly individual interviews. Lastly, key informants, who are all involved in HIV and AIDS programme communication work, and are therefore assumed to be knowledgeable about the different populations that they work to assist, were interviewed. In addition, the moderator/experienced researcher and one research assistant undertook the data collection for the FGDs, with the research assistant note-

taking and audio taping. A different person professionally transcribed the audiotaping, and another person did the qualitative analysis using NVivo software.

3.11.1.2 *Member checking*

At the end of each theme in the in-depth interview(s), as well as the FGDs, there was confirmation with the interviewee(s), concerning what has been captured and understood – corrections and clarifications were immediately noted, as they came up.

Creswell (2009) defines member checking as a process where the final report and specific descriptions or themes are taken back to the respondent (Loh 2013: [6]). Similarly, Patton (2002) states that member-checking gives them an opportunity to give context and alternative interpretation (Loh 2013: [6]). Though member checking does attract some criticism, this technique double checks what was initially reported to ensure accuracy. Controversy has arisen whereby members are said to possibly have an agenda or want to portray a more positive self-image in refuting or disagreeing with the interpretation. Hence, according to Bloor (2001), the term is ‘checking’ and not ‘validation’ (Loh 2013: [6]). It is ethical to have the respondents review their responses and the interpretations thereof and to ask them for their feedback (Loh 2013: [6]).

Audience validation is a sub-category that falls under member checking, as do peer validation and audio recording.

- Peer validation

Under this technique, peers in a similar field or branch of research would be familiar with the research literature, research methods and would have undertaken similar research. They would therefore be able to review and check the interpretation, give their views on what they agreed with and what, in their opinion, should be re-looked at and re-analysed (Loh 2013: [6-7]). One suitable peer, an HIV specialist and PhD candidate, was identified by the researcher, for peer validation. The researcher emailed the draft thesis to the peer, who gave their input before the researcher finalized the thesis.

- Audience validation

Kwale in 2007 suggested that audience validation is validation from “the primary intended users and readers” of the study and according to Patton in 2003, as well as validation from those whom the study is about (Loh 2013: [7]). The key informants represented the intended audience (users and readers), while the young urban women represented whom the study was about. Therefore, audience validation was covered.

Specific descriptions given by the target populations and the key informants during the in-depth interviews, were confirmed.

- Audio recording

The in-depth interviews were recorded, after first seeking permission, as were the FGDs; the recordings were later transcribed. This allowed for confirmation during analysis as to what exactly was said by respondents. The key informant interviews were not recorded. However, emails and phone calls were made to clarify aspects of the interviews (see Chapter 4).

3.11.2 Dependability

This refers to how stable the data are overtime and under different conditions (Elo et al 2014: [2]). Lincoln and Guba (1985) state that dependability or reliability are covered by two techniques: overlap methods (triangulation of methods); dependability audit (examining the process of the inquiry – how data was collected, kept and its accuracy). (Loh 2013: [5]). The researcher engaged in both overlap methods and dependability audit.

3.11.3 Confirmability

Confirmability is also known as objectivity, meaning the potential of congruence between at least two independent people regarding the data's accuracy, relevance or meaning (Elo et al 2014: [2]). In the current study, this is a peer reviewer, the research assistant and a qualitative data analyst, all of whom are researchers. According to Lincoln and Guba (1985), confirmability or objectivity uses the technique of confirmability audit; the technique examines the product to attest that the findings, interactions and recommendations are supported by data (Loh 2013: [5]). Further, to ensure confirmability in this study, key informant interviews, had similar themes as the target groups, and therefore similar questions were asked (Loh 2013: [5]).

3.11.4 Transferability

Transferability is the potential to which the generated data can be extrapolated. According to Lincoln and Guba (1985) and Polit and Beck (2012), the assumption is that findings can be generalized or transferred to other settings or groups (Elo et al 2014: [2]). Lincoln and Guba also state that transferability is also known as external audit. To ensure transferability, the researcher will engage in thick description (Loh 2013: [5]).

The researcher aimed for the research findings to be transferable because of the impact of the HIV epidemic particularly on women. The researcher anticipated that the findings

would inform guidelines for improving HIV and AIDS communication for women in general, though specifically for those aged 20-29 years in urban settings in Africa, with a similar context to Zimbabwe, and perhaps beyond Africa, as well as communication for women in sexual reproductive health and public health in general.

3.11.5 Reflexivity

Reflexivity is when critical reflection goes into what has been thought and done during the qualitative research and by so doing the researcher, locates the researcher in the study. Researchers deliberately attempt to acknowledge their own involvement in the study. It is a type of check and balance during the study. There is awareness of the interaction between the respondents, researcher and the research and there is consideration of the process of the researcher affecting the findings and eventual outcomes. Things considered include personal response and thoughts about the research respondents and research (Holloway & Wheeler 2010:8).

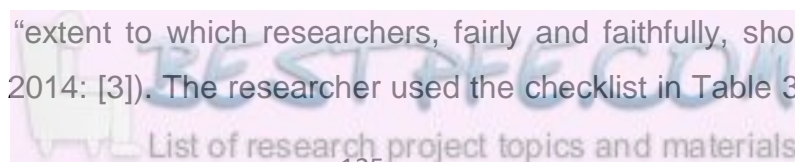
The reason reflexivity is important is because in health research, researchers usually have been socialised into professional ways of thinking. Researchers have a significant role in data collection and interpretation and in the relationship with the respondents as well as with those who will read their research. This way the perspective of the researcher will shape the research (Holloway & Wheeler 2010:8-9).

Reflexivity can potentially be negative, for example, if self-reference is overdone. Instead, the phenomenon and voice of the respondents should be the priority. The researcher is however the main research instrument, deciding what constitutes data, what to focus on, how to analyse; they determine how to illuminate the phenomenon and they also write the research report and at their discretion, decide what to include and exclude (Holloway & Wheeler 2010:9).

The researcher can confirm that being the main research instrument, they had to deliberately leave some of the quotes out from the results, particularly because of the huge volume of data and therefore impossibility of presenting and analysing all statements. The researcher selected statements that were significant and that answered the question that was asked.

3.11.6 Authenticity

Authenticity is the “extent to which researchers, fairly and faithfully, show a range of realities” (Elo et al 2014: [3]). The researcher used the checklist in Table 3.3 as a guide



to ensuring trustworthiness in the study (Elo et al 2014: [3]). The third column, on the extreme right, indicates what was done during the research.

Table 3.3: Checklist for researchers attempting to improve the trustworthiness of a content analysis study

Phase of the content analysis study	Questions to check	Done in the current study
<p>Preparation phase</p>	<p>Data collection method How do I collect the most suitable data for my content analysis? Is this method the best available to answer the target research question? Should I use either descriptive or semi-structured questions? Self-awareness: what are my skills as a researcher? How do I pre-test my data collection method?</p> <p>Sampling strategy What is the best sampling method for my study? Who are the best informants for my study? What criteria should be used to select the respondents? Is my sample appropriate? Is my data well saturated? Selecting the unit of analysis What is the unit of analysis? Is the unit of analysis too narrow or too broad?</p>	<p>The most suitable data collection methods to answer the research questions, were in-depth interviews and focus group discussions.</p> <p>Structured open-ended questions were asked, with room for probing.</p> <p>I have adequate skills to carry out qualitative research.</p> <p>Pre-testing was done with one focus group and one in-depth interview.</p> <p>Four types of sampling were selected for the study because of the nature of the study: purposive; cluster; convenience; snow-balling.</p> <p>The best informants were those from government, who are experts in HIV communication, and their partners (NGOs) involved in the same area.</p> <p>The criteria for selecting respondents is described in Table 3.2.</p> <p>Sampling was done until data saturation was reached.</p> <p>The unit of analysis is a group (young urban women).</p>
<p>Organization phase</p>	<p>Categorization and abstraction How should the concepts or categories be created? Is there still too many concepts? Is there any overlap between categories?</p> <p>Interpretation What is the degree of interpretation in the analysis? How do I ensure that the data accurately represent the information that the respondents provided?</p> <p>Representativeness How do I check the trustworthiness of the analysis process? How do I check the representativeness of the data as a whole?</p>	<p>Themes guided by the UNAIDS HIV and AIDS Communication Framework, were predetermined. Sub-themes and categories were also generated prior to the data collection.</p> <p>Categories were rearranged or merged to eliminate overlaps.</p> <p>The degree of interpretation in the analysis is significant – the researcher selected interpretivism as the philosophical approach.</p> <p>Member-checking and audio recording ensured the data was accurately represented.</p>

		<p>Trustworthiness is covered in detail under ethical considerations.</p> <p>Representativeness is assumed to be good as the sampling was done in two cities that represent most of the urban population in Zimbabwe, and data saturation was reached.</p>
Reporting phase	<p>Reporting results Are the results reported systematically and logically? How are connections between the data and results reported? Is the content and structure of concepts presented in a clear and understandable way? Can the reader evaluate the transferability of the results (are the data, sampling method, and respondents described in a detailed manner)? Are quotations used systematically? How well do the categories cover the data? Are there similarities within and differences between categories? Is scientific language used to convey the results?</p> <p>Reporting analysis process Is there a full description of the analysis process? Is the trustworthiness of the content analysis discussed based on some criteria?</p>	<p>The results were recorded systematically and logically according to themes, sub-themes and categories.</p> <p>The data collection themes, sub-themes and categories correlate with the results.</p> <p>Content and structure of concepts is presented clearly.</p> <p>The data, sampling method, and respondents are described in detail and allow evaluation of transferability.</p> <p>Quotations are used systematically and as the key reporting method for the respondents.</p> <p>The themes, sub-themes and categories cover the data well.</p> <p>There are both similarities and differences in sub-themes and categories.</p> <p>Scientific language is used throughout.</p> <p>There is a comprehensive description of the analysis process.</p> <p>The trustworthiness of the content analysis is covered under ethical considerations for the study.</p>

(Elo et al 2014: [3])

3.12 Ethical considerations

The researcher outlines the measures that were taken to ensure an ethical study as much as is possible.

Sales and Folkman (2000) state that five basic moral principles exist for ethical guidelines: respect for persons and their autonomy, beneficence and non-maleficence, trust, justice, fidelity and scientific integrity (Christensen et al 2011:105). The researcher will discuss these as well other ethical considerations such as the necessary approvals. In addition to these factors, the researcher ensured that all interviews and FGDs were carried out in private venues: a designated room, if it was within a building, or in some cases when it was outside, in an isolated space with no thoroughfare. The researcher considered it ethical to disallow anybody else to have access to any of the data collection information i.e. responses from interviews and FGDS (paper-based and audio recordings), completed demographic data forms and consent and confidentiality forms. The researcher therefore kept all the physical data stored in a lockable immovable cupboard where the key is kept on the researcher's person; all electronic information was kept on a laptop with the researcher's password, which is known to the researcher alone.

3.12.1 Research approval

Ethical clearance was obtained from the University of South Africa (UNISA), as demonstrated by the clearance certificate. In addition, the researcher also sought approval to carry out the research in Zimbabwe from the MRCZ before proceeding with data collection.

3.12.2 Voluntary participation/autonomy

Autonomy occurs when a person can make decisions and committing to them. Respecting this means that a person has the right to choose to be in a study and to be allowed to do so. This can be facilitated by offering the relevant information for a study and allowing a person to accept or refuse to participate (Christensen et al 2011:106).

Written (through consent form) as well as verbal assurance, was given to all the respondents during the study, that they are free to participate or to drop out of the study at any time, should they choose to do so. Consent ought to be sort, but the respondents needed to have adequate information about the study, which they obtained.

Informed consent involves obtaining consent from the respondents after providing information about the study, for example, adequate purpose, the funder, introducing the

research team, explaining how the data will be used, what is required of the respondents, an overview of the likely topics and the duration of the data collection (Snape et al 2003:66).

Informed consent was sought before engaging in the individual in-depth interview and FGDs. The individual and FGD respondents were given language appropriate informed consent forms, which outlined the purpose and issues surrounding the study; their concerns and questions were addressed before they were asked to sign the consent forms. The signed consent forms were an indication that they had understood and accepted their role and this will be proof of following ethical guidelines by the researcher.

In the case of key informant interviews, letters for permission to interview the relevant person were presented to each organization.

3.12.3 Anonymity and confidentiality

3.12.3.1 Anonymity

The issue of anonymity was explained and clarified to the respondents. Anonymity guarantees the identity of a respondent will not be known outside the research teams. In a case where a third party (organisation) is involved in facilitating participation to a study, it should be clarified that absolute anonymity cannot be given (Snape et al 2003:67). The researcher also explained this when the key informants, who were representing their organisations in the study, were interviewed.

3.12.3.2 Confidentiality

Confidentiality means that attribution of comments in reports or presentations to identified respondents must be avoided. This is in both directly (linkage to a name-specific role) or indirectly (referring to a collection of characteristics that may lead to identification). The data storage needs to be carefully done: tapes and transcriptions must be labelled in a way that also guarantees anonymity (Snape et al 2003:67-68).

For the FGDs and individual interviews, numbers were made use of on the biodata forms; the same applied for individual interviews. The key informant interviews recorded the name of the organization and the title of the interviewee for purposes of referring back. The names of all respondents in the study were not be used in the thesis write-up nor will they be shared with anyone in the future.

3.12.4 Justice

Justice seeks to answer the question: who is the recipient of the research benefits and who bears the burdens? The goal is for a sense of fairness in the distribution of the study benefits to be established. Therefore, the following should be under consideration as the study is designed and carried out: the distribution of possible benefits of the study; whether all research respondents should receive equal benefits; whether non-respondents and research respondents should benefit equally. It is suggested that the research respondents should benefit more. However, this is a simplistic view as the varying benefits at distinct stages are not always known, including for respondents. It is unlikely that justice will be achieved as, according to Sales and Folkman (2000), it is a difficult moral principle to accomplish (Christensen et al 2011:108-109). The researcher however proposed that justice will be served to the target population of young urban women as their story will have been captured and will be told, and guidelines developed and hopefully implemented to some extent to improve HIV and AIDS communication in their world and ultimately make positive impact on the HIV epidemic.

3.12.5 Beneficence and non-maleficence

3.12.5.1 *Beneficence*

Doing good is termed beneficence. Studies are required to be designed in such a manner that maximal probability of benefit is rendered to the respondent minimal probability of harm is rendered to the respondent. This ethical consideration is screened by second and third parties: it is considered when approvals are being sought to carry out the study. The researcher obtained an Ethical Clearance Certificate for the study from the UNISA Ethics Committee and permission from MRCZ. In this manner, independent parties examined the benefits and the costs of the study and approved the research (Christensen et al 2011:107).

3.12.5.2 *Non-maleficence*

Doing no harm is termed non-maleficence (Christensen et al 2011:107). Consideration needs to be given to how a study may potentially harm a respondent and mitigating actions to be implemented. This is common in studies of sensitive topics since painful experiences may be uncovered and previously undisclosed information may be divulged (Snape et al 2003:68). The researcher acknowledges that the study falls under this category as it is centred on HIV and AIDS and the context of young urban women which may cover a range of sensitive issues such as violence, sexual abuse, poverty and religion.

As a result, respondents were given clear understanding of the issues to be addressed before consent to participate was sought. Sensitive and potentially sensitive topics were addressed through clear and direct questions. In this manner, respondents were not faced with ambiguity or confusion about subjects they might have possibly preferred to avoid. Throughout the study there was cognisance to signs of discomfort and sensitivity and flexibility in continuing or stopping the interview (Snape et al 2003:68-69). The researcher did not envisage that the study would harm any of the respondents in any way. No harm was reported during or after the study.

3.12.6 Trust

Trust is a moral principle that needs to be upheld during studies. Researchers must establish and maintain a relationship of trust with the research respondents. Informed consent goes a long way in achieving this as it lets the respondents know and understand what they are committing to (Christensen et al 2011:109). The researcher made sure that during training for data collection, the research assistants and moderator had this highlighted to them and it was explained that trust must be carried through until completion of the study.

3.12.7 Fidelity and scientific integrity

Scientific integrity and fidelity is the goal of discovering valid knowledge, through quality research that is truthful (Christensen et al 2011:109). The study was well designed, and the data collection tools were appropriate for the type of study. This confirms the scientific integrity and therefore high quality of the study (Christensen et al 2011:109). Audio-recording, triangulation and member-checking ensured that the information generated in the study was not questionable but instead truly stated. Since the study was of good quality and truthful, the knowledge generated is therefore deemed to be valid.

3.13 Conclusion

The methodology that was used for the study was described. The researcher described the interpretivism philosophy, which underpins the study, and the qualitative paradigm was deemed the appropriate for the study, which seeks depth and aims to explore and understand rather than to measure and issue. Phenomenology and case study were the chosen research designs. The non-probability sampling method for the study made use of purposive, convenience, snowball and cluster sampling. FGDs were employed together with in-depth interviews; in-depth interviews were carried out for the key informants. Three tools had been developed to facilitate data collection. Preparations for

the study were outlined and Colaizzi's method of data analysis was the selected analysis method. Trustworthiness issues and ethical considerations are covered in detail.

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CHAPTER 4

4 DATA ANALYSIS AND PRESENTATION OF RESULTS

4.1 Introduction

The chapter presents the findings of the study by the researcher. Firstly, the pilot phase is described and discussed, followed by the data collection phase findings, which are presented in detail. The demographical information was analysed using the Statistical Package for the Social Sciences (SPSS), and presented primarily using statistics; it covers all the women who were interviewed, combining those from individual interviews and those from FGDs, from both Harare and Bulawayo. The qualitative analysis for the FGDs and in-depth interviews was done by merging transcripts from the audio recording together with corresponding notes taken during data collection - for FGDs, NVivo software was used; the individual interviews were analysed manually. The key informants' data analysis was done manually and did not involve audio recording.

As indicated in the Methodology Chapter, Colaizzi's method of analysis was followed, which involved the following: familiarization with the data, identifying statements that are significant and formulating relevant meanings, clustering themes and formulating deep descriptions and capturing the essence of the phenomenon and verifying the data collected (Morrow et al 2015: [9]).

The 'respondent validation' step of Colaizzi's method was done immediately on completing each interview. The themes, sub-themes and categories were largely predetermined by the researcher and were part of the data collection tool.

4.2 Pilot phase

Prior to data collection, pretesting of the research survey tools was conducted over two days in Kambuzuma, a high-density suburb in Harare, in early December 2016. One FGD which has urban women aged 20-29, and one in-depth interview with a woman of the same age group, were carried out. The consent and confidentiality forms and the demographic forms were used in each case, as shown in Annexes H to K. The researcher, moderator and one research assistant participated in the pilot phase of the study. The findings were as follows:

The interview-guide was not amended in terms of the number of questions. Instead, one question was rephrased so that it was correct and made better sense. Three questions from the FGD interview guide were removed as they solicited duplicate answers.

The English version of the interview guides had to be used together with the Shona (most common indigenous language in Harare) versions, to assist in explaining, elaborating, and clarifying certain questions, to ensure that the meaning was clear, including for terms such as 'vulnerable', 'mass media', 'IPC' etc.

The recording was audible and clear when listened to after the pilot, therefore the Dictaphone was deemed adequate for the research itself.

It was decided that the moderator would not read the introduction during the actual research, as in the pilot, as it appeared more natural to talk as a way of introduction than to read, and they gave more confidence to the respondents. In addition, it was decided that each respondent would do a 30 seconds introduction about themselves, to put them at ease and to make them feel significant.

It was decided that for the consent forms, both English and Shona versions would be on offer and that the explanations about them could come from either or both versions and that the respondent would sign in the language they were comfortable with. The English demographic forms were adequate for collecting information - the Shona versions were not necessary.

The duration of the focus-group interview was one hour and 24 minutes, while the in-depth interview took 45 minutes. Both times were deemed appropriate.

4.3 Data collection phase: demographic data for target population (urban women aged 20-29 years)

Although the study was not a comparative study of Harare and Bulawayo young urban women, some of the data is presented reflecting the results in each city, in certain instances, as this is the manner in what it was collected.

Table 4.1: Sampled areas and size (N=87)

			Focus group discussions		Case studies
	Density	Suburb	Number of FGD	Number of people in FGD	Number of Case Studies
HARARE	Low	Borrowdale			2
		Gunhill	1	8	1
	Medium	Southerton	1	6	3
		Houghton Park			2
	High	Budiriro	1	9	2
		Dzivarasekwa	1	8	2
	Subtotal Harare			4	31
BULAWAYO	Low	Paddon Hurst	1	8	2
		Famona			3
	Medium	Mpopoma South	1	10	3
	High	Eminyela	1	6	2
		Mabuthweni	1	7	3
	Subtotal Bulawayo			4	31
TOTAL			8	62	25

A total of eight FGDs, four each in Harare and Bulawayo respectively, were conducted altogether. Each city had 31 respondents who participated in the FGDs, making a total of 62 respondents. In both Harare and Bulawayo, one FGD was conducted in a low and medium density and two FGDs were conducted in high density suburbs as shown in Table 4.1.

Twelve individual interviews distributed across all the sampled suburbs of Harare were conducted. In Bulawayo, thirteen individual interviews were conducted across all the sampled suburbs. This culminated in 25 individual interviews conducted. The total sample size of respondents both in FGDs and individual interviews in Harare and Bulawayo came to 87 (43 from Harare and 44 from Bulawayo).

4.3.1 Distribution of respondents by city of residence

Of the total study participants, 49.4% (n=43) were Harare residents, while 50.6% (n=44) were resident in Bulawayo. This is shown in Table 4.2.

Table 4.2: Distribution of respondents by city of residence (N=87)

% of Respondents	
Harare	Bulawayo
49.4%	50.6%

Of the total respondents interviewed, 27% (n=24) of them resided in low density suburbs, while 28% (n=24) resided in medium density suburbs and 45% (n=39) were resident in high density suburbs, as shown in Figure 4.1:

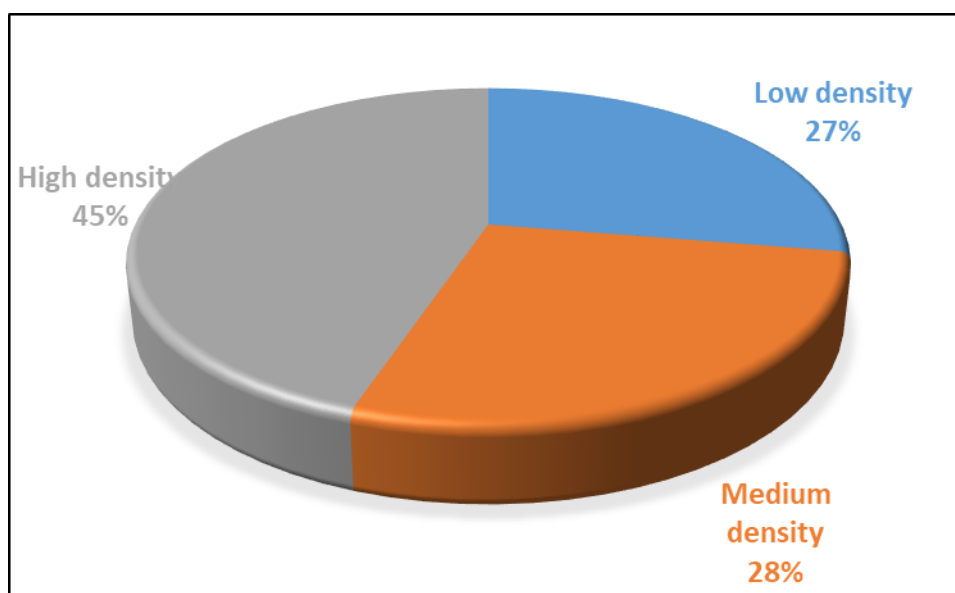


Figure 4.1: Distribution of respondents by suburb type (N=87)

4.3.2 Distribution of respondents by place of origin

The survey sample consisted of women originating from various parts of Zimbabwe and two other countries. Towns, districts and countries were represented. The towns/districts in Zimbabwe were grouped by province as shown in Table 4.3. Malawi had 3.5% (n=30) originating from it, while 1.1% (n=10) reported to have originated from South Africa. The remainder all originated from various parts of Zimbabwe, as shown in Table 4.3.

Table 4.3: Distribution of respondents by place of origin (N=87)

Province	% of respondents
Manicaland	17.3%
Mashonaland East	19.5%
Mashonaland West	3.5%
Masvingo	10.4%
Midlands	9.2%
Matebeleland South	17.1%
Matebeleland North	18.4%
Malawi	3.5%
South Africa	1.1%
TOTAL	100.0%

4.3.3 Distribution of respondents by age group

Of the total respondents interviewed, 42.6% (n=37) were aged 20-24 years, while most of the respondents, 57.4% (n=50) fell in the age group of 25 – 29 years. Analysis of age group by city shows the same pattern in both cities, with more than half of the respondents in the category 25 – 29 years, as shown in Table 4.4:

Table 4.4: Distribution of respondents by age group and city of residence (N=87)

City of Residence	Age group	
	20 – 24 years	25 – 29 years
Harare	48.8%	51.2%
Bulawayo	36.4%	63.6%
Total	42.5%	57.5%

4.3.4 Distribution of respondents by marital status

Most of the women were single, 47% (n=41), followed by those who were married or co-habiting, 41% (n=36). Divorced, widowed and separated women formed the remaining 12% (n=10), as shown in Figure 4.2:

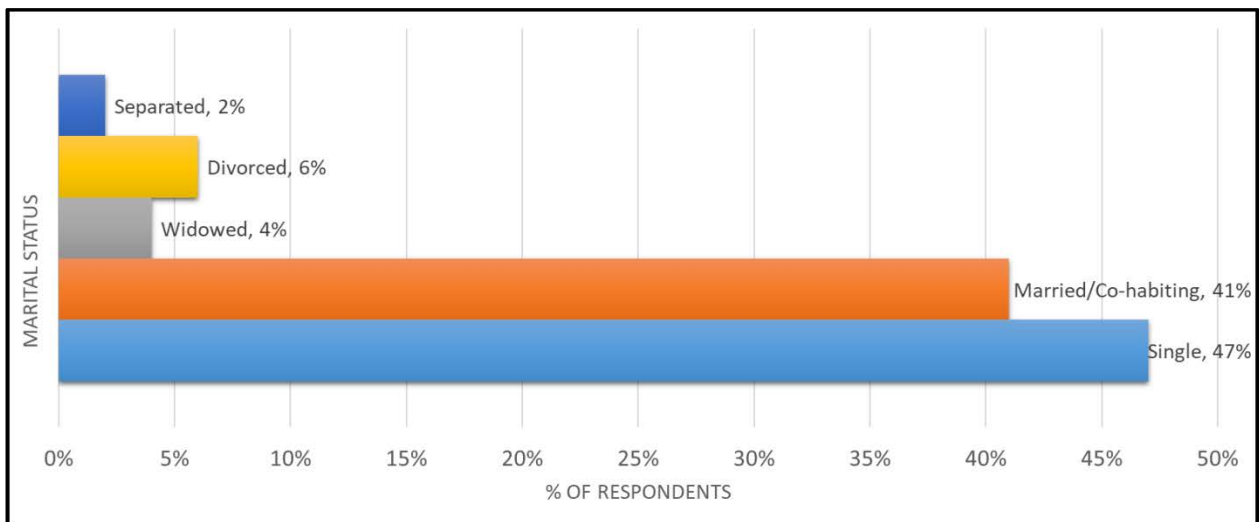


Figure 4.2: Distribution of respondents by marital status (N=87)

4.3.5 Distribution of respondents by religion

The Pentecostal religions were the prevailing ones among the respondents, with 45% (n=39). The Apostolic sect was the second most common in both Harare and Bulawayo, followed by the Seventh Day Adventist, with overall percentages of 22% (n=19) and 12% (n=11) respectively, as shown in Figure 4.3:

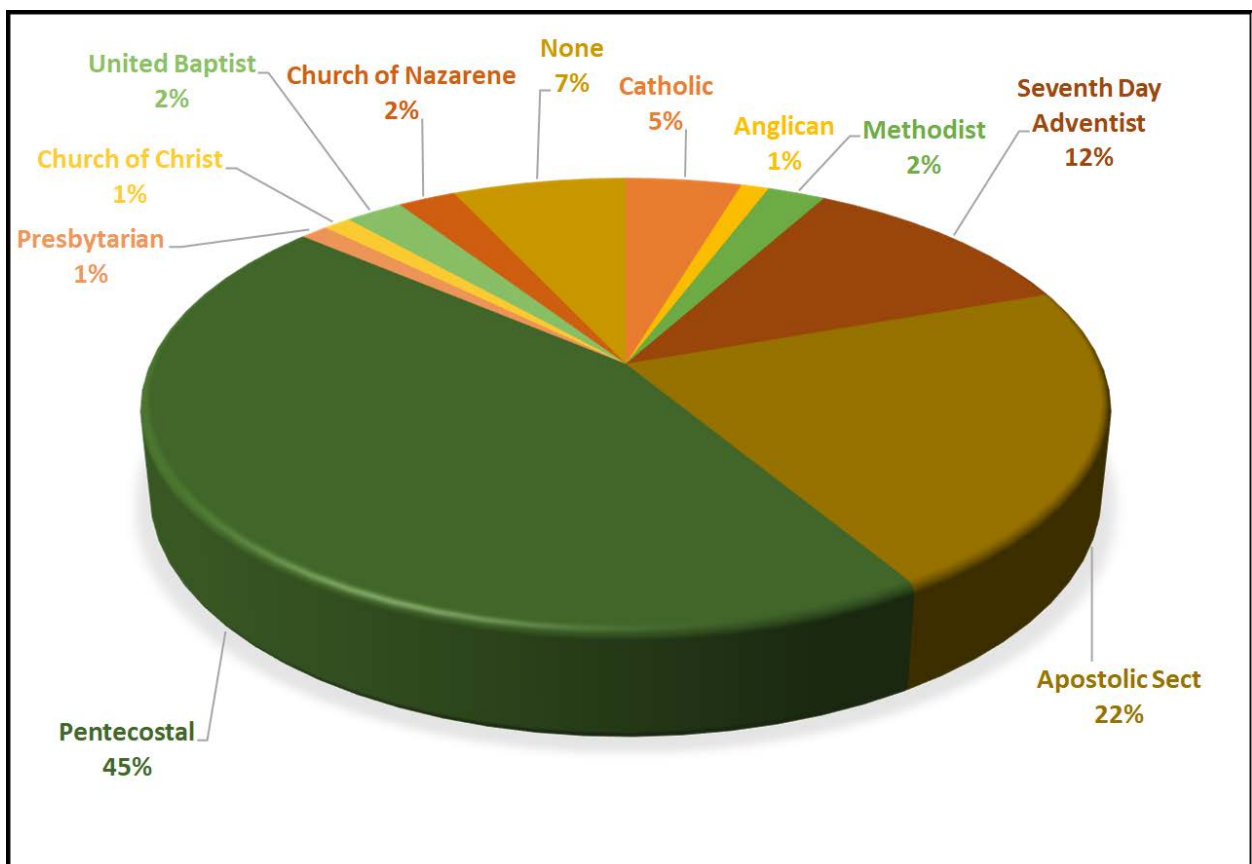


Figure 4.3: Distribution of respondents by religion (N=87)

Analysis by city of residence, for religion, shows the same trend in both Harare and Bulawayo, with most of the women reporting to belong to Pentecostal religions, with 48.8% (n=21) and 40.9% (n=18) respectively as shown in Table 4.5:

Table 4.5: Distribution of respondents by religion and city of residence (N=87)

		City	
		Harare	Bulawayo
Religion	Catholic	2.3%	6.8%
	Anglican	2.3%	0.0%
	Methodist	4.7%	0.0%
	Seventh Day Adventist	4.7%	18.2%
	Apostolic sect	23.3%	20.5%
	Pentecostal	48.8%	40.9%
	Presbyterian	0.0%	2.3%
	Church of Christ	2.3%	0.0%
	United Baptist	4.6%	0.0%
	Church of Nazarene	0.0%	4.5%
	None	7.0%	6.8%
TOTAL		100.0%	100.0%

4.3.6 Distribution of respondents by educational level

Analysis by city of residence shows a similar trend in both cities, with most of the women reporting to have attained at least Form 4 level of education, as shown in Table 4.6. However more of the Bulawayo women had attained University level 18% (n=8) as compared to Harare women with only 2% (n=1) having reported to have attained University level. Form 2 correlates with the second year of high school; form 4 with the second year; Form 6 with the sixth and final year.

Table 4.6: Distribution of respondents by educational level attained and city of residence (N=87)

City of Residence	Highest Educational Level Attained						
	Grade 7	Form 2	Form 4	Form 6	College	University	Total
Harare	5%	7%	74%	0%	12%	2%	100%
Bulawayo	5%	9%	48%	2%	18%	18%	100%
Average	5%	8%	61%	1%	15%	10%	100%

4.3.7 Distribution of respondents by employment status

48.35% (n=42) of the respondents reported to be unemployed, while 51.65% (n=45) reported to be having some form of employment. However, an analysis by city of residents depicted a higher percentage of women were unemployed (58.1% (n=25)) in Harare, as compared to Bulawayo with 38.6% (n=17). In Bulawayo, of the women who were employed, a higher percentage, 38.6% (n=17) were self-employed, while in Harare, of those who are employed, a higher percentage, 25.6% (n=11), were employed by someone else or a company/organization.

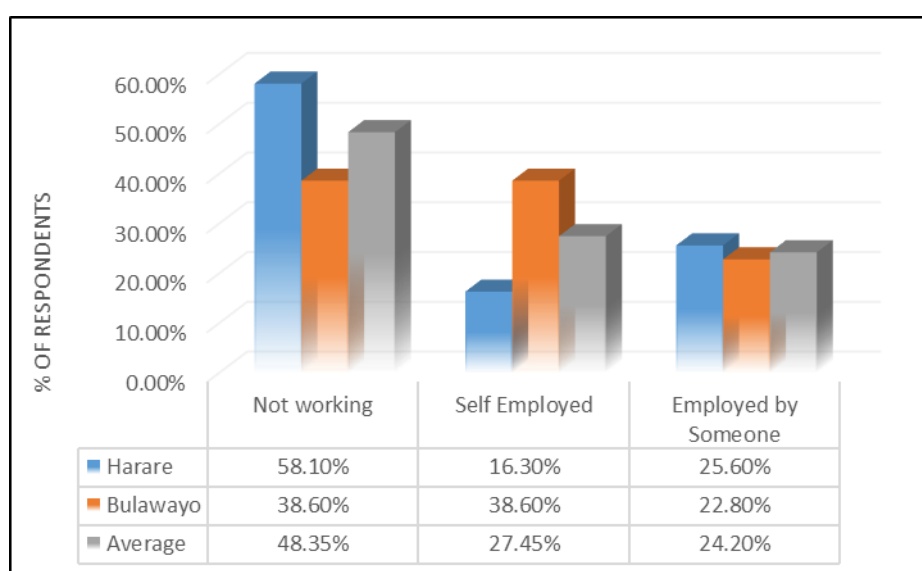


Figure 4.4: Distribution of respondents by employment status and city of residence (N=87)

4.3.8 Distribution of respondents by language fluency

All the respondents could choose more than two languages, indicating the languages they were fluent in. All the respondents (n=43) in Harare are fluent in both Shona and English, while only 14.6% (n=6) are fluent in Ndebele. In Bulawayo, 88,6% (n=39) were fluent in English, 50% (n=22) fluent in Shona while 93.2% (n=41) were fluent in Ndebele, the dominant language in Bulawayo. Therefore, of all the respondents, 94.3% (n=82) reported to be fluent in English, followed by 75% (n=65) with Shona fluency and 53.9% (n=47) with Ndebele fluency. Several of the respondents were fluent in other minority languages as shown in Table 4.7:

Table 4.7: Distribution of respondents by fluency in language (N=87)

Language	% of Respondents, Fluent in the Language		
	Harare	Bulawayo	Average
Shona	100.0%	50.0%	75%
Ndebele	14.6%	93.2%	53.9%
English	100.0%	88.6%	94.3%
Sotho	4.7%	4.5%	4.6%
Nyanja	4.7%	0.0%	2.4%
Venda	4.7%	0.0%	2.4%
Chewa	2.3%	0.0%	1.2%
French	0.0%	2.3%	1.2%
Kalanga	0.0%	4.5%	2.3%
Tswana	0.0%	2.3%	1.2%

4.4 Results from individual interviews

A total of 25 interviews were conducted. The transcription process was from January to April 2017. Annexe L is a sample transcript from one of the individual interviews. An experienced transcriber who is fluent in all the three key languages: English, Shona, and Ndebele, was used for this exercise. Four themes guided the interviews, namely Communication, HIV and AIDS Knowledge, Perceptions and Belief, and Context. The themes for the data analysis, are identical to those for data collection. Some of the themes and sub-themes had categories. 'INT' denotes Individual interview, in this section.

Table 4.8: Themes and sub-themes for individual interviews

Theme	Sub-theme	Categories
1. Communication	Interpersonal communication	People who women have heard HIV and AIDS information from
		People who women are most comfortable hearing HIV and AIDS information from
	Communication channels	Channels women have heard HIV and AIDS information through
		HIV and AIDS information
		Language appropriateness
Communication preference	-	
2. HIV and AIDS knowledge	Knowledge of HIV and AIDS	Distinguishing between HIV and AIDS
		HIV transmission
		HIV prevention
		HIV status
		Disclosure of HIV positive status
		Male circumcision
		PMTCT
	HIV treatment	
HIV and AIDS champions	-	
3. Perceptions and beliefs	Epidemic drivers	-
	Interpersonal communication	Most accurate information
		Least accurate information
	Communication channel effectiveness	-
	Information sensitivity to needs	-
	Vulnerability	-
	Blame/fault perception	-
	Risk perception	-
	Impact of knowledge on behaviour	-
	HIV prevalence	-
	Educating others	-
4. Context	Community involvement	-
	Spirituality	-
	Socioeconomic status	-
	Culture	Negative cultural influences
		Positive cultural influences
		Incorporation of culture in HIV and AIDS communication
	Young Urban women's context	-
	Government policy	-
	Vulnerability	Polygamy
	Small house	

		Sugar daddies
		Sex work
		Gender roles
		Gender-based violence
		Educational level

4.4.1 Theme 1: Communication

The sub-themes falling under communication were IPC, Communication Channels and Communication Preference.

4.4.1.1 Sub-theme: Interpersonal communication

IPC was comprised of several categories, namely: people from whom women have heard HIV and AIDS information from; people whom women are most comfortable hearing HIV and AIDS information from.

- Category: People from whom women have heard HIV and AIDS information from (sources of HIV and AIDS information)

The women interviewed have heard about HIV and AIDS through IPC from mostly teachers at school and nurses at clinics or hospitals. Other people they have heard talking about the epidemic are general people in the community, doctors, workmates, PLHIV, friends, parents, relatives and counsellors at HIV testing centres:

“I once went and got tested. The counsellor was the one who gave me information about AIDS. I am also a blood donor. So, before you donate blood, they first counsel you about HIV and AIDS” (INT1 Harare, low-density).

“I heard the information from my aunt or ‘Maiguru’, and my sister. They advised me not to be intimate with HIV positive men, not to use sharp objects for example razors or needles that have been used by an HIV positive person. They also told me not to touch anyone’s blood because you never know their status” (INT7 Harare, high-density).

“From a number of people, I would say firstly from high school and then also after school I attended a few programmes and workshops on HIV and AIDS” (INT13 Bulawayo, low-density).

“I heard the information from doctors at the hospital” (INT18 Bulawayo, high-density).

- Category: People who women are most comfortable hearing HIV and AIDS information from

The people most women were comfortable obtaining information from were nurses, followed by anyone who was knowledgeable enough, followed by counsellors. Other people named were doctors, parents, relatives, with those singled out being aunt, sister and grandmother, health workers, teachers and any female person:

“From parents because they love us and they are the ones who would usually make sure we protect ourselves from being infected with HIV” (INT6 Harare, medium-density).

“I am comfortable getting information from anyone, even those who are not infected because they get information from different sources. So, we tend to learn from others” (INT10 Harare, low-density).

“No one can explain better than health workers at the clinic. That is the only place I can understand fully about HIV and AIDS” (INT23 Bulawayo, high-density).

“...In this case, I am referring to people around me. More specifically, the people in my neighbourhood, people I live with in my area, here in Southerton. These are the people I grew up with, my friends and relatives. When you get information from people you are familiar with, it’s easier to relate to it...” (INT12 Harare, medium-density).

“Available sources such as class teachers and television but mainly I am comfortable with teachers because they will be taking reliable information from textbooks” (INT21 Bulawayo, medium-density).

“These are issues to do with health and you have to be very careful so if there was no internet, I would prefer talking to a doctor or even a health worker at the clinic.” ...they are trained and well informed. I really don’t believe in getting information from anyone else. People have a lot of theories when it comes to HIV and AIDS. But thankfully now, I think people understand what the disease is all about...” (INT14 Bulawayo, low-density).

4.4.1.2 Sub-theme: Communication Channels

Communication Channels is comprised of the channels women have heard HIV and AIDS information from, HIV and AIDS information adequacy, Language appropriateness and Information accessibility.

- Category: Channels women have heard HIV and AIDS information from

The channels through which the women have heard about HIV and AIDS are radio, television, billboards, posters, pamphlets, books, the internet, magazines. On television, this was in the form of talk shows, dramas, programmes, adverts, interviews; on the radio – talk shows, programmes, interviews, adverts; newspapers and magazines – stories, adverts, articles. Billboards were located at schools, New Start Centres, workshops, along roads; posters – New Start Centres, clinics and hospitals, on poles along the roadside in town centres, at schools, outside shop walls; pamphlets at New Start Centres, clinics and hospitals, nursing homes, doctors' rooms, NGOs, workplaces, school libraries, being handed out in the streets or door-to-door. 'New Start' began in Zimbabwe in 1999 in support of the Ministry of Health and Child Welfare (MoHCW) Testing and Counselling programme. New Start Zimbabwe is affiliated with New Start South Africa and New Start Zambia (Centre for Health Market 2017):

"I have seen the billboards at workshops that I usually attended. They are normally put up at these workshops" (INT25 Bulawayo, high-density).

"I have seen the posters at the Total Garage nearby and posters are also put up at the grocery shops every time there is a testing campaign" (INT23 Bulawayo, high-density).

"I have seen pamphlets and brochures being given in public to the general public" (INT21 Bulawayo, medium-density).

"On the radio, normally it will be an interview where an HIV positive person will be interviewed. If they want to teach about HIV... On television it is just like on radio they bring an HIV positive person for interviews... On magazines and newspaper, they will be advertising free testing by organisations such as New Start Centre, MAC and NAC. Articles in newspapers are of how a person can get HIV" (INT20 Bulawayo, medium-density).

“There is a radio programme called ‘Emoyeni loDokotela’ (On the air with the doctor). The programme is usually aired around 9am. It’s an educational programme... They advise what to do when you get to know that you are infected. They also encourage you not to give up on life and inform people that the virus is there amongst the people, it’s a reality” (INT19 Bulawayo, high-density).

“...Maybe music. But for me it’s TV. There are some programmes that I used to watch on SABC especially on SABC 1, there was a programme called “Siyanoqoba – I Beat It” and also programmes from a whole lot of other African countries... I remember reading about a certain South African personality in a magazine, she also hosts a programme on SABC called Relate although I don’t remember her name. I didn’t know that she was actually HIV positive until I read about her story in a certain magazine. I read that she has been living with HIV for years and years and I was inspired. I said to myself this woman has been HIV and lives her life the way she does and she is famous and looks like she has things under control” (INT14 Bulawayo, low-density).

“I saw an article in a magazine which showed different types of diseases caused by AIDS. The articles showed in picture form how the different diseases had manifested themselves in people’s bodies” (INT16 Bulawayo, low-density).

“I have seen billboards at hospitals and clinics. But as much as I may have seen them there, I have hardly paid much attention to them “(INT10 Harare, low-density).

“I usually watch a programme called “Positive Talk” on television” (INT8 Harare, high-density).

- Category: HIV and AIDS information

The HIV and AIDS information available on mass media is viewed by most of the women as being adequate, very useful and informative. Almost all the women see the information that is available, is adequate and available ‘everywhere’, with just four thinking otherwise and one saying they were unsure. It is felt that there are many places where the information is accessible but that people are not taking heed and have a bad attitude or are just ignorant. The places with information included churches, clinics and New Start Centres:

“The information is important, it reviews some things people don’t know about” (INT21 Bulawayo, medium-density).

“HIV and AIDS awareness is there, it’s real. The information has been circulated so widely. I don’t think I have question marks on the information that I have gotten. It’s so rich, thoughtful and it’s given freely. You can get the information anywhere even at such places as the New Start Centre. You can go there and access the information freely. When I went there, I got tested and got information about HIV and AIDS” (INT12 Harare, medium-density).

“The information is put in such a way that one can easily understand it. If you are of loose morals, you may want to change your ways because you would have heeded the information that is being given. I am 21 years of age and I now have an idea as to how I should lead my life. I might make a mistake and get involved with someone who has the virus. I am however now more informed about the virus through the programmes that I watch on TV” (INT7 Harare, high-density).

“I think they are trying, but there is need for more information and for the content to be clearer because you will find that people are still stigmatizing people that have HIV and AIDS. So, there is need to have more information on what HIV and AIDS is all about and how do we associate with people who are infected in society” (INT15 Bulawayo, low-density).

“The content is informative and educative. It is then up to you, how you are going to use that knowledge that you would have gained” (INT18 Bulawayo, high-density).

“It teaches a lot to those who want to learn. We no longer have aunts to guide us through the tribulations of life compared to the older days where aunts played their role in guidance. Nowadays we get information and learn from TVs. TV is the only medium of communication where we learn about life than going to a relative” (INT17 Bulawayo, low-density).

“It’s helpful because HIV and AIDS is real and it’s out there so the information is there. But I am not easily convinced, even when I see something on a pamphlet and it catches my attention I would still have to go and Google to verify it. I do generally accept the information though” (INT14 Bulawayo, low-density).

“The content is okay as it is informative. Most of the time we are ignorant of HIV and AIDS issues and some of the content is educative” (INT8 Harare, high-density).

“It could be adequate, but the way it is relayed may not always be clear. As a result, I don’t take the information seriously” (INT5 Harare, medium-density).

“In my view, the information on HIV and AIDS is particularly beneficial to us the youth. We have been able to get a lot of information through the mass media that we were not aware of” (INT4 Harare, high-density).

“I don’t have much time to sit and watch TV nor read newspapers, but I do get HIV and AIDS information through WhatsApp as I spend most of my time on WhatsApp” (INT3 Harare, high-density).

“...HIV and AIDS is talked about in the radios, the TVs, pamphlets, billboards, etc. There is enough information and it is up to each person to take that information and put it to good use. Others will just say, “Whatever!” They just don’t care” (INT1 Harare, medium-density).

“The information is everywhere, at schools, clinics, etc., I doubt there is any place without HIV and AIDS educational information. So, in my opinion there is enough information” (INT3 Harare, high-density).

“People still carry on with their loose behaviour fully knowing that they may get infected. They have all the information on HIV and AIDS, but there is no behaviour change” (INT8 Harare, high-density).

“Like I mentioned earlier, I think if there are friendlier centres or a medium where you don’t feel like you are going to be judged when you walk in there. So, yes, the information is there but the issue is, where to get it, where atmosphere is friendly” (INT13 Bulawayo, low-density).

“...I think there is need to be constantly irritated and flooded with this information. They need to be constantly reminded of the consequences that HIV is real and that people who have HIV these days are not in wheel chairs and hospital beds and slim. They look very healthy, the ladies are wearing make-up, lipstick and they

look all curvy. The guys are masculine and handsome and they drive nice cars and they are sweet talkers. You know. People also have certain medical conditions that make them look thin. People should stop thinking that people who are HIV have a certain look. Gone are the days when people who had HIV and AIDS were wasted away due to weight loss” (INT14 Bulawayo, low-density).

“I wouldn’t say yes, I wouldn’t say no because I have not seen many campaigns in urban areas compared to rural areas” (INT17 Bulawayo, low-density).

“Some group of women don’t have the information and don’t know about the virus. For others, information is available but some women are not interested in the information. Some married women are not being allowed by their husbands to attend any programmes related to HIV and AIDS issues or to attend any community functions” (INT20 Bulawayo, medium-density).

“Information is there but the information should spread and be easily accessible in churches and workplaces, etc.” (INT21 Bulawayo, medium-density).

“I think people should take heed of the information so that we reduce the spread of HIV and AIDS...I think the information is more than adequate” (INT3 Harare, high-density).

- Category: Language appropriateness

The language appropriateness in the mass communication of HIV and AIDS was said to be appropriate, with the general acknowledgement that English and Shona were the dominant languages used, with Ndebele also being used at times and thus all three main languages are catered for:

“They use the English language. I believe it’s appropriate because everyone can understand English. If they spoke in Ndebele, some people may not understand. It’s the same if they used Shona, some people may not also understand. English is a universal language” (INT1 Harare, medium-density).

“English, Ndebele and Shona are used, by so doing everyone can understand the message being relayed. In fact, these days they even use Namibia and Tonga.

With the use of all these different languages, everyone is catered for” (INT3 Harare, high-density).

“I think they try to simplify. Most of the time the information is in the three languages Ndebele, Shona and English. I there are other languages that are not used, for example Tonga, Xhosa and all other minority groups. We tend to forget about them, but generally I think the language is somewhat understandable” (INT13 Bulawayo, low-density).

“People need to be on the ground, they need to speak the same language as the common person on the ground. They don’t have to be using all the big words and stuff. Otherwise the language is okay. I think people just want to get all complicated, using big words, being too educational and stuff. When you go to the “hood”, just talk the same language with people there. You should be able to speak the language that the common person speaks. If it’s Ndebele and you are in the hood, talk the Ndebele ‘gazekas’ (local slang). If it’s English and you are talking to someone like me, you just have to, I don’t know, maybe edit the information so that I understand it, you don’t have to be all complicated and sound like a professor” (INT14 Bulawayo low-density).

- Category: Information accessibility

The most readily accessible mass media channel is television, followed by the radio and then the internet:

“The television is the most accessible channel. I spend most of my time at home so, I can easily see any information shown on television. Every time I need a newspaper I have to pay for it and I may not readily have money to buy it. Whereas, I already have a television set at my disposal” (INT4 Harare, high-density).

“You can find a radio everywhere including at home, on public transport, at work (there might not be a television set at work, but a radio is available)” (INT9 Harare, low-density).

“I always have internet on my phone and I can even get to know that maybe there is a USB test kit for HIV and AIDS and you can do tests on yourself, or whatever it is that is on offer. I can actually get all this information while I am even in a queue

anywhere. I can then go and Google for the information later” (INT14 Bulawayo, low-density).

4.4.1.3 Sub-theme: Communication preference

Almost all the respondents preferred IPC as compared to mass communication. Three preferred mass communication while three others said they liked both types equally. The common reason given for preferring IPC was that there is the ability to probe and ask more questions and get more clarifications. Mass communication was preferred for its anonymity as well as its ability for others' views to be listened to:

“I would prefer interpersonal communication because I am able to get further clarification on any issue that I would not have understood on television” (INT2 Harare, medium-density).

“I think one-on-one is better because if I heard information over the radio, I may not be able to ask something that would have been said and I did not understand it. It's the same with TV. I can see something but will not be able to ask if it was not clear to me. Right now, we are discussing and if I am not clear on what you are saying, I will ask and you will answer me” (INT25 Bulawayo, high-density).

“I would prefer interpersonal communication because if I were to have a one to one discussion with a nurse, I would be able to have a full discussion her/him unlike on television or radio. I am definitely able to get detailed information from a nurse, discuss and ask questions. On television, the advert is recorded in advance and there is no room to ask questions or have a discussion” (INT4 Harare, high-density).

“I would prefer interpersonal communication because I am able to fully understand the issues at hand. The information on radio or television can last for about 2 minutes and I might not understand or ask questions. I am, however, able to get full details when I have a one to one discussion” (INT7 Harare, high-density).

“I am comfortable with all types of communication, it all depends on what is available at that given time” (INT10 Harare, low-density).

“I think all channels of communication are okay. I however think that the internet is better for me as I am able to search for all the information that I want. I may not be comfortable asking the next person about my personal health problems which are as a result of my positive status. But I am more comfortable looking for that

kind of information on internet. I can get answers to some of my questions through the internet without fear of anyone questioning or judging me” (INT17 Bulawayo, low-density).

“Mass media the reason being that many people will be involved and many solutions can be proffered rather than one to one” (INT21 Bulawayo, medium-density).

4.4.2 Theme 2: HIV and AIDS knowledge

4.4.2.1 Sub-theme: Knowledge of HIV and AIDS

This sub-theme was divided into Distinguishing between HIV and AIDS, HIV transmission, HIV prevention, HIV status, Disclosure of HIV positive status, Male circumcision, PMTCT and ART.

- **Category: Distinguishing between HIV and AIDS**

The women were very well versed with the difference between HIV and AIDS, and understood that HIV was the infection which could progress to be the disease AIDS; some knew there was a difference between the two but could not elaborate:

“From my understanding, HIV is a virus and if that virus remains unchecked in your body, it will develop into AIDS” (INT2 Harare, medium-density).

“I am not sure what the difference is, but I know HIV and AIDS are different” (INT6 Harare, medium-density).

“HIV is a virus. It’s just a virus that one contracts. One can have it and still live. You can live with it and be healthy. But at times, it then suppresses the immune system so much that you can contract diseases and infections. So, when you contract some of these diseases, for example TB, you then get to a position where you get to have AIDS. AIDS is when you get sick because of the virus. This is how I understand it” (INT12 Harare, medium-density).

- **Category: HIV transmission**

Infection routes mentioned by the women were: unprotected sexual intercourse with an infected partner; sores; encountering contaminated sharp objects such as a needle and razor; mother to child through breast feeding and during birth; blood contact through injuries such as road traffic accidents:

“It’s mainly spread through sexual intercourse. Rarely is it spread by being pricked by sharp objects that have been exposed to the virus. The chances of the virus spreading in this way are slim. For example, if one is HIV positive and they had an open wound they must not get into contact with someone who also has an open wound. If one is helping out an HIV and AIDS infected person, they must put on gloves if they have wounds on their hands so as to avoid exposing themselves to the virus” (INT3 Harare, high-density).

“One can get infected if they sleep with multiple partners without protection” (INT5 Harare, medium-density).

“Ok, there are various ways, but the major one is through sexual contact with someone who is infected with HIV. You can also contract it through blood to blood say open wounds or through injections and sharp objects like razors and knives. If you have blood on an object and it’s contaminated, you can get infected with HIV. Also through mother to child transmission at birth, through pregnancy and after birth” (INT12 Harare, medium-density).

“1. By having unprotected sex with someone who is infected. 2. Mother to child transmission through breastfeeding. 3. At birth. 4. If you cut or are pricked by a sharp object which has been used by someone who is HIV positive” (INT14 Bulawayo, low-density).

“You can get infected through sex, ‘emacancini’ – ‘pabonde’ (sexual intercourse)” (INT22 Bulawayo, medium-density).

“Yes, there is a difference. HIV is a virus. I am not sure about the definition of AIDS, although I know there is a difference” (INT25 Bulawayo, high-density).

- Category: HIV prevention

The most common methods to prevent HIV that were mentioned were using condoms, followed by abstinence, faithfulness (was often linked to self-discipline) and getting tested to know one’s status. Most responses referred to more than one method. Other prevention methods were education and acquiring more information, prompt treatment when infected and avoiding contaminated needles. All the women knew at least one way to reduce the spread of HIV infection:

“You also have to be faithful and sleep with one partner at a time. If you are married, stick to your spouse. Abstinence also minimises the chances of getting HIV” (INT12 Harare, medium-density).

“Abstinence reduces the chances of infection by 100%. I think these young girls and boys must be taught to just wait, maybe not until marriage but when one is mature enough to be able to make decisions. I don’t see how it makes sense for someone who is 13 years old, and I am not being judgemental but that is my opinion, being sexually active at that age. I am 25 years old and if I was to engage in sexual activities with someone, I am at a better mental state to be able to decide whether I should use protection and maybe minimise the number of sexual partners, etc. At 25, I am more informed and at a better stand point of making decisions. At a young age, you tend just do things and make stupid decisions. I think people should wait, especially girls” (INT14 Bulawayo, low-density).

“By having protected sex” (INT3 Harare, high-density).

“I, for instance, am not married, so when the time comes for me to get married I would have to go for testing at least three different times before committing myself to someone. The person I will settle with will also have to go for testing before we get married. By so doing we will minimise our chances of getting infected with HIV” (INT10 Harare, low-density).

“...there are those who are positive they don’t want to use condoms. People fall into relations without knowing the status of their partners and never get tested. Some of the children are virgins and yet they were born positive. It seems people easily fall in love” (INT20 Bulawayo, medium-density).

“1. Using Protector condoms. 2. Not being of loose morals” (INT19 Bulawayo, high-density).

“Using protection during sex and avoid using needles that have been used by an infected person” (INT16 Bulawayo, low-density).

- Category: HIV status

All the women felt that it is important for them to know their HIV status. The prevailing reason was that one can be proactive once they know their status, for example seek

treatment if necessary, including for the unborn baby for those who are pregnant and HIV positive, as well protecting oneself to remain negative:

“I believe it’s important for me to know my HIV status so that if I am infected, I would want to know how to live with the virus. If it turns out that I don’t have it, I would continue to protect myself. This is why it is important for me to know my status” (INT1 Harare, medium-density).

“It is very important to know your status because you can go on with life thinking that all is well and yet you do not know your status. So, if you go for testing you are able to know your status. If you are negative you will then be advised to go for another test after 3 months to confirm your status. It is also important to know your status if you are expecting, because you can go for the whole nine months and go on to give birth to an HIV positive baby. However, if you know your status, you can take preventative measures so that you do not pass the virus to your unborn baby” (INT4 Harare, high-density).

“Health wise, it is important to know your status because once you know you are positive, you can start taking medication. You can live longer because of the treatment you are on. These days the stigma associated with HIV and AIDS is less, you are able to take your medication in the glare of everyone. There is no longer any need to hide your status and not go on medication” (INT10 Harare, low-density).

“Yes, it is important to know your HIV status as in my case I have a small baby and I would want to make sure that the baby is not infected with the disease” (INT21 Bulawayo, medium-density).

“I would tell my relatives and especially my sister who I am very close to. And also, I would find a way to tell my children as they are eventually supposed to know as well” (INT20 Bulawayo, medium-density).

“There is no need to hide my status because if you do that it is tantamount to killing oneself. I will give you an example, the reason why I left my marriage was because my husband was a medical doctor, in fact, he was a student doctor. He had girlfriends all over and would spend a week without coming back home. During the week, he would not be at home, he would move from one girlfriend to the next. I would hear from the grapevine that he is Harare, he is Gweru, he is here and he

is there. The next thing he comes home and he wants to come back home and still sleep with you. Obviously, my mind will not be at peace. You can contract an STI in such situations. As a wife, you will be faithfully staying at home. You then visit a doctor out of concern just to find out what you are suffering from and this is when you are told you have an STI. In my case, I then decided to leave my marriage. I moved back home and I told my mother that whatever the outcome of my HIV test, I would deal with it head on. I explained to her what had been happening and I actually saw no reason not to accept the outcome of my test results. My thinking was, test results don't kill, I am still to meet someone who has died because they were told that they are positive. If you take the correct measures, when you know your status, you can live longer. You can live maybe up to 20 or 30 years and still go on to have healthy HIV negative children. So, this is the angle I took. I approached my male doctor and told him everything and he put me through a number of tests. He went on to counsel me, but I had already made up my mind to accept whatever the outcome of my status was. I thank God, my tests came out negative. I went back again after three months for the tests because I wanted to be sure..." (INT17 Bulawayo, low-density).

- Category: Disclosure of HIV positive status

The people ranked highest as able to be confided in, in a case where a young woman finds she is HIV positive, is a mother, followed by husbands and sisters equally. Other confidantes mentioned were grandmothers, best friend, brothers, parents and children. The selected confidantes were selected because they are trustworthy, are close relatives, can assist and/or one can speak freely to them. One respondent mentioned that they would prefer a stranger such as a social worker, while three said they would not confide in anyone for fear of stigma and being judged:

"I would tell my husband so that he would also go and get tested so that he can also get to know his status" (INT2 Harare, medium-density).

"I think I would tell one of my siblings because that's the person I would normally entrust with my secrets and the other way round. I know my secret would be safe with them because they would have entrusted me with their secret too. As a result, I know they would not divulge my secret to anyone" (INT3 Harare, high-density).

“My grandmother because she would be able to comfort me in case it’s not good news. She would also be able to encourage me to protect myself should my status be negative” (INT5 Harare, medium-density).

“I believe people judge you and it’s worse if you are young. I feel people associate HIV with irresponsible behaviour. It’s like you are a prostitute and sleep around with a lot of people. That’s the perception. So, I wouldn’t want to be judged and have people gossiping about me. People change the way they behave around you, so that’s why I would hide it from people” (INT13 Bulawayo, low-density).

“I would tell my mother because I am free to discuss matters with her” (INT6 medium-density).

“You can hide your status, but as time goes on you would have to tell someone. It can be any member of your family, but I think your mother is the first person that you should tell because mothers are important. She is the only person who can genuinely comfort you...” (INT7 Harare, high-density).

“I can tell my husband...I guess it’s because of the fact that I wouldn’t know how I got infected and there would now be need for me to seek treatment. So, If I hide my status, I will end up getting ill” (INT8 Harare, high-density)

“I would tell my relatives and especially my sister who I am very close to. And also, I would find a way to tell my children as they are eventually supposed to know as well” (INT20 Bulawayo, medium-density).

“Probably someone who is a counsellor or a social worker who would help me to accept my status and how to go on from there” (INT15 Bulawayo, low-density).

“Aaah yaa, that’s a difficult one. As a radio personality and musician, the first thing that I would do in my life, ahh, personally I would fear being judged. One, because of my job, it is perceived that artists are reckless and are players. You are already stereotyped, you know those connotations. If I was to find out today that I am HIV positive, personally I wouldn’t share it with the world. I would share it with my very close family. I would tell my mother, my father because he is my father. I would keep the circle small for fear of being judged” (INT14 Bulawayo, low-density).

- Category: Male circumcision

Most women have heard about male circumcision reducing the chances of transmitting HIV infection, while a few do not know about the link. One respondent heard that male circumcision is totally effective against getting infected:

“It’s something to do with the removal of foreskin on the male organ or something, something...I understand, it helps to minimise the chances of HIV infection and STIs.” (INT17 Bulawayo, low-density).

“Yes, I understand what circumcision is. Unfortunately, I don’t know the connection” (INT1 Harare, medium-density)

“Like I did mention earlier, I was involved in the campaign for male circumcision. They say it reduces the chances of HIV infection by 60%, but it does not prevent one from getting infected. And this is one of the reasons why this whole male circumcision campaign was being questioned by a lot of people, because sometimes I think, for me, it all goes back to being misinformed. I think there were a lot of people who were genuinely misinformed about male circumcision and thought because 60% is quite high therefore circumcision prevents HIV infection. There was a bit of confusion there. I however, don’t blame the people who were spearheading the campaign because men were encouraged to get circumcised because they were told that you can be circumcised if you want to be hygienic or do it because it reduces the changes of HIV infection and cancers in women. It was a good campaign but there were a bit of questions there on how the campaign was carried out” (INT14 Bulawayo, low-density).

“I heard that the chances of a man who is circumcised transmitting HIV are low compared to someone who is not circumcised. I once worked with this guy who said he had been circumcised. When I asked him the purpose of being circumcised. He told me that it all about hygiene. Dirt under the foreskin could can be passed on to your partner during sex. When the foreskin is removed, the chances of getting infected are also reduced. I don’t know how far true this is though” (INT10 Harare, low-density).

“I understand that when a man is circumcised he will not be infected with HIV... This is what I have heard. Men now go around saying they are circumcised and they can longer be infected with HIV” (INT11 Harare, low-density).

“I understand male circumcision reduces the chances of HIV infection by 60%” (INT22 Bulawayo, medium-density).

I heard that if one is circumcised, their chances of getting infected is very low (INT2 Harare, medium-density).

“I am not sure if there is a link. I don’t know” (INT5 Harare, medium-density).

- Category: Prevention of mother-to-child transmission

PMTCT was an area almost all women understood clearly, with just a few having incorrect understanding, and two not knowing about it at all:

“I know there is a pill that you take when you first get your labour pains if you are pregnant and HIV positive. I however don’t know how successful that is, I don’t have the numbers or percentages. I do know of a situation whereby the pill did not work. So, I am really questioning the effectiveness of that tablet. I know of one person who took that tablet and the child is HIV positive as we speak...” (INT14 Bulawayo, low-density).

“...For the unborn child, there is the nevirapine drug that is given to its mother to prevent infecting the unborn child...If you decide to breast feed your baby, it has to be exclusive breast feeding only. Exclusive breastfeeding is meant to prevent the virus from being transmitted through the baby’s mouth as feeding the baby with other foods could irritate the baby’s mouth and cause infection” (INT12 Harare, medium-density).

“If you decide to feed the baby with milk formulas, then you must not breast feed. During the first three months after getting pregnant, one should go for HIV testing. If you test positive for HIV you are immediately put on medication to prevent mother to child transmission. You are put on this medication during pregnancy until you give birth” (INT4 Harare, high-density).

“From what I heard from my mother, is that when she was pregnant, she told me she got to find out that she was HIV positive. She had gone for testing at the local clinic and this was first time that she got to know that she was HIV positive. She was then given a medical chart sheet. From what I read on her medical chart sheet, she was put on Cotri and her CD4 count was also monitored while she was on medication. There is medication she was also taking when she was breast

feeding. The baby is alright right now...There are pills that she was taking for six months. After six months, she was advised to stop breastfeed. The baby too was on medication. I don't know what the pills were called though. After six months, the baby was put on a diet" (INT10 Harare, low-density).

- Category: HIV treatment

Most of the women knew the treatment of HIV to be ARVs, though just few did not know the type of medication, with just one naming one of the antibiotics used for opportunistic infections, cotrimoxazole:

"What I know is that when you get infected with HIV, you are given pills. I however don't know the name of the pills. Umm ARVs. That is all I know, that HIV infected people are given pills" (INT1 Harare, medium-density).

"I am not sure which medication they initially give you, what I know I that the medication that you get depends on what stage your illness is at. I have forgotten what the pills are called" (INT9 Harare, low-density).

"There is no treatment for HIV and AIDS but they are ARVs that boost the immune system which helps a person to live much longer" (INT21 Bulawayo, medium-density).

"What I know is that if you get HIV, you cannot be cured but you can be treated. They check your CD4 count and then they prescribe ARVs. I don't know if it's popular or whether people in Zimbabwe know about this, but there is a tablet called Post Exposure Prophylaxis (PEP). If you have unprotected sex with someone and you feel you made a mistake, or you wake up in the morning and your mind tells you the guy I just slept with looks like he has symptoms of HIV and you feel like you might be in danger of exposure, you can get PEP for 30 days. I am not sure about the percentages, but PEP reduces the chances of HIV infection. It is usually given to rape victims. I also really think medical personnel need more education when it comes to issues regarding sex. I know that a lot of women are afraid to go to the clinic and say that "Yesterday I had unprotected sex, I got drunk or I got excited and had unprotected sex and I think I might be at risk of HIV infection and I need PEP". If you say this at the clinic, the nurses will ridicule you. Imagine someone having been raped and someone having made that stupid decision to have unprotected sex and you go to the clinic and the nurses make fun of you.

The next time that happens, you will not go back to the clinic. Because you would have to think twice before going to the clinic because if you go to the clinic you are assured of having all the health workers calling each other to come and listen to your story as they ridicule you. Even rape victims are affected as well. Usually when someone is raped the rapist doesn't use protection. So, rape victims too get scared and reluctant to go to the clinic because they will be made fun of by the health workers. So, I think health workers should just treat people and not be judgemental. Their job is just to treat you that's all" (INT14 Bulawayo, low-density).

4.4.2.2 Sub-theme: HIV and AIDS champions

Personalities that were named the most for HIV and AIDS advocacy or awareness were Oliver Mtukudzi, Jah Prayzah (musicians), Mai Chisamba (Zimbabwe Television or ZTV talk show host) and Albert Nyathi (Poet). 'Positive Talk' show host Tariro Chikumbirike, musicians Winky D and Charles Charamba, as well as radio personality Richmond Siyakurimwa, were the next most popular figures. Others mentioned were musicians Alick Macheso, Sulumani Chimbetu, Kapfupi, who does dramas and who is also a musician, Thandekile Simango, talk show hosts, Carol and Alice Makaya, Nisalda, who is an active ambassador of HIV and radio personality on SABC, radio presenters Phatisani and KBG on Star FM channel in Zimbabwe. A few knew of media personalities involved in HIV and AIDS communication but could not remember their names, while only a few knew no-one at all. Male circumcision was specifically mentioned as an area being talked about during HIV and AIDS awareness:

"I remember seeing adverts by Oliver Mtukudzi, I could have seen others but I have forgotten their names. However, Oliver Mtukudzi stands out. He is a musician" (INT2 Harare, medium-density).

"No, I don't know any personalities who promote issues related to HIV and AIDS" (INT5 Harare, medium-density).

"Charles Charamba did a song with an HIV and AIDS theme. I don't remember the title of the song though. Some presenters also did a song that went, "...celebrate your life in a healthy style...", I have forgotten the title of the song. The programme was called 'Who is Next?' It was a television programme produced in early 2000" (INT10, Harare, low-density).

“I have heard HIV and AIDS being discussed on Mai Chisamba show on TV.”

(INT16 Bulawayo, low-density).

“All the male artists in Zimbabwe who took part in the male circumcision campaign. I know there are some who declined to take part. For me it’s all the people who participated, the likes of Winky D, who were sending out the message to say come on guys go for circumcision so you can be hygienic and reduce the chances of infection. If I may be honest, I haven’t really seen any famous personality in this country, maybe they are there, but I haven’t seen these personalities being busy out there talking about HIV and AIDS. I haven’t come across them” (INT14, Bulawayo, low-density).

“In Zimbabwe, I can’t think of anyone. But in South Africa there is a certain lady I think her name is Nisalda, I can’t remember her surname but she is a radio personality. She is HIV positive and she is an active ambassador of AIDS, she is involved in a number of campaigns. In Zimbabwe, no I can’t think of anyone” (INT13, Bulawayo, low-density)

“Jah Prayzah, Sulumani Chimbetu, Oliver Mtukudzi” (INT23, Bulawayo, high-density).

4.4.3 Theme 3: Perceptions and beliefs

This section covers Epidemic drivers, IPC, Communication channels, Information sensitivity to needs, Vulnerability, Blame/fault perception, Risk perception, HIV prevalence, and Educating others.

4.4.3.1 Sub-theme: Epidemic drivers

Epidemic drivers, from the women’s perspective, involved several elements. Multiple sexual partners, including during sex work and adultery as well as ‘clubbing’, was singled out as the main culprit. Lack of faithfulness, and lack of self-discipline were also described as what promotes the spread of HIV. Reckless use of sharp objects, rape, blood transfusion, unprotected sex knowing one is HIV positive, lack of knowledge about one’s HIV status, unprotected sex, loose morals, lack of information, poverty, failure by HIV positive mothers to seek treatment whilst pregnant, lack of disclosure when HIV positive were all described as promoters of the HIV epidemic:

“Many people are not going for testing. They don’t disclose their status. One may know that they are HIV positive and then they still go on to have more than one

partner. HIV and AIDS information should also be taught to teenagers at school. The information could be part of the curriculum at schools” (INT25 Bulawayo, high-density).

“Lack of employment and lack of money” (INT21 Bulawayo, medium-density).

“People are the epidemic drivers. This is because they don’t learn and they do not take the disease seriously” (INT20 Bulawayo, medium-density).

“1. Being unfaithful. 2. Unhygienic tendencies, for example sharing contaminated sharp objects like razors. 3. Not protecting yourself when you are expecting so that you end up infecting your unborn child” (INT19 Bulawayo, high-density).

“It’s poverty. When women are desperate, they go to desperate measures in order to look after their children. They end up sleeping around just to get money. They may forget to take preventative measures to protect themselves, that is, using condoms and things like that, so long as they get to feed their children. As a result, you will find so many prostitutes in the streets, they seem not to mind dying but their aim is to just to take care of their children. This attitude, I believe promotes the spread of HIV. This is all due to poverty. In our society, you will find that poverty mainly affects women. So many women in our age group are living as single parents, not by choice. Most of the women are not formally employed and the father of her children would have deserted them. They find themselves in poverty and just want to find a means to survive and this is when they start living recklessly for the sake of getting money so as to look after their children” (INT12 Harare, medium-density).

“Promiscuity. You may be aware that your neighbour is infected and yet you still go on to have an affair with him, fully knowing too that he is having affairs with other women. Also, unprotected sex promotes the spread of the virus” (INT18 Bulawayo, high-density).

“I think there are a lot of factors that promote the spread of HIV but 1. mostly adultery, 2. then you also get the fact that in the economy that we are living in, people might want to make easy money, ladies might want to use what they have to get something they want” (INT15 Bulawayo, low-density).

“Over the years the knowledge of HIV and AIDS has advanced. People have accepted the disease now better than before. I am not sure if people are ignorant or they are not well informed, information is the key and people need to be constantly reminded about how HIV infects people. They also need to be constantly reminded that sometimes people who may look healthy can still be HIV positive. So, I think it all boils down to information. I have read some surveys and studies that poor communities record high numbers of HI/AIDS infection. Sometimes young women resort to prostitution because of poverty hence HIV infection is very high” (INT14 Bulawayo, low-density).

“...I think people no longer have love for each other. Once someone knows that they are HIV positive they deliberately start spreading the virus to other people because they don't disclose their status. So, they don't inform their sexual partner that they are HIV positive, they end up infecting them...” (INT10 Harare, low-density).

“HIV is spread through prostitution and one cannot always know the status of her suitor” (INT6 Harare, medium-density).

“People are not trustworthy. If I and my boyfriend were HIV and faithful to one another, we can manage the virus. However, if one of us is not faithful, they can spread the virus to other partners” (INT3 Harare, high-density).

4.4.3.2 Sub-theme: Interpersonal communication

- Category: Most accurate information

The people seen as most likely to pass on the most accurate information on HIV and AIDS are health workers, particularly nurses and doctors. Other people named were health workers at clinics, counsellors, health professionals working in HIV and AIDS work including at NGOs and NAC, social workers, teachers, parents, PLHIV and researchers in HIV and AIDS work:

“I believe it's the doctors and nurses, because they have more knowledge about HIV and AIDS” (INT1 Harare, medium-density).

“My parents are most likely to give me the most accurate information because they are the ones who always advise me on every aspect of life. And they are always truthful in whatever they say” (INT8 Harare, high-density).

“Medical personnel. I think it’s their job, so they should know. I would be disappointed if they didn’t” (INT14 Bulawayo, low-density).

- Category: Least accurate information

Those viewed as likely to pass on the least accurate information, according to most of the women, are the public including friends and neighbours in the community. Others singled out were: those who have never gone for HIV testing; people who are not HIV-infected; people who are not affected by HIV in any way; old people; teenagers; witch doctors; false prophets; teachers:

“I am a good example of someone who would give out the least accurate information because I have limited information on HIV and AIDS. Generally, most people in the neighbourhood have the least accurate information. They were not trained nor have researched on HIV and AIDS. So, they are not qualified to pass on that information. Some of the information circulating on WhatsApp is also not very accurate. So, one must be careful what they read. Nurses on the other hand are actually trained as it is part of their job” (INT3 Harare, high-density).

“Just anyone in general. Those that don’t belong to any organization. These people will just talk in general without adequate information as they would have heard that information from the grapevine” (INT4 Harare, high-density).

“People who are not infected by HIV and AIDS are likely to give out the least accurate information. We all have some knowledge about the virus, but those who are infected know better than those who are not infected” (INT10 Harare, low-density).

“The society at large because it’s a mixture of different perceptions that are put together. You will find conflicting information from people. You will find different versions due to different experiences and/or from their different sources of information. It becomes tricky and you would have to verify the information to confirm whether it’s real from doctors who are trained and exposed in the subject matter” (INT12 Harare, medium-density).

“Teenagers. I think they don’t have that much information and at this age, I don’t think it has really sunk in that there is something called HIV and AIDS. They know it’s there but they don’t know the effects of it. To them it’s just something that is like any other disease that is there” (INT15 Bulawayo, low-density).

“Traditional healers and prophets in the apostolic sects. Some of them end up raping albinos and virgins thinking that they can cure HIV” (INT20 Bulawayo, medium-density).

4.4.3.3 Sub-theme: Communication channel effectiveness

The most effective channel was viewed as television, followed by radio, while the least effective mass communication channel was viewed as newspapers, followed by other forms of print media, such as posters, pamphlets and magazines:

“I think the television is the most effective. Most of the time there are dramas about AIDS and as a result people relate to what they see” (INT1 Harare, medium-density).

“Television produces sound and vision. As a result, you are able to see the consequences of not seeking treatment and these can be fatal. Whereas with radio you can only hear the adverts, drama or discussions and not visualize what it all really means. So, to me television is the most effective communication channel” (INT4 Harare, high-density).

“Television because a lot of people watch television. Most people don’t read newspapers, they are lazy to read, just like me” (INT16 Bulawayo, low-density).

“I think the newspapers are the least effective communication channel because not everyone buys a newspaper” (INT1 Harare, medium-density).

“The newspapers and billboards are the least effective. One can read the information and not understand what it means. No one will be readily available to explain the information on the billboards or newspaper to you. Whereas on radio and television, the programmes usually have a phone-in facility. People can phone in for further clarification” (IN3 Harare, high-density).

“Newspapers are the least effective because in my case I may not be able to buy the newspaper. Perhaps those who can afford to buy newspapers may be able to understand the information on it. Radios are all over, one way or the other you are bound to listen to a radio and hear HIV and AIDS information. You can listen to the radio as you do your household chores. People hardly sit down to read a newspaper” (INT 10 Harare, low-density).

“I believe fliers are the least effective mass communication, because if I am given a flyer along the road, I can just take a quick glance at it, tear it up and throw it away. So, the information on that flyer is not taken seriously” (INT6 Harare, medium-density).

“Pamphlets; people rarely have time these days to read through pamphlets. We are a generation that is busy to sit down and read. We would rather listen or watch than read” (INT12 Harare, medium-density).

“I think the television because not everyone in the country can afford to get a television” (INT15 Bulawayo, low-density).

4.4.3.4 Sub-theme: Information sensitivity to needs

The women felt that the information available on HIV and AIDS is sensitive to their needs as young urban women, though some were unable to elaborate. Two felt it was not sensitive and one was not sure. A key reason as to why the information is sensitive was that it addresses issues relevant to their age-group:

“They have different programmes targeting different age groups and gender. At times HIV people are hosted on the shows. Thus, you get to know issues that you were not aware of. You also get to learn how to look after yourself if you are HIV positive” (INT8 Harare, high-density).

“I find it sensitive to my needs, but then it may not be to the next person because it may not be important to them. On the other hand, if you are infected, it becomes sensitive to your needs” (INT9 Harare, low-density).

“I am able to understand the information and it is sensitive to my needs” (INT10 Harare, low-density).

“I can’t really say yes or no because I have not been really paying much attention to that as I was listening to the programmes. You will find that the programmes are generalized I guess to cater for everyone. They are not necessarily targeted at our age group. But I think we are covered” (INT12 Harare, medium-density).

“Not fully, but most of the time the information is generalized not really targeting a specific age group. It’s always talk about abstinence or get information on HIV and AIDS. I feel like each age group has different needs and maybe the information is not necessarily targeting someone who is 20 to 29 years old or someone who is

younger for example teenagers. It's always abstain and it is not really packaged to suit any age group. This is how I see it" (INT13 Bulawayo, low-density).

"For me it all goes back to that thing; you know you have to tell me something that I am going to be able understand. You have to be sensitive to my surroundings, who I am, etc. The life that I fall under, like the age group, sex, geographical location, you know stuff like that. What I do for a living..." (INT14 Bulawayo, low-density).

4.4.3.5 Sub-theme: Vulnerability

Various things were named as contributing to young urban women's vulnerability. Sex work was the most frequently mentioned reason, but related to that, the need of livelihood, general lack of money and jobs because of economic hardships, poverty and the presence of 'blessers' and sugar daddies, were the main reasons cited. Other reasons were alcohol drinking coupled with 'clubbing' as typified by *Vuzu* parties, lack of self-discipline, promiscuity such as sex with multiple partners, unprotected sex, peer pressure, the fear of getting tested, getting into relationships with much older men who normally have relationships with a lot of other people, the fear of initiating conversation on HIV status with partners, laziness, rape and early marriages. 'Blesser' is commonly used for a man who starts off, for example, paying for a teenager's bus for school, progressing to spending increasingly more money on the teenager, then eventually having sex with the adolescent. It has been shown that this is central to South Africa's HIV transmission, which has the largest HIV epidemic (Maxmen 2016). It is evident that it is also a challenge in Zimbabwe. *Vuzu* parties are wild parties, predominant in Bulawayo, attended by teenagers during school holidays. Alcohol and drug abuse, as well as sex and nudity are celebrated (Tekere 2016). Drug abuse and living in a city with lots of thorough fare and mobility were other reasons:

"Urban women of my age love material stuff. They end up getting those luxury things from "sugar-daddies" or have relationships with married men. So, this puts them at risk of getting infected with HIV" (INT1 Harare, medium-density).

"It's poverty. There are some single mothers who have children that need to be looked after. These women face a lot of challenges as a result, some will end up going to pubs and engaging in prostitution. This exposes them to the virus" (INT4 Harare, high-density).

“Some of the challenges that women face is unemployment and as a result they have no access to money. The woman is then forced to find other means of survival and this is where she will end up getting infected” (INT7 Harare, high-density).

“Women of my age are lazy, they don’t want to work. They want to get free money. Some of them are now engaging in prostitution, having affairs with married men or with different men. I think this could be the reason why the urban woman of my age are getting infected with HIV. It is better to find other means of generating income than to sleep around...yes, we understand there are no jobs but people buy tomatoes on a daily basis. People are selling stuff in the CBD. You must surely just find something to do. We all know that money is hard to come by and we are facing numerous challenges as a result. But surely you must find something to do because prostitution is not the solution. Prostitution is the reason people are getting infected” (INT10 Harare, low-density).

“I saw that article where they were saying Bulawayo was once a hot spot for HIV. I heard someone say Bulawayo is a metropolitan city. It got me thinking because, yes there are people from all walks of life in Bulawayo. There are a lot of truck drivers who pass through Bulawayo on their way to Harare and Masvingo. These drivers leave their wives in South Africa and drive all the way through Bulawayo and some of them come from Botswana on the N1 highway and the Bulawayo/Gwanda Road. So, it might just be true what people say and that is Bulawayo is a hot spot because of all this” (INT14 Bulawayo, low-density).

“When you are not working, and have no source of income that puts you in a vulnerable position to HIV infection” (INT19 Bulawayo, high-density).

4.4.3.6 Sub-theme: Blame/fault perception

There was a range of responses concerning who the women perceived was to blame for the spread of the HIV epidemic. The majority felt that each person needs to take responsibility for their actions and that it was everyone’s fault, that is, both men and women. In the same vein, only two said that it was the young urban women themselves who are to blame, because of lack of discipline and reckless behaviour. It was said of parents and/or guardians that some are bad role models, some do not educate their children, while others are absent and are in the diaspora instead of caring for their children. These were also blamed for HIV and AIDS. Three respondents blamed men for

the epidemic, explaining that they are more promiscuous. Other elements that were blamed were lack of information, high unemployment, lack of rural background (meaning some have departed from traditional good morals), HIV positive persons who have unprotected sex, people ignorant of their HIV status, peer pressure, and pregnant mothers in a case where the unborn child acquires HIV:

“The person who is HIV positive is at fault because they have that negative attitude and want to deliberately spread the virus. In so doing, they hope that a lot of people will be infected” (INT2 Harare, medium-density).

“It is because men are not able to control themselves” (INT5 Harare, medium-density).

“I would attribute the fault to one’s parents or those that you live with because they would have failed to take care of your welfare” (INT7 Harare, high-density).

“I think it’s the urban women who are at fault because they love luxurious things as I have mentioned before. So, they want to own all these beautiful things and at the end they will get the infection from those who give them those luxurious things” (INT1 Harare, medium-density).

“It’s both the men and women’s fault. At times, its lack of knowledge. It’s not everyone who has access to HIV and AIDS information. Some people may be at work when some of the programmes are aired on radio or TV. When there are road show campaigns, they will be at work. So, some people may not have the knowledge. Some people may just do it out of negligence. There is that “I don’t care attitude”, this is what most people do. This negligence is by both men and women. I cannot blame one and not the other. Women play a part and the men play a part. Women are after money while with men it’s about lust” (INT17 Bulawayo, low-density).

“I cannot put blame on anyone. It is one’s attitude, it seems people are not able to contain their feelings. The problem is with each and every one of us. We cannot blame one person because that person cannot be the only one responsible for spreading the virus” (INT8 Harare, high-density).

“I think peer pressure makes the urban woman at fault” (INT9 Harare, low-density)

“It’s the men’s fault. We know that HIV is spread mainly through sex interactions. My perception is that men are fun loving or pleasure driven. They have sexual relations for pleasure. As for women, yes the pleasure part is there but its’ more responsibly done in the context of marriage or women can be driven into sex by poverty as I did indicate earlier. Their drive is not so much for pleasure or fun, but they do it to get money so they can feed their family. Because they need the money, men have sex with them for pleasure. So, men are at fault in terms of HIV spreading” (INT12 Harare, medium-density).

4.4.3.7 Sub-theme: Risk perception

The risk perception among the women was very low, with most of the women of the opinion that they were not at risk of acquiring HIV infection. Reasons given were that some currently had no sexual partners, and that some were HIV negative and faithful to their partners/husbands who they believed were also faithful. Those who said that they were at risk of acquiring HIV infection, explained that they were not sure if they could totally trust their husbands or partners; one said being a woman made them vulnerable and exposed them to situations such as rape, thus putting them at risk. Some said knowing their status as a couple took the risk away, while some said they were sexually active as women and this increased their risk. Several felt that everyone is at risk:

“Yes, because I am a married woman, I don’t know what my husband does when I am not around” (INT21 Bulawayo, medium-density).

“I am not at risk, I have a baby and I have already been tested twice. I also do not suspect my husband of anything” (INT19 Bulawayo, high-density).

“I think for now I am not at risk. If I get a partner, I will abstain until after marriage and besides that we have to go for testing. So that we know we are safe. We will go for the first test. After the window period, we will go again for the test after 3 months so that I am sure. I am well aware that I survived being infected in my last marriage so I wouldn’t want to repeat the same mistake again.” (INT17 Bulawayo, high-density).

“Yes. As long as you are sexually active you are at risk. So yes, I am at risk.” (INT14 Bulawayo, low-density)

“...because anything can happen. I am female, I am vulnerable like someone may just rape me. Or you go out with a friend and you end up sleeping with someone

because a lot of times as young people we look at someone and you think that they look healthy. You then don't really think about their HIV status before you indulge in sex. That is why I think everyone is at risk because you really don't know, anyone could have it and you wouldn't know." (INT13 Bulawayo, low-density)

"The way you lead your life determines whether you are at risk or not" (INT8 Harare, high-density).

"I am not at risk because for now, my husband and I are still negative" (INT4 Harare, high-density).

4.4.3.8 Sub-theme: Impact of knowledge on behaviour

Most of the women said that their knowledge about HIV and AIDS has influenced their behaviour positively with only a few saying this was not the case – these few said that they continued behaving the way they have always behaved while one maintained the knowledge had not impacted her; one respondent was not sure if their behaviour has been influenced or not:

"The information I have gained is influencing my behaviour because now I know the do's and don'ts of getting the disease" (INT1 Harare, medium-density).

"The knowledge that I have gained so far has influenced my behaviour. I no longer put myself at risk of being exposed to the virus" (INT3 Harare, high-density).

"Yes, it has influenced my behaviour. As of now, my status is HIV negative and I have told myself that I do not want to be infected. If I avoid sleeping with different men, some of whom might be infected without my knowledge, I will be safe. I should only be truthful and faithful to my husband" (INT4 Harare, high-density).

"I am now condomizing" (INT25 Bulawayo, high-density).

"With the knowledge and information that I have, even when I am tempted to stray, I usually then refocus my energies to something else. So that information helps me make sound decisions." (INT17 Bulawayo, low-density).

"Yes, it has. I don't sleep around because I know that the virus is a reality. Even when I have a boyfriend, I will tell him that we should wait for the right time because "God's time is the best". Once I want to get committed, I will first go for testing three times" (INT10 Harare, low-density).

“I knew about HIV and AIDS when I was still a virgin, fortunately. And I decided to stay a virgin for a very long time. There is someone who is close to me who is HIV positive. I know HIV and AIDS is out there and I know what people who are infected go through. I could have flu and I am able to shake it off just like that, but if someone who is infected gets flu everything becomes a struggle. Unfortunately, that is a very sad situation for me. But I have always known about HIV and AIDS and I have been behaving” (INT14 Bulawayo, low-density).

4.4.3.9 Sub-theme: HIV prevalence

The consensus was that the HIV prevalence in Zimbabwe is high, with only a few with a different opinion:

“There are a few people who are HIV negative these days” (INT23 Bulawayo, high-density).

“I think its medium. It’s not high or low” (INT1 Harare, medium-density).

“...I don’t care about the percentages but the rate is still high.” (INT14 Bulawayo, low-density)

“I wouldn’t say it’s very high, it’s not also low either. I think the fact there are more people who are still getting infected by HIV and there are many programmes in place to actually lower transmission rate shows it’s a real cause for concern. So, while the level of HIV infection is decreasing somehow, I feel it’s still a cause for concern” (INT13 Bulawayo, low-density).

“I think its low now, the education that is circulating has helped to lower HIV infection” (INT12 Harare, medium-density).

“I think it’s high. I heard that Zimbabwe is second on the list of high HIV and AIDS infections. From the time I heard this, I believe it’s still spreading at a high rate” (INT3 Harare, high-density).

It’s high because I see a lot of people at clinics and hospitals seeking treatment” (INT7 Harare, high-density).”

“I believe it is low because when most people are educated about HIV and AIDS, they quickly seek help from the hospitals. Those found to be HIV positive are put on medication and they go through their medication religiously in order to stay

healthy. As a result, the HIV infection in Zimbabwe remains low (INT4 high-density).

4.4.3.10 Sub-theme: Educating others

Most of the women have never educated anyone about HIV and AIDS, though a sizable number have:

“No, I haven’t” (INT22 Bulawayo, medium-density).

“Yes, when I was on maternity, when we were at the clinic” (INT21 Bulawayo, medium-density).

“Yes, I have, at the mine where I used to stay, we would hold meetings where we educated people on HIV and AIDS” (INT20 Bulawayo, medium-density).

“Not really, but to say that “you know if you are promiscuous you will probably end up having HIV and AIDS, but not in detail to say a, b, c” (INT15 Bulawayo, low-density).

“Yes. I have four beautiful nieces. The eldest is turning 19 this April and the other one is turning 15 in December. They are at that age now, you know. Like I have already mentioned before, I believe in waiting. My older niece has a boyfriend so I always tell her that she must just wait because there is HIV out there. I always tell her that if she indulges early she will get infected and will get sick and eventually die when she is still young. I even tell her that we will cry when she dies, bury her and move on with life” (INT14 Bulawayo, low-density).

“Yes, when my friend’s husband had to live and work at a mine. I had to advise her to join her husband or to discourage her husband from making such a move because of the possibility that he could be exposed to the ladies who go there targeting the informal miners (makorokoza). So many men who go to the mines, come back sick. I was very worried and I had to educate her to either discourage him from going or she had to move with him. I told her they had to stay together to prevent the possibility of getting infected.” (INT12 Harare, medium-density).

“There are girls of my age who like clubbing, I am not that kind of person. They follow musical bands everywhere they perform. Obviously when they go to these musical shows they meet men there. I have told some of them that there is this virus these days and it is a reality. I have a 21-year-old relative who unfortunately

got pregnant and got infected with the virus. I do tell her the little information I know” (INT10 Harare, low-density).

“We have had discussions among friends about HIV and AIDS although I have not personally educated anyone on the matter” (INT6 Harare, medium-density).

“...I wouldn’t want to lie. I have not talked or educated any of my family members” (INT4 Harare, high-density)

“Yes, I have, at a ladies’ meeting at church. I was assigned to talk to some of my peers at church on the subject” (INT1 Harare, medium-density).

4.4.4 Theme 4: Context

The context sub-themes were Community involvement, Spirituality, Socioeconomic status, Culture, Young urban women’s context, Government policy.

4.4.4.1 Sub-theme: Community involvement

The consensus was that the community has a role to play in communicating HIV and AIDS issues, with some emphasizing a ‘big’ role; while one did not think the community had any role in this, and another did not know what role they could play. There was a range of roles the community was already playing or seen as should be playing: colleges and schools teaching children about HIV and AIDS, including peer counsellors; conducting awareness campaigns in the streets, including with the help of nurses and NGOs; sports activities followed by teachings; convening meetings and gatherings; door-to-door awareness; home-based workers and health care workers going around the community teaching people about HIV and AIDS:

“I believe those trained and are knowledgeable about HIV and AIDS should go around the community educating people on HIV and AIDS” (INT7 Harare, high-density).”

“There are peer counsellors at schools, perhaps this can extend to the community. People could also gather and be addressed by educators” (INT9 Harare, low-density).

“The community may be playing a role but people’s negative attitude may be hampering change in behaviour. The message is not getting through and people are still not changing their ways...people may gather and be taught about HIV and AIDS, but as soon as the facilitators of that gathering leave, people don’t heed

what they were taught, the attitude is “Ndezvekwavo izvo” (That’s their own problem). There is that tendency to just go back to old ways.” (INT11 Harare, low-density)

“I think if the elderly in the community could lead in communicating information on HIV and AIDS, it would help because people tend to listen to the elderly in their community” (INT12 Harare, medium-density).

“I think the youth centres are not being fully utilized. There should be rehabilitation of these centres. There should be programmes that actively engage people it might work. Community leaders like churches and councillors can also be seen to be doing something even if it is providing assistance for people that have been affected by HIV. They could do awareness programmes. In my opinion when I look at where I live, I don’t think anything is being done at all” (INT13 Bulawayo, low-density).

“...If people are well informed and know that there is something that is going to take place it will work. It should be an educational programme where they could start with entertainment followed by the educational programme and then sporting activities. Even at school, if a teacher is all about education, education, it becomes boring and yet if a teacher interjects serious teaching and jokes it can be fun. And so, if there is variety during these educational programmes, it makes everything more entertaining and yet educational” (INT17 Bulawayo, low-density).

“Communities help people especially in the rural areas. There are NGOs such as World Vision which help people in the rural areas by giving assistance. In the urban people are educated as well but people don’t want to listen” (INT20 Bulawayo, medium-density).

4.4.4.2 Sub-theme: Spirituality

All the respondents felt that spirituality had a role to play in HIV and AIDS communication. Respondents gave ideas of how this could be done or what they had already observed was being done. Examples of what was already happening include teaching girls about HIV and AIDS and testing them for virginity by the Brethren in Christ church, reaching out in cash and kind to HIV positive people including orphans, offering lessons on HIV and AIDS to the congregation through a department within the church, including youth, girls’ and ladies’ meetings. Inviting professional counsellors to church meetings is something

that is also happening. Suggestions on further involvement by churches were that elders, pastors and other leaders should take the lead in teaching HIV and AIDS issues, and that platforms such as Bible study groups, couple's and men's' meetings could be used to impart knowledge and discuss these issues. Awareness campaigns were also seen as something churches could organise. Churches were viewed as places that promote good behaviour and morals:

“Yes, religion does play a role. Women are educated during their weekly gatherings on Thursdays (Olwesine). Men too, meet and are taught about the virus. Children are also taught during Sunday School” (INT25 Bulawayo, high-density).

“My church the Seventh Day Adventist has a department called Zimbabwe Adventist AIDS Ministry (ZAAM) which helps people with lessons about AIDS, provide financial assistance to deceased families and gives material assistance such as clothes” (INT21 Bulawayo, medium-density).

“I do not know about other churches but my church the Presbyterian Church helps its members. But I believe churches should also play a leading role especially in these couple's meetings” (INT20 Bulawayo, medium-density).

“As an example, we have meetings at my church for different age groups and gender. This is where people are taught about HIV and AIDS. So, you will find groups of married women gathering, teenagers, etc. in different groups per age and gender.” (INT1 Harare, medium-density).

“Yes, I think so. I will give you an example of people who come to our church seeking to be healed through prayer. Instead, people are educated about the virus and always encouraged to avoid risky behaviour because prayer alone may not heal them” (INT2 Harare, medium-density).

“At church, there are HIV and AIDS communication programmes. This topic usually comes up when issues of trustworthiness are discussed. These topics are also specifically directed at us the youth. We are encouraged to be faithful in the eyes of God” (INT3 Harare, high-density).

“HIV and AIDS education can be incorporated during bible study” (INT5 Harare, medium-density).

“Churches should preach what the bible says, for example there is a verse in the bible that talks about “one man and one woman”. By so doing people will know that it is against the bible to have more than one partner” (INT8 Harare, high-density).

“I have not heard that communication in my church.” (INT18 Bulawayo, high-density)

“The church could appoint an “elder” who could teach the youth about HIV and AIDS. They could teach the youth about protection and encourage the youth to uphold their morals” (INT16 Bulawayo, low-density)

“We get HIV and AIDS information through our pastors and we are better able to receive that information through them” (INT12 Harare, medium-density).

“It does play a role but I think the way it’s communicated doesn’t work. It’s always “don’t have sex before marriage”. But then the minute you tell someone “don’t do that”, they want to do it. I believe, if there was a more diplomatic way of communicating, something like “let’s do this”, in a positive informative way. If you sit down with someone and say, “Don’t do this, because of ABC”. Then give reasons and consequences it makes more sense. With the church it’s usually, “don’t do this and don’t do that”, and then they leave it there and they don’t really explain why. They don’t create awareness, so I think if they did that it might be better (INT13 Bulawayo” (Low-density).

“I think it has a big role. The church teaches people to be more responsible. Most churches don’t encourage irresponsible behaviour. Most churches nowadays have ways of dealing with HIV and AIDS issues” (INT14 Bulawayo, low-density).

4.4.4.3 Sub-theme: Socioeconomic status

Almost all the women felt that the socioeconomic status of women was linked to the HIV epidemic, with one not being sure and two not seeing the connection. The general feeling was that the economy is in a bad state, there are no jobs and women are put in a position where they must make a living in ways that promote HIV, which is mostly sex work, with some turning to bladders:

“The socioeconomic status of women plays a big role because these days most women are not unemployed. They then rely on prostitution to survive and this

exposes them to the HIV infection. You will find them even going to nightclubs in search of meagre income, it can be as little as a dollar, just to survive. The current economic situation is really bad” (INT1 Harare, medium-density).

“Poverty drives people to do all sorts of things. I may have a girl child and then I will push her to go and look for money out there for the family’s survival. The girl will bring the money of course, but the next thing is that she will come back home infected too because she would have been going out with a man who could be going out with other women” (INT25 Bulawayo, high-density).

“I don’t see the relationship because if the country does not have money it means even the men in that country will not have money. Even if you try to trade your body for money, you won’t be paid because there is no money. When the country’s economy is poor, it also means that there will be a shortage of medicine” (INT20 Bulawayo, medium-density).

“There is a link because most women are forced into prostitution due to the socioeconomic meltdown. As a result, these women are at risk of being exposed to the virus. You can get a situation where a woman is offered more than what she would have bargained for (financially) in exchange for unprotected sex. She is left with no choice but to put herself at risk for \$500 instead of a \$1 that she was expecting. Meanwhile the client knows fully well that he is HIV positive” (INT2 Harare, medium-density).

“Urban women, those in the middle class, I think if someone is educated and they are a bit well off they are able to make better decisions concerning their life. Now that the economy is so tough due to financial issues, some women tend to be forced into certain situations because they are trying to make a living. However, I think the more independent a woman is the less likely she is not to be at risk. She can make better decisions because she is in control of her body. But, I have noticed that women who are less educated, women who are not so well off tend to then get into prostitution. And this business of blessers, because the women want to survive and take care of their families then they end up going for blessers. This is how I view it” (INT13 Bulawayo, low-density).

“I think because of that; young women are affected and they start resorting to such things as prostitution to get money. I am sure you have heard about ‘blessers’ and

“blessees”. I think all this should be banned. I don’t think human beings should ever find themselves in a situation where they pay women to entertain them. I think it’s just taking advantage of women. Because in society, most of the time men are bread winners, men are the providers. So even if there is no employment, people get by selling and buying and men seem to be always at a better position than women. Because the woman still has other obligations to attend to, for example looking after the children and doing household chores they can never be able to match the men. Women, I think are at a disadvantage compared to men in terms of everything, including the economy. If things are hard for men imagine what it can be for women. As a result, women will resort to such things as prostitution and having blessers. This is when you also find a woman who may have a not so well-off boyfriend going out with other men (including the married) so she can be financially looked after” (INT14 Bulawayo, low-density).

4.4.4.4 Sub-theme: Culture

Culture had three categories, namely Positive cultural influences, Negative cultural influences and Cultural incorporation in HIV and AIDS communication.

- Category: Negative cultural influences

The women gave quite similar responses concerning aspects of Zimbabwean culture that promote the spread of HIV and AIDS, with polygamy being the most common one, followed by child marriages and widow inheritance. Other aspects were that some Apostolic sects refuse for their members to seek medical treatment, the acceptance that men can cheat and they are not to be challenged, when incisions are made on the body with a razor blade, and when a young or elder brother is made to have sexual intercourse with the wife of their brother if the husband would have failed to impregnate the wife. Only one respondent was not sure which cultural aspects could promote the spread of the epidemic:

“There is this African custom where a woman is inherited by her dead spouse’s brother after he passes on called “kugarwa nhaka”, I believe it promotes the spread of HIV and AIDS. I am not sure if it’s still being practised. The other custom that I feel also promotes the spread of HIV and AIDS is given a situation where your husband is proved to be sterile and the family elders agree to have one of his brothers or male relatives to have a child or children with you. This is all done without your husband’s knowledge” (INT3 high-density).

Traditionally, women are discouraged from dressing in a provocative way (INT19 Bulawayo, high-density).

“An example is when family elders call a traditional healer to come to a homestead and perform traditional rituals whereby incisions (kuchekwa nyora) are done on all family members using the same razor. These incisions are made to protect the family from evil spirits. However, no one knows the next person’s HIV status and the virus is likely to be spread this way. The custom that is also likely to spread HIV and AIDS is when an elderly man’s wife dies and he is given a young female relative from the wife’s side to inherit and make a wife. This could be a young woman aged 20 years and she is inherited by a 45-year-old man. This is all done in the name of our African culture, but the HIV status of that man is never disclosed. He could be HIV positive and the young woman gets to be exposed to the virus” (INT4 Harare, high-density).

“...The other cultural custom that can promote the spread of HIV is when women douse their private parts with herbs so as to tighten them. I believe these herbs can harm your system and you will end up infected by the virus” (INT7 Harare, medium-density)

“I think this whole thing that men are allowed to cheat. I know it’s not just in Zimbabwe, it includes the whole of Africa. Women easily forgive men when they cheat. But if a woman cheats or she is impregnated by another man when she is married to a husband who is out of the country, it’s highly unlikely that the society at large will forgive her, let alone her husband. On the other hand, a man is easily forgiven even if he impregnates a relative. The family will sit down and discuss the matter and the man will be forgiven. Men are allowed to have more than one wife. Those are the things that are not fair you know” (INT13 Bulawayo, low-density).

“Polygamy also promotes the spread of HIV and AIDS. The fact that a man can have more than one wife makes it possible for him to expose his other wives to the virus because he can unknowingly marry a woman who is already compromised” (INT8 Harare, high-density).

“We have this culture of being advised to listen to our husbands. So, in the case of using condoms, if your husband refuses to use them, you are left with no choice

but to listen to what he says. We were taught how to respect and listen to our husbands by our aunts (anaTete). We are advised not to question our husbands much and not to challenge them much. The aspect of not challenging your husband even when you know you are right can lead to dire consequences which might even lead to your death. This promotes the spread of HIV and AIDS because your husband refuses to use a condom” (INT12 Harare, medium-density).

“Members of the apostolic sect don’t go to hospitals due to their religious beliefs. Unfortunately, with AIDS, you just must just go to hospital. The virus spreads within the apostolic sects because they don’t go for testing and treatment, they don’t even prevent mother to child transmission” (INT16 Bulawayo, low-density).

“In an early marriage, if a child is married at 12 years old, that girl would not have had time to go through the natural process of growing up, you know the usual teenager stuff. At 18, that girl will meet someone who proposes love to her and yet she would have a husband at home, an older husband. And because she did not go through that process of having fun as a teenager, she is now meeting someone of her age. Once she falls for her age mate, it will not stop there. She will have one affair after the other as time goes on. The virus will spread by having all these affairs” (INT17 Bulawayo, low-density).

- Category: Positive cultural influences

Cultural aspects that reduce the spread of HIV and AIDS are the encouragement of abstinence especially for girls, a norm and or expectation that females are to submit and not cheat on their husband, male circumcision, sticking to one partner as a Christian, no sex before marriage, sticking to one partner, dressing decently and virginity testing. However, the majority could not identify any cultural aspects that discouraged the spread of HIV and AIDS:

“For the girl child, abstinence is encouraged. When getting married, there are signs that are displayed to show that the girl is a virgin. Abstinence helps to minimise the spread of cancer. In our culture, married women are expected to be faithful and not have affairs outside the marriage. Culturally married women do adhere to this custom, but unfortunately men don’t seem to take heed of this custom. Because married women are not supposed to question their husbands, this will result in married men getting away with the fact that they have girlfriend(s).

In our culture, it is normal for men to have girlfriends and you can even be blamed for him having a girlfriend” (INT12 Harare, medium-density).

“When the girl child was growing up, she was advised not to have relationships with men before marriage. She was encouraged not be involved in any sexual encounters. She was also encouraged to wait until she was old enough for marriage, at least at about 25 years. This in turn helped to minimise the spread of HIV and AIDS. Unfortunately, these days, you will find sexually active 16-year-old girls and yet years back, women got married when they were 25 years or older” (INT4 Harare, high-density).

- Category: Incorporation of culture in HIV and AIDS communication

Male circumcision was named as a cultural aspect incorporated in HIV and AIDS communication, as well as good morals. Some said that through dramas and talk shows, cultural issues are catered for. The majority said that cultural aspects were catered for, but could not expound. The rest did not know if cultural aspects are incorporated in HIV and AIDS communication, with just one of the opinion that cultural aspects were not included:

“I have not heard any of the cultural aspects being incorporated in the communication expect once when the issue of polygamy was discussed. But then the issue of polygamy may be a cause of concern with women, men might not find anything wrong with it” (INT3 Harare, high-density).

“All I can say is that I think people are now adopting the Western culture that they see on television” (INT5 Harare, medium-density).

“I have seen a drama incorporating early child marriage” (INT9 Harare, low-density).

“Antenatal clinics do incorporate HIV and AIDS communication. It is culturally a known fact that men don’t want to use condoms, so the health workers teach us on how to negotiate with our husbands on the use of condoms, your husband’s possible reaction to the use of condoms and how to counter these reactions” (INT12 Harare, medium-density).

4.4.4.5 Sub-theme: Young urban women's context

The overall description of young urban women's context was mixed but mostly viewed in a negative manner, with a few responses coming across as neither good nor bad, for example, not being married. Positive responses referred to life being fine, and some being in employment and focusing on their careers, running businesses and others studying at universities.

The negative aspects included: being trapped in rushed marriages; struggling as single women; hustling and informal employment buying and selling goods in a very competitive environment; not being well educated for lack of interest or failing exams or not being able to afford money for further studying; pressure to get married; working to look after siblings and parents; having multiple concurrent sexual partners; peer pressure; being involved in sex work; drugs; alcohol; partying, reckless and 'fast' life-style:

"Most of them are struggling. The majority are single mothers and some frequent pubs" (INT2 Harare, medium-density).

"Most of the women in my age group who are married, seem to be facing difficulties in their marriages. I have advised those in my age group and younger than me to delay getting married, because there are a lot of difficulties in the institution of marriage" (INT3 Harare, high-density).

"Urban women of my age are facing a lot of challenges. There are people who look up to us for financial support and we have no financial resources because most of us are unemployed. We have no money to buy food and send our children to school. Some will end up running food stalls 'musika' while others will opt to go to pubs and engage in prostitution" (INT4 Harare, high-density).

"Some of the girls have respect for their parents, they go home in good time and are well behaved. There are those who want to have fun all the time. They can run away from their homes and spend the night out" (INT5 Harare, medium-density).

"Some of the challenges we face are due to the fact we did not go to school. We have no money and as a result we are not able to buy food. I can say there is a lot of poverty amongst women of my age. Another example is when you see your friend putting on a nice skirt and if you enquire as to where she got the skirt, she will tell you that she got it from this man who offered her money in exchange of

sex. This may also result in me doing exactly as my friend did because my parents may not afford to buy that kind of skirt. Peer pressure can result in us getting infected by the virus” (INT7 Harare, high-density).

“My life is okay because I know what I want to achieve in life. I however wouldn’t know about the other women in my age group. I generate income in a clean/straight manner. I work hard to look after myself...working is the only way of getting money. Others are buying and selling all sorts of things. Some are even selling airtime. You can find something to do to get income, you can be a tailor. One has to find clean means of earning a living so that they don’t get into complicated situations later on in life” (INT10 Harare, low-density).

“The age at which we are is transitional. It’s from girlhood to womanhood to motherhood. This is when sexual activity starts. Life at this age is adventurous, experimental, there are so many changes taking place in our lives and there is also a lot of pleasure at this age. This is the age also where women are under pressure to get married and there is also desperation towards the age of 27, 28 and 29 years for women to get married...this desperation can lead to HIV infection as one will get involved with any man who comes their way in a bid to get married. Because one is desperate they don’t even suggest to go for testing as they fear that their suitor may run away at the mere suggestion of going for testing. This desperation may also lead you to get married to someone much older than you, of the same age or to someone who is already infected with the HIV virus. Ideally in the early 20s someone is at University, I think most urban women are more focusing on their career first and think about marriage later. The working class urban women are more independent. They are making their own money they are not dependent on other people. But then at the same time there are those other urban women in the same age group who have to take care of their families. I think our economy has really affected them because some of them can’t afford to go to school. They are then forced to start working early maybe even in their early 20s, just after they finish high school. They have to find a job to take care of either their siblings or their parents. These are the two scenarios, these are the two contrasting ones. The urban woman who has the privilege of being able to go to school and then getting a job later and delay marriage. Then there are those who unfortunately can’t continue with school and they have to find a job and work” (INT13 Bulawayo, low-density).

“We are living in, I hate to use the term, a ‘global village’, we see other people’s lifestyles on internet and on TV for example keeping up with the Kardashians and we see girls with lots and lots of money. And you are here in Zimbabwe and you are unemployed and you see someone on TV celebrating their birthday and they are given the latest Jeep you know. So, the young woman in Bulawayo has been exposed to things mostly because we are well travelled. Most of us have travelled outside the country and we have seen this good life, then you come back home and things are just not moving and mind you most of the young women are not employed. Most of them are not employed and yet most of them are intelligent people” (INT14 Bulawayo, low-density).

“Most of the young women of my age are still living with their parents. Some are working, while others are into prostitution because they don’t want to work” (INT16 Bulawayo, low-density).

“She is at risk” (INT20 Bulawayo, medium-density).

“Life is tough. You can be teased and ill-advised if you are not in a relationship. They will call you all sorts of names” (INT22 Bulawayo, medium-density).

4.4.4.6 Sub-theme: Government policy

The women saw the role of Government and could expound on what it and some policy makers are doing regarding HIV/AIDS communication, though some women were not aware of their efforts or of any relevant existing laws. Areas where Government were active included advocacy work in child marriages, in clinics (including for pregnant mothers) and through the MoHCC, in the Ministries of Education at schools, in the department of Social Welfare and by reviewing and/or setting certain laws. NGOs, female Members of Parliament (MP) and human right lawyers were visible for child marriage issues. Some of the women had some ideas on what role the Government could play:

“No unfortunately I am not aware of any laws that have been put in place” (INT1 Harare, medium-density).

“I think the government is responsible for all the HIV and AIDS literature at the clinics” (INT2 Harare, medium-density).

“The government is involved through clinics, schools, etc. Especially at schools, there is a lot of HIV and AIDS communication. There is a school in Bulawayo where condoms were put in toilets for school children” (INT3 Harare, high-density).

“The government has policies in place at hospitals. When we take our children for routine check-ups we are usually approached by government health workers on issues related to HIV and AIDS” (INT4 Harare, high-density).

“I am not aware of any policy that the government has enacted as law. However, they do have educational programmes where they teach people on how to prevent being infected by HIV. By so doing I believe the government is active in issues pertaining to HIV and AIDS” (INT8 Harare, high-density).

“When we first heard of HIV and AIDS, before it had spread like nowadays, the government had put in place committees that went around on awareness campaigns.” (INT9 Harare, low-density).

“I could say that the police are trying by all means and discouraging young girls from moving around at night and engaging in prostitution” (INT25 Bulawayo, high-density).

“Government has done so much on radios, television and programmes. Many infected people are getting ARVs for free and this is being catered for by the government. Also, government is allowing NGOs to operate and assist the infected, this is a great milestone by the government” (INT21 Bulawayo, medium-density).

“Government promotes the use of condoms” (INT19 Bulawayo, high-density).

“I believe the government is responsible for all the educational programmes that we have seen around. I have seen government ministers on that TV Talk Show called “Positive Talk”. The Minister of Health, Dr Parirenyatwa is one such government minister that I have seen on the show. He talked about HIV and AIDS. So, I think the government is helping. It’s really up to each individual to heed the information at hand” (INT17 Bulawayo, low-density).

“I have not seen any communication by government” (INT16 Bulawayo, low-density).

“The government is trying through the Department of Health they are trying to raise the awareness. But there is still room for improvement, they really need to get the information across so that almost everyone in Zimbabwe would have the knowledge to say, “ok, there is HIV and AIDS, I need to protect myself”. And if I have HIV and AIDS, how do I not spread it to other people and to learn to live with the pandemic and take your pills and live a healthy life” (INT15 Bulawayo, low-density).

“I know Zimbabwe has joined other countries in advocating for a ban on child marriages. And if I am not mistaken, there was a campaign where the girl child was encouraged to report any case where she felt she was being married off and felt she was still young for marriage. At some point, they made it impossible for a woman younger than 18 to get married...yaa. And so, there is that whole thing about the age of consent concerning HIV and AIDS. If a man sleeps with a girl who is younger than 16, then its statutory rape. I think those are some of the laws that I have seen. As far as our government is concerned, I don't think it's doing enough. I think the women in parliament including our first lady and the vice presidents' wives should be doing more. I wonder what they feel when they hear that women between the ages of 20 and 29 are the ones that are the most vulnerable age group in terms of HIV and AIDS. I really wonder what they feel when they hear the statistics? So, I really don't feel like they are doing enough, that is, the policy makers, the people who sit in parliament, they” (INT14 Bulawayo, low-density).

“Honestly, I don't follow government policies but like the few times I have watched parliament proceedings, I have seen a few female MPs talking about issues of HIV, family planning and women rights. So, I think in terms of parliament, I think there is something being done. The police, law enforcement, etc., I am not really sure, but maybe the human rights lawyers and NGOs, I think I think they are more vocal about these issues” (INT13 Bulawayo, low-density).

“The mandatory HIV testing for pregnant women is one such policy. The communication that we are getting at antenatal clinics is one other policy for pregnancy women. It's now mandatory to get a card at the clinic in order for you to go through medical checks and HIV and AIDS lessons. That information is

communicated to all pregnant women when they visit clinics whether they like it or not” (INT12 Harare, medium-density).

4.4.4.7 Sub-theme: Vulnerability

Vulnerability is classified into seven categories: Polygamy; Small house; Sugar daddies; Sex work; Gender roles; Gender-based violence; Educational level.

- **Category: Polygamy**

All the women, with very few exceptions, were of the view that polygamy is a driver of HIV infection. One respondent highlighted that in the case of polygamy, the urban woman was unlikely to be a part of such an arrangement:

“Yes, there is a link because the husband will not be able to satisfy all the wives' needs. As a result, you might find the first wife no longer getting so much attention anymore from the husband and she will end up cheating. In fact, all the wives are capable of cheating and this puts everyone in that marriage at risk. HIV and AIDS is easily spread as a result” (INT3 Harare, high-density).

“If the husband is infected, he is bound to spread the virus to all the wives” (INT25 Bulawayo, high-density).

“Yes, there is a link. For example, members of the Johanne Marange can marry up to 10 wives, so if one of the family members is HIV positive it means all of them will be infected” (INT8 Harare, high-density).

“...Unfortunately, in this case more people are going to be infected as compared to a monogamous marriage. One person can spread the virus to several people easily in a polygamous marriage” (INT12 Harare, medium-density).

“I believe polygamy is linked to the spread of HIV and AIDS because there are a number of women linked to one man” (INT5 Harare, medium-density).

“Sometimes one person who is not faithful can have an affair outside the marriage and they can get infected and when that person is infected everyone in that marriage will be at risk of infection. But if everyone is faithful in that marriage, then they are safe” (INT22 Bulawayo, medium-density).

“Yes, there is a link between polygamy and AIDS, in the sense that you don’t know the kind of a person your husband is going to marry for a second wife and the disease can be spread from one to the other” (INT20 Bulawayo, medium-density).

- Category: Small house

The consensus was that small houses do facilitate the spread of HIV:

“A small house can be a married woman. She will have an extra marital affair with a married man. Unfortunately, when one person is infected in that set-up, everyone will be infected” (INT22 Bulawayo, medium-density).

“The small house will usually not easily be infected because she will insist on using protection. Of course, there are some small houses who will not use protection. It’s the wife at home who will end up getting infected” (INT23 Bulawayo, high-density).

“If a man goes to his small-house, does he know what the small-house gets up to when he leaves that small-house and goes back to his wife? This is what Mai Chisamba always asks men, “What happens when you leave your small-house?” (INT8 Harare, high-density).

“Small houses help in spreading the virus because people who promote small houses are the same people who like clubbing. While they are out clubbing they will get involved with a small house who is already infected and the husband can also spread the virus to the wife” (INT21 Bulawayo, medium-density).

“...The small house will be in love with a number of men, she will have one who comes in the morning, the next one will come in the afternoon and one in the evening. The virus is spread in such a set up” (INT19 Bulawayo, high-density).

“Urban women wouldn’t get into a polygamy set up, so I think in that case an urban woman would be against the risk of contracting HIV because she wouldn’t willingly or knowingly get into a polygamous relationship” (INT13 Bulawayo, low-density).

“To me it’s just similar to a polygamous marriage setup. The only difference is its presentation to society but the idea is the same...” (INT12 Harare, medium-density).

- Category: Sugar daddies

All the women linked sugar daddies to the spread of HIV infection. The reason is that many are viewed as having several other girlfriends, being HIV positive and passing on the virus to young women because usually unprotected sex takes place in exchange for money or other material goods. Some said that this lifestyle was a type of polygamy:

“There is a link. It can be both ways, the young girl going out with a sugar daddy may be infected and can infect the sugar daddy, the sugar daddy will in turn infect his wife at home. It may also be the sugar daddy who may infect the young girl and she in turn will infect her boyfriend” (INT9 Harare, low-density).

“Sugar daddies usually target young girls. You can find a 45-year-old man targeting 16-year-old girls who are still at school. They lure these girls using money and end up sleeping with these girls. There is a high chance of the virus spreading in such liaisons. Unfortunately, that girl’s future is ruined in the process. Out of ignorance the girl will get into marriage without realizing that she is already infected and will end up giving birth to HIV infected children” (INT4 Harare, high-density).

“Sugar daddies are the ‘Owners of HIV and AIDS’. They are responsible for spreading HIV and AIDS because they lure girls with money. Even when he asks for unprotected sex, girls will just consent because they need money” (INT23 Bulawayo, high-density).

“Some of the sugar daddies believe getting involved with young girls will eradicate AIDS. Sugar daddies are also victims of AIDS. Most of the sugar daddies look healthy because they are on treatment and the young girls get infected because they will be ignorant of the fact that these sugar daddies are already infected” (INT20 Bulawayo, medium-density).

“In my opinion, I think those are the worst. Most of those sugar daddies have lived a full life, they have done things and they have had sex with lots of women. If a guy is 20 years older than you then it means they have been having sex ever since you were born. Think about it, back in the 80s when people were not yet aware about HIV and AIDS, that guy was already having sex. So, you must think about that” (INT14 Bulawayo, low-density).

“Those involved with sugar daddies are not just waiting for one sugar daddy. Those girls can change from one sugar daddy to the other, it’s like a business to them” (INT8 Harare, high-density).

“It’s all the same, if someone has an extra marital affair with that young girl, that girl will also have a boyfriend and if someone is infected amongst all these people, the virus will affect everyone involved” (INT22 Bulawayo, medium-density).

“That is even worse. They lure young girls and it is usually more than one girl. The sugar daddies can have affairs with a number of girls” (INT5 Harare, medium-density).

“...They then go on to deliberately infect young girls. And what I have discovered is, women of my age group once we get to know that we are infected, we have this attitude that I must also spread the virus because I was also infected by someone too. So, they deliberately sleep with as many people as possible just to fix them...” (INT17 Bulawayo, low-density).

“Women of my age group, the 21 to 29-year olds, this is where we are turning to, the sugar daddies. In fact, I can say from the age to 12 to 29 years, girls are getting involved with sugar daddies. We even brag about our ‘sugar babas’ to our friends and encourage them to connect with them so they can also get their own ‘sugar baba” (INT7 Harare, high-density).

“Those are also the worst, now they call them ‘blessers’ and these blessers probably have AIDS. Because girls want the money they will go ahead with whatever the blesser wants without realizing that you are putting yourself at risk” (INT Bulawayo, low-density).

- Category: Sex work

All the women except for one, saw a link between sex work and the HIV epidemic, because of multiple partners being involved and the frequent lack of protection. The view was that both those in sex work and their partners become vulnerable because of the set-up:

“I think so, if these women were to be honest, there is a fine line between being a sex worker and being raped. One should ask themselves why these men prefer engaging sex workers instead of just having a girlfriend. To me that guy is very

promiscuous because if they were not, they would just find a girlfriend. But they like to sleep with different women so they hook up with sex workers. And if you are a prostitute and someone refuses to use a condom are you going to say no, take me back where you picked me up from? No. Also, because you are a prostitute you are looking for money, you are just going to sleep with that guy. I don't think sex workers make a lot of money, I don't even know why they do it. From what I have heard it doesn't sound like they make a lot of money because they are always in the streets. If indeed they were making lots of money, surely, they would be off the streets within a year because they would have made enough money. But sadly, they will be in the streets for years and years and years. They don't even look well as far as I am concerned. So yes, there is a link between HIV and AIDS and sex workers" (INT14 Bulawayo, low-density).

"There is a link because these women will be sleeping with several men. Sometimes not even using protection. So, HIV is easily spread in these relationships. One of her customers may be infected and because she sleeps with several men the infection will spread easily" (INT1 Harare, medium-density).

"They are also one of the worst culprits because they sleep with different people every day. They even sleep with more than one customer per night, they can be three to five. May be one or two may still be negative, but they could all be infected" (INT2 Harare, medium-density).

"Yes, the sex workers are linked to HIV and AIDS. As I did indicate before, these sex workers can have a customer who is willing to give them a lot of money for unprotected sex. Because of their dire straits at home, they are easily lured into unprotected sex. They are so vulnerable to these requests because this is the only way they make an income to look after their children, pay rentals, school fees, etc. They are lured by hundreds and thousands of dollars for unprotected sex" (INT3 Harare, high-density).

"I believe the commercial sex workers are responsible for the high prevalence of HIV and AIDS. You can never know who many men they sleep with when they go to the pubs. HIV is spread that way" (INT8 Harare, high-density).

"They are the major culprits, they are responsible for all the deaths in the country" (INT19 Bulawayo, high-density).

“Surprisingly the information that we get from the clinic is that sex workers nowadays are now pro-protection. They go to the clinics to collect condoms for their use. The health workers were actually saying the sex workers are now smarter compared to married women because they come to the clinics on their own accord to collect condoms for their protection. I believe they are putting to good use the HIV education that they are getting. They are trying to protect themselves even though sex is their source of income” (INT12 Harare, medium-density).

“If there could be a law that says, this is banned completely, I would be very happy for the protection of everyone” (CINT5 Bulawayo, medium-density).

“The virus is also spread by the sex workers and most married men go for these sex workers. The married men end up infecting their wives” (INT16 Bulawayo, low-density).

“Sex workers go out there looking for the virus” (INT18 Bulawayo, high-density).

“Most of the prostitutes are not infected. They use condoms. It’s the wives at who are vulnerable to HIV and AIDS” (INT23, high-density).

In scenarios described, of polygamy, small house, sugar daddies and sex work, the issue was that multiple sexual partners for all parties usually exist.

- Category: Gender roles

Most women saw a link between gender roles and HIV infection, while the rest were either not sure or saw no link. The ones who saw a link referred mostly to the societal acceptance of one male gender role aspect which promotes HIV infection - the norm that men have extramarital affairs or are promiscuous coupled with at times being mobile because of work, unlike the women:

“I am not sure. However, you may never know what men get up to when they go to work” (INT5 Harare, medium-density).

“I think I have already mentioned earlier that women usually won’t take the initiative to even ask their partner about their HIV status. So, with gender roles, women traditionally live in a patriarchal society, women are expected to be very submissive. Women will do things as the husband pleases, whatever he wants the wife will do it. As a result, a lot of women tend to be timid and they are

not really vocal so that's how it is. Then there is also this perception that men can have a number of relationships” (INT13 Bulawayo, low-density).

“To some extent, I guess the roles define a woman to be a housewife and the men go out there and are exposed to the outside world. Some of these men when they get exposed to the outside world, they get exposed in every sense of the word, “exposed”. They are easily excitable. They spend a lot of time away from home because of their role as men. While they are out there, they may meet other women and they may get careless and in the process, get infected. They will in turn infect their wives. Women too, can be frustrated by always being indoors as housewives. They too might end up getting into extra-marital affairs with for instance their garden boy. This is all done due to frustrations. So, yes gender roles can be connected to the spread of HIV and AIDS” (INT12 Harare, medium-density).

“I don't see any link. It is only the mind-set of an individual” (INT19 Bulawayo, medium-density).

- Category: Gender-based violence

Gender and domestic violence was viewed as having a link to fuelling the HIV epidemic, by most women. The reasons given included that being abused at home might drive the victim elsewhere for affection, it may cause her to rebuff her husband and he then must look elsewhere for sex, it may result in separation or divorce and eventually new sexual partners, thus widening the sexual network and increasing chances of acquiring HIV, or the woman might become scared to negotiate safe sex. The underlying feeling was that the couple's vulnerability increases because of domestic violence:

“What domestic violence does is that it leads to frustrations. One may endure the violence but the frustration in that relationship can lead someone to seek solace in an extra-marital affair. One can indulge in careless activities out of frustration and as pay back. While one is frustrated they can't end up not using protection because they are in that affair out of anger and that affair is emotion driven” (INT12 Harare, medium-density).

“I don't see the link, it's only but violence” (INT3 Harare, high-density).

“I don’t see the connection between domestic violence and HIV and AIDS” (INT18 Bulawayo, high-density).

“I think it ties with the gender roles because women are expected to be submissive even if her husband or partner abuses her, she just tends to stay put and be at his mercy instead of being able to stand up against his abuse and violence. I hope I have answered you adequately” (INT13 Bulawayo, low-density).

“There is a link because if a woman is constantly being beaten up by her husband, she can end up denying him his conjugal rights. The husband may end up having extra marital affairs with someone who is HIV positive. After reconciling with his wife, the man might already be compromised and he is likely to infect his wife” (INT4 Harare, high-density).

- Category: Educational level

The link between HIV and AIDS and education level was not seen by most of the women, but some identified this link. In the women’s opinion, educated and uneducated alike could contract HIV, and the emphasis was more on behaviour; some pointed out that some of the most educated were the worst offenders in terms of promiscuity. Those who could see the connection explained that education gives women options and they have a better mind set, they are better informed and knowledgeable about issues, and they are also able to get better employment and not rely on women. Some felt that the issue was tricky and could not be easily explained:

“I don’t think education has anything to do with HIV and AIDS. Babies can be born HIV positive and will grow with that status. HIV and AIDS has nothing to do with the fact that you went to school or not. You can be infected whether you went to school or not” (INT2 Harare, medium-density).

“Yes. We are all human, but the chances of those educated getting infected is low. Those who are educated will be busy at work and they have no time to be chasing after men. They are better off. Those who are not educated are usually busy looking for men” (INT23 Bulawayo, high-density).

“Everyone is at risk; it does not matter if one is educated or not” (INT9 low-density).

“I think ok, ideally the more educated you are the more aware you should be of these issues. But I still feel like maybe because I have seen or because I see it

around, most people who are educated seem to be reckless. So, I don't understand, I would have thought education would ideally open someone's mind as they have access to information. But, I think at the end of the day it's up to that individual to then use that accordingly. The fact that you have a PhD does not mean that you understand everything about HIV and AIDS. I have also noticed that people tend to just ignore the information at hand. It's just like doctors, they will tell you don't smoke, don't drink but they are drinking and smoking and yet they are the same people preaching against these things. So, there is that contradiction, people are aware that aware of HIV and AIDS, but for some reason they choose not take it seriously" (INT13 Bulawayo, low-density).

"I think so, yes, because education gives a certain power to a woman. A woman who went up to Grade Two is fighting a whole set of demons compared to a woman who has a Master's degree. A woman who is not educated is vulnerable to all sorts of things. Even their way of thinking is different. That's why I was also saying kids should wait and not engage in sex until they are older and wiser. So, I think even with education, it's like that. When you are educated, you are more informed, more confident and make well informed choices. So, you can even have the power to make decisions so that you are not with certain people that may put you at risk of HIV and AIDS infection" (INT14 Bulawayo, low-density).

"Yes. I think the more educated you are, the more you open up your eyes to see certain things and say, "ok fine, this I am not supposed to do". You can also say, "ok, this is my career, this is my life, I need to ensure that I continue advancing myself". Whereas sometimes when you are not educated, your step-up would be getting someone who is rich. But when you are educated, getting someone who already has money would just be an additional thing so to say. But when you are not educated, you think that getting someone who has money "just the money and anything else you don't care" because it would be a step-up for you. So, yes there is a link there" (INT15 Bulawayo, low-density).

"Yes, there is a link because if one is not literate, they are not able to read some of the HIV and AIDS communication and information. You can find someone who did not even go up to Grade three and may not comprehend some of the language used, for example the proper disposal of sharp objects are taught in upper grades. So, this illiterate person may use contaminated razor blades out of ignorance. By

so doing, he exposes him/herself to the virus. However, if one went up to say Form Four they are aware that they should not just use used razors and that they must use a new razor. So, I believe education does a play role in the spread of HIV and AIDS” (INT4 Harare, high-density).

“I think it all depends on how someone has decided to lead their life” (INT5 Harare, medium-density).

“Everyone is at risk. Education has no connection to HIV and AIDS” (INT3 Harare, high-density).

4.5 Results for FGDs

4.5.1 Introduction

The number of FGDs held was eight, and these were recorded. Annexe M is a sample transcript from one of the FGDs. The transcribing was carried out during the same period as for the individual interview transcriptions, and the corresponding notes were then merged using NVivo. Colaizzi’s method of analysis was used. The themes for the data analysis, are identical to those for data collection: Communication, HIV and AIDS knowledge; Perceptions and beliefs; Context. The only sub-theme that had categories was HIV and AIDS knowledge. The researcher decided not to have categories for all other sub-themes because the FGDs were anticipated to take longer than the individual interviews, and adding content would have augmented this.

Table 4.9: Themes and sub-themes for Focus Group Discussions

Theme	Sub-theme	Categories
1. Communication	Interpersonal communication	-
	Communication channels	-
	Language appropriateness	-
	Communication preference	-
	HIV and AIDS information	-
2. HIV and AIDS knowledge	Knowledge of HIV and AIDS	Distinguishing between HIV and AIDS
		HIV transmission
		HIV prevention
	HIV and AIDS champions	-
3. Perceptions and beliefs	Epidemic drivers	-
	Information sensitivity to needs	-
	Vulnerability	-
	Blame/fault perception	-
4. Context	Community involvement	-
	Spirituality	-
	Socioeconomic status	-
	Culture	-
	Government policy	-
	Young urban women's context	-

4.5.2 Theme 1: Communication

The Communication theme is divided into Interpersonal communication, Communication channels, Language Appropriateness, Communication Preference and HIV and AIDS information sub-themes.

4.5.2.1 Sub-theme: Interpersonal communication

A range of people were named as key sources of information for HIV and AIDS for the women. They are primarily primary and secondary school teachers, health workers, including nurses, doctors and counsellors at clinics, hospitals and New Start Centres, as well as staff from NGOs such as Grassroots, Restless Development (awareness campaigns) and PSI:

“I got to know about HIV and AIDS from the hospital. People were taught about HIV when they got to the hospital before being treated” (FGD1 Harare, high-density).

“I had just gone to hospital on a visit, this is when I saw people gathered and out of interest I also joined in just to hear what was going on” (FGD3 Harare, low-density).

“I first got to hear about HIV and AIDS when I was at secondary school. After school, I volunteered for an NGO, it’s called Risk This Development Now. So basically, it was about peer education. We learnt a lot about HIV and AIDS. I would say, generally I got to hear about HIV and AIDS from the media” (FGD5 Bulawayo, low-density).

“Through personnel from Population Services in the streets and from New Start Centre. I also heard it from the clinics when I went there for treatment. I also heard the information from school, through nurses and from those health workers who make house calls” (FGD4 Harare, medium-density).

“I first got to know about HIV and AIDS when I was still at primary school. We used to do HIV and AIDS awareness. There was a small segment on HIV and AIDS awareness in Primary School where we were taught about HIV and AIDS and how to avoid it. But we were mostly taught about how to treat people with HIV and AIDS. I think those were the days when people used to think that washing your hands or eating in the same dish or plate with someone who has HIV and AIDS, one could get infected. This is when we started to get to know about HIV and AIDS. And then when I went to secondary school, I was part of the HVI/AIDS Awareness Group” (FGD5 Bulawayo, low-density).

Other sources of information were as follows: parents (mothers were singled out by some); church leaders; peer educators; street children; Tariro Chikumbirike, a television presenter of a programme called Positive Talk; those in home-based care; lecturers during lectures at college in modules on HIV and AIDS and Culture; the national broadcaster, Zimbabwe Broadcasting Corporation (ZBC); people in the society:

“I got my insight about HIV and AIDS when we did our module at school. I was in Part One doing a degree. The topic was on HIV and AIDS and culture. That was the first time I got to know about HIV. Yes, that is where I first got the information from” (FGD5, Bulawayo, low-density).

“People talk about it everywhere, even on public transport” (FGD7, Bulawayo, medium-density).

It was important to establish the people women were most comfortable hearing about HIV and AIDS information from. These were mostly health workers namely medical doctors, nurses, counsellors at clinics and other health institutions. Several were comfortable with peers, and staff from NGOs who do door-to-door campaigns while one respondent reported to be comfortable getting information from her parents; one respondent was comfortable with anyone availing that information:

“I would rather get the information from a doctor because he is more knowledgeable about the subject and you can even have an interactive discussion with him/her...People living with the virus are also the best people to talk about HIV and AIDS” (FGD1, Harare, high-density).

“From relatives who are HIV positive. They are able to tell you exactly what they are going through” (FGD2, Harare, high-density).

“We are comfortable getting information about HIV and AIDS from nurses. Nurses are health professionals with the necessary educational background and hence are a source of accurate information with regards to HIV and AIDS. We are also comfortable with counsellors because there is one-on-one interaction and privacy and you can ask and get detailed information on issues you do not understand. We are comfortable with staff from NGO who does door-to-door campaign, because some of us are shy to ask questions or participate in a group setup” (FGD4, Harare, medium-density).

“I believe counsellors are more informed about the virus because some of them are living with HIV and are more knowledgeable” (FGD1, Harare, high-density).

“Peers, because they are same age mates and we can relate better but however the information might not be very accurate” (FGD5, Bulawayo, low-density).

The trend was similar for those who were perceived to be able to pass on the most accurate information. PLHIV, including well known personalities such as Tendai Westerhof and media personality Tariro Chikumbirike, together with health professionals, took the lead in this area. The health professionals mentioned were medical doctors, nurses, counsellors (including those from New Start Centre), because of their educational background on the subject matter, and social workers. PLHIV were seen as those having

first-hand experience about HIV and AIDS. Others named were First Lady, Grace Mugabe, Radio presenters such as Tilda and Mai Chisamba, peer educators, science teachers at school and Mentor Mothers in the community. Mentor mothers were said to be women in the community who are there for the youth. They listen to problems and give advice. One person named parents as those with the most accurate information:

“Doctors are the only people I feel can give me accurate information about HIV and AIDS” (FGD3 Harare, low-density).

“The good thing about doctors is that they have this doctor/patient confidentiality clause. They would never disclose your status to anyone, in fact they can even go on to counsel you” (FGD3 Harare, high-density).

“Doctors because they are more informed about it. They read and education in the field. They know that HIV and AIDS is a reality” (FGD6 Bulawayo, high density).

“I think nurses at the clinic are the ones likely to give the most accurate information about HIV and AIDS. When expectant mothers go to the clinic for routine check-up, they are educated about HIV and AIDS. They are also tested and if found to be positive, they are put on medication so that they do not transmit the virus to their unborn child” (FGD2 Harare, high-density).

“Mai Chisamba’s programmes are very educative. She goes out of her way to inform and educate us. She tells the truth and has a ‘no-holds-barred’ talk show. One can clearly understand and comprehend what is being discussed” (FGD1 Harare, high-density).

“Peer educators are also most likely to give you accurate information. I think an educator may make the information understandable because you they are of the same age group compared to someone who is younger or older than you. Information is better shared amongst peers” (FGD7 Bulawayo, medium density).

4.5.2.2 Sub-theme: Communication channels

There was a wide range of mass media channels where the women interviewed were acquiring information about HIV and AIDS from. The format in which the information came was also established, where possible. The channels were radio, television, pamphlets, leaflets and brochures, posters, billboards, newspapers and to a smaller extent through

music (for example by Oliver Mtukudzi), books, magazines such as 'Bona', t-shirts, the internet, WhatsApp and other social media.

On radio, the information was in the form of advertisements and programmes, for example '*Chakafukidza dzimba matenga*' (Things are not always what they seem in the home) and on Radio Zimbabwe there is *Pamhepo naChiremba* (On air with the doctor). There is also a health programme on the radio station Sky Metro FM, where issues relating to HIV and AIDS are discussed.

On the television, the information was in the form of adverts and local dramas, which starred famous actors including Paraffin and Mai Sorobhi, and talk shows such as *Mai Chisamba*, and programmes such as 'Positive Talk' by Tariro Chikumbirike and 37 Degrees, facilitated by Charlene Mangweme. Non-local content has been in the form of documentaries and South African dramas which are edutainment, such as 'Generations', 'Soul City', 'Soul Buddy' and 'Intersection'.

In newspapers, information is in the form of articles and adverts. Billboards that were seen were in the Central Business District, along roads and at clinics. Posters were seen at clinics and hospitals as well as on the walls of buildings in town and at shops, and on poles, fences and trees. Pamphlets were given out in the streets by an organization called PSI on 1 December AIDS Day. In the newspapers, there are adverts encouraging people to go and get tested for HIV and AIDS, as well as awareness articles. Pamphlets are also seen at clinics, New Start Centres, family planning centres, inside magazines and at workshops. One of the women read a book entitled 'Positive Living Strategies':

"I have seen pamphlets and brochures being distributed along the roads sometime in December, during world AIDS Day" (FGD1 Harare, high-density).

"There was an HIV and AIDS drama that was called 'Yesterday'. It was about segregation whereby HIV and AIDS infected people were removed from the community because people didn't want to associate with them. Some people feared that they would also be infected by the virus" (FGD2 Harare, high-density).

"In newspapers, it can be an article. At times, it can be an awareness campaign advert. It can also be a report on an HIV and AIDS event that would have taken place" (FGD4 Harare, medium-density).

“We have heard about HIV and AIDS through numerous communication channels. As I did indicate earlier, our local television station ZTV has several HIV and AIDS programmes. Pamphlets are distributed at clinics; you can read the pamphlet in the comfort of your home and you can get to know more about HIV and AIDS this way. HIV and AIDS issues are also covered in newspapers. Billboards with HIV and AIDS messages are also scattered all over town” (FGD4 Harare, medium density).

“I have seen vehicles driving around distributing pamphlets. Some of the leaflets are just thrown around the streets for people to pick. If you are interested you can pick up the pamphlets on the streets and read” (FGD7 Bulawayo, medium density).

“There is a channel of DSTV that airs health programmes. It has an educational programme on HIV and AIDS. On that program, they talk about Tuberculosis. Before people would be infected by TB when they got in contact with someone who had TB through coughing but nowadays TB is found in your bones and in your blood stream. That programme is aired from morning until 10PM, the channel is solely for HIV and AIDS issues only” (FGD7 Bulawayo, medium density).

“It was a talk show called “Positive Talk” shown on TV. People who are already infected with the HIV virus are invited to the show and they encourage those who are also infected by the virus to take their medication on time” (FGD3 Harare, high-density).

“I have seen billboards advertising the use of condoms called “Protector Plus”. I saw the billboard along the Mutare Highway as you approach Mutare at Christmas Pass. I have also seen billboards advertising circumcision here in Harare at the flyover along the road towards Southerton. It talks about the advantages of being circumcised. Apparently, circumcision reduces the chances of being infected by the HIV virus” (FGD4 Harare, medium-density).

“In magazines, there is usually a column on HIV and AIDS. The column also has a section where people write in and the columnist answers their questions” (FGD5 Bulawayo, low-density).

“Besides programmes, I can say I first heard about HIV and AIDS, through adverts. If you remember there were adverts that were aired on TV about condoms and this lady talking about being married and her husband having tested HIV negative while

she tested HIV positive. After that we started seeing programmes being aired on TV and radio informing people more about HIV and AIDS” (FGD5 Bulawayo, low-density).

“People are still getting involved in risky behaviour even when they know there is HIV and AIDS. So, if there are more HIV and AIDS road shows it might influence people to change their behaviour” (FGD3 Harare, low-density).

“My only comment is that the HIV and AIDS information that we read on pamphlets is very educative for those who can read. I once overheard someone saying if you want “black” people not to get information, write it in a book. What this means is that “black” people do not have a reading culture. They hardly read. Information can be at their disposal but they will not read it” (FGD4 Harare, medium-density).

The women were asked to discuss how they generally viewed the material/content or information on HIV and AIDS that is communicated through the mass media. There was a consensus that there is a lot of information and most people are aware of HIV and AIDS. The stigma associated with HIV and AIDS was said by one women, to have reduced significantly. It was said that knowledge levels have increased considerably but that most people are not using the information. The information has been found to be useful, accurate, adequate, and easy to understand; and women are content with it. Some even said that the information is too much, but that it is good. The information is helpful, reaches a wide audience and encourages the women to live a good life full of hope, including those found to be HIV positive.

In terms of the mass communication perceived as the most effective and most accessible, responses were similar, with radio and television taking the lead, followed closely by mobile phones. However, others believed radio was most effective while others said television was the most effective, and the same differing opinion prevailed for accessibility. Reasons given include that radios are everywhere, including on mobile phones, while many spend time watching television at home. Phones are a mode of communication through short media messages, but mostly using social media, especially WhatsApp. Phones were said to always be on one’s person and were easily accessible as most people are on WhatsApp most of the time. One respondent singled out workshops as being one of the most effective mass communication channels as they attract young people, in her opinion. Another respondent mentioned school curriculum as

being the most effective way to share HIV and AIDS information to large numbers of people, while another cited pamphlet.

The languages used in mass media were appropriate - English, Shona and Ndebele; therefore, everyone is covered:

“I believe the information has been steadily increasing over time and people are now more knowledgeable about HIV and AIDS. People are now comfortable talking about their status than before and will even disclose that they are on medication” (FGD1 Harare, high-density).

“The information is very helpful, especially on radio because if there is a programme being aired, people are invited to phone in and contribute to the discussion” (FGD7 Bulawayo, medium-density).

“The information on radio and television is understood by people who are not able to read. It is relayed in Shona, Ndebele and English and everyone can understand it” (FGD2 Harare, high-density).

“There is a lot of information and most people are aware of HIV and AIDS in the urban areas. The information is too much and is good. However, there is lack of information in the rural areas because most health centres and clinics are far away. Posters have a drawback in that if you do not understand some of the issues you written on the poster, there is no one to ask and you are stuck with your questions. A one-on-one way of communication would be advantageous as you have the opportunity to ask questions as necessary. Pamphlets are not appropriate for those people who cannot read and also the blind people. Young people do not have a reading culture and most of the times, we do not even read these pamphlets, and rather, we browse through and look at pictures. We recommend Braille pamphlets so that the blind are taken care of because they are also being affected and infected with the HIV virus as well” (FGD3 Harare, low-density).

“It depends on where you live. Those who live in the urban areas are at an advantage compared to those who live in the rural areas. For some of us who live in the urban areas, we might have adequate information as we get pamphlets from clinics and hospitals but those in the rural areas are at disadvantage because they are not getting enough information because the clinic may be far away. Because the clinic is far away people will usually go to the clinic due to illness and not for

HIV testing. So, when they go to the clinic because of ill health, this is when they get information on HIV and AIDS. The advantage with those in the urban areas is that one can now choose whether they want to read or watch the mass media, but the information is there and available” (FGD4 Harare, medium-density).

“Pamphlets are definitely a disadvantage to those who cannot read. They are freely distributed at hospitals, but some people may not be able to read them. However, the information is available at the hospital. So, information is better gotten on one-on-one for it to be understood. The other thing is we have those who cannot see, mind you the virus infects everyone including the blind and the disabled. So, the blind may not be able to read those pamphlets. So, if I were to take my visually impaired relative to go for testing at the clinic, they will not be able to read the pamphlets, posters or billboards for themselves. That printed information will not be of any use to my relative. I am not sure how this can be addressed, because we also have the visually impaired who are also affected by HIV and AIDS, if they are not affected, they will be infected” (FGD4, Harare, high-density).

“I believe television is more effective because you will find that most young women spend their time at home and are able to watch TV. TV provides sound and vision. You are able to see someone with HIV and AIDS from time they are diagnosed up to when they start getting treatment and their health starts to improve” (FGD2 Harare, high-density).

“Phone is the mass communication channel most readily accessible to us. Most of us have phones. On the phones, we can receive short media messages (SMS) and WhatsApp messages. Everywhere you are you and doing, you are always with your phone” (FGD3 Harare, low-density).

“WhatsApp messages are also readily accessible. I have also received text messages from Eco-Health on my mobile phone but most of the information is on diabetes. It would be an idea if that channel of communication is used to also send HIV and AIDS messages. When these messages are sent usually people read them because if a phone beeps, one usually reads the message” (FGD4 Harare, medium-density).

“Most people do not watch our local TV channels, they only do so maybe when there are special events for example Heroes Acre burial. I believe people are always listening to the radio” (FGD2 Harare, high-density).

“I believe television is more effective because you will find that most young women spend their time at home and are able to watch TV. TV provides sound and vision. You are able to see someone with HIV and AIDS from time they are diagnosed up to when they start getting treatment and their health starts to improve” (FGD2 Harare, high-density).

“Some of the programmes on TV also provide sign language” (FGD2 Harare, high-density).

“These days people use are into phones, almost everyone now owns a mobile phone” (FGD6 Bulawayo, high-density).

“WhatsApp currently tops the mode of communication. Everyone in our generation has WhatsApp. This is where we have access to all the news taking place. If there is anything that you want to know, you will find it on WhatsApp. The news circulates very fast on WhatsApp” (FGD7 Bulawayo, medium-density).

“Most people access this information on TV. People of our age in the urban areas watch TV most of the time” (FGD8, Bulawayo, high-density).

4.5.2.3 Sub-theme: Language appropriateness

The languages used when HIV and AIDS information is being communicated to the masses were generally viewed as appropriate and catering for everyone. The languages being referred to are the three main ones of English, Shona and Ndebele. In addition, one respondent highlighted that there are some words that cannot be explained in Shona but are better explained in English and that therefore the languages used complement each other. Some highlighted that not everyone understands English and that Shona would be good to use as the majority understand it. Some respondents felt that most of the mass media material is primarily in English and that not all understand this language. Some of the women felt that there is need to also include minority languages such as Nyanja, Tonga and Venda, but they did acknowledge that some radio stations are promoting and using some of these languages in their programmes. It was felt that use of some minority languages such as Tonga would cater for these groups of people in remote rural areas:

“Some people may be comfortable with English because there are some words which are better understood in English than in Shona. However, the majority of people understand Shona. It also depends on where you live, if you are in an area where Ndebele is the major language, then obviously, Ndebele will be better understood” (FGD4 Harare, medium-density).

“I think, most of the time people will not fail to find one language that they understand” (FGD6 Bulawayo, high-density).

“The good thing about radio is that information is broadcast in the three main languages, that is, English, Ndebele and Shona” (FGD1, Harare, high-density).

“English is used for the majority of the programmes on the mass media communication channels” (FGD3 Harare, low-density).

“They should use all languages including Shona and Ndebele. Most of the communication is in English. And yet the target group for these programmes is not the educated. It would seem the programmes are meant for the educated only. There are too many English programmes” (FGD7 Bulawayo, medium-density).

“The language is appropriate, it’s alright” (FGD8, Bulawayo, high-density).

“I think the language used on TV, radio, pamphlets, etc. is appropriate because the same message is relayed in different languages, that is, Shona, Ndebele and English. So, it is up to an individual to choose which language they are comfortable with and then tune into the station offering that language. Most of the information is relayed in the three major languages in Zimbabwe” (FGD4 Harare, medium-density).

4.5.2.4 Sub-theme: Communication preference

While some of the women preferred the mass media as a method of communicating HIV and AIDS issues, some preferred IPC, others still liked a combination of both and others were indifferent and said either was fine since getting the information was what matters. One of the respondents liked both types of communication and said that it depends with the information she will be seeking. However, the majority preferred IPC.

The reason given by some for preferring the mass media was that they could interact with other people and hear the views and opinions of others. One respondent explained that she is shy, so if the information comes in form of pamphlets, it is fine with her and then she just reads on her own.

IPC was preferred because it presents an opportunity to solicit for clarity or ask questions on issues one does not understand and it is a two-way communication.

The disadvantage of mass media was seen by one respondent as that there is a lot of mob psychology and due to that, some people are shy to say out their honest opinions:

“I would prefer to hear the information from the radio first. Once I have heard the information on radio, I can now go for one and one so that I can then ask questions on what I would have heard on radio including my own personal questions” (FGD2 Harare, high-density).

“I prefer interpersonal communication because although sometimes mass media is where I want to get information from. This is my thinking, way before people heard about HIV and AIDS on TV, etc. When one heard this information on let’s say radio one would say, “oh, ok it’s happening in Harare and oh, ok it’s happening next door or oh, ok it’s happening in Gweru”. Hearing the information on mass media did not personalize things. But when someone is talking to you one-on-one, then you get to know that this thing can happen to you, it becomes a reality” (FGD5 Bulawayo, low density).

“I would also prefer one-on-one although group discussions have their advantages too. While I am able to freely ask personal issues on one-on-one I may be able to learn one or two things in a group discussion. I believe both communication channels are helpful” (FGD4 Harare, medium-density).

“I would prefer one-on-one communication because I am able to ask all the question that I have. I may not be able to do the same on radio, that is, ask questions. I believe information on radio is meant for one to just listen” (FGD3 Harare, low-density).

“We have a local mobile company that offers free calling on different issues, that facility should also be extended to HIV and AIDS matters. People can call for free and get advice or information and discuss one-on-one on the phone. The write-in

programmes are not so good because your letter may not be read” (FGD7 Bulawayo, medium density).

“To me the mode of communication does not matter whether it is one to one or mass media, as long as the information is appropriate. As long as you are able to listen to the radio and TV and your questions are answered there and there” (FGD6 Bulawayo, high density).

“There are some programmes on television where they usually invite an expert into the studio. People can then send their questions through WhatsApp and the expert answers whilst you listen” (FGD6 Bulawayo, high density).

“I prefer interpersonal because when you are in a group, there is this mob psychology. You will be telling each other things that do not really make sense, but when its one-on-one you actually take that person seriously. It’s like a wakeup call if you were leading a reckless life when someone tells you directly, with a serious face, this is when you take things seriously” (FGD5 Bulawayo, low density).

“So, for me interpersonal becomes a one-on-one thing, so that anything I want to share with that person I become so free and that person can always tell me anything that I want to hear. So, it becomes an advantage and like what my colleague has already alluded to, with mass media there is that mob psychology” (FGD5 Bulawayo, low density).

“I think it could be a better idea if pamphlets were distributed door-to-door so that people can read about the negative effect of defaulting in taking their medication. They can read all this information on the pamphlets in the comfort of their homes” (FGD7 Bulawayo, medium density).

“I would prefer one-on-one communication because I can have an interactive discussion with the health worker. I am able to ask about how I can protect myself and if I am positive how can I lead a healthy lifestyle?” (FGD4 Harare, medium density).

4.5.2.5 Sub-theme: HIV and AIDS information

Almost all the women felt that the information available to young urban women about HIV and AIDS is adequate or even plentiful, and that most people are aware of HIV and AIDS. The information was said to be useful and there is contentment regarding it. Some went

one further to say that there is free information coupled with free treatment for those who are HIV positive, which is good. One woman felt there was not enough information out there and a second felt that even if the knowledge is there, it should continue to be shared. It was felt that the challenge was said to be not with the information adequacy, but with not listening to advice and with the negative attitude of men:

“I believe the information is adequate because when you go to the clinic you are told about the virus and encouraged to use protection. However, we always face the usual resistance by our husbands. They won’t even entertain what we would have learnt from the clinic. They can go as far as telling you to go and stay at the clinic. Most married men do not want to use protection with their wives” (FGD1 Harare, high-density).

“There is enough information because when a woman gets pregnant, she has to visit the clinic and this is where she is told about the virus. They are tested for the virus after every three months until they give birth. So, for women, the information is enough because of the clinic visits” (FGD3 Harare, low-density).

“There is enough information on HIV and AIDS, we are the ones who seem not to heed what is being said. There is a lot of information on our local television ZTV, but most people are now subscribing and watching DSTV” (FGD2 Harare, high-density).

“People usually get more information through the one to one communication channel. Other than that, there is not enough information out there” (FGD2 Harare, high-density).

“There is adequate information, it’s just that we are ignorant. Imagine a situation where I have just been given an HIV pamphlet and just after reading it, I still go on to have unprotected sex. We would be lying if we claim that there is not enough information on HIV and AIDS, there is plenty of information” (FGD4 Harare, medium-density)

“Indeed, the information is in abundance, however, people now have this attitude that we are all going to die at some point anyway and they continue to sleep around without protection. There is this ‘I don’t care attitude’ and we give each other false hope in matters concerning HIV and AIDS” (FGD4 Harare, medium-density).

“Information should be constantly channelled to the people even when we have knowledge of the virus, but I think there is need to just keep adding it on” (FGD6 Bulawayo, high density).

4.5.3 Theme 2: HIV and AIDS knowledge

Knowledge about HIV and AIDS is the second theme. It is subdivided into Knowledge and HIV and AIDS champions. Knowledge is further divided into three categories: Definitions of HIV and AIDS; HIV Prevention; HIV status.

4.5.3.1 Sub-theme: Knowledge about HIV and AIDS

- Category: Distinguishing between HIV and AIDS

Most of the women had a very good understanding of what HIV and AIDS are and the difference between them, but a few did not have the right understanding. The majority understood that it is possible to progress from being HIV infected to having AIDS (the sickness, which is a group of diseases) when treatment is not given, and that this leads to death. They explained HIV as the virus that one contracts. It was understood that a person can be infected with the HIV virus but still live a healthy life upon treatment, although there is no cure. One even had some knowledge about CD4 count:

“You can take medication when you are HIV positive and lead a healthy life. However, it’s different when you have AIDS the consequences are fatal. Life can be short if you have AIDS” (FGD1 Harare, high-density).

“When you have AIDS, you are then vulnerable to all other diseases including TB because your “body soldiers” are no longer able to fight any diseases. You get so weak and you are not even able to fan off flies. If your “body soldiers” are lower than 200, you are put on ARVs because by then you are so weak to fight off all the other diseases including TB, herpes, pneumonia, etc.” (FGD7 Bulawayo, medium-density).

“HIV stands for Human Immuno Virus and AIDS stands for Acquired Immuno Deficiency Syndrome” (FGD5 Bulawayo, low-density).

“The difference is that HIV is a virus in your blood stream and at this stage it does not affect you. AIDS is when it is in your blood stream and you are affected” (FGD7 Bulawayo, low-density).

“Yes, there is a difference. HIV causes AIDS. The progression from HIV to AIDS differs from person to person and this is according to someone’s lifestyle. Some people may even die before the HIV has progressed to AIDS” (FGD4 Harare, medium-density).

“AIDS is a disease. We heard that when your blood is tested that is when they can know that you have AIDS. When you have a headache, it means you have AIDS. When you have a stomach problem you have AIDS. This is what we were taught at school. We were taught that if you have these frequent problems it means you now have AIDS” (FGD6 Bulawayo, high-density).

- Category: HIV prevention

HIV prevention was viewed as possible through various means: abstinence; using condoms; self-discipline; sticking to one faithful partner; avoiding multiple sexual partners; consistent HIV testing every three months; testing before sexual intercourse; continuous exposure to awareness campaigns and teachings. One respondent emphasized that abstinence is the most effective method of them all. It was highlighted that condom use is ineffective or challenging in a marriage setup as the wife is then branded a sex worker. It was felt that single women can be in a better position to negotiate for condom use with their boyfriends. Some were of the view that condoms are not one hundred percent protection because they can burst and that therefore HIV is a real challenge:

“Sticking to one partner may be tricky because they could be cheating by the other partner” (FGD2 Harare, high-density).

“I understand if one is pregnant and they are HIV, they should immediately be on medication so that they do not transmit the virus to the unborn child” (FGD3 Harare, low-density).

“Using Protector Plus condoms” (FGD6 Bulawayo, high-density).

“That virus is not preventable. The condoms are not reliable, they can burst. So, what would you have prevented” (FGD6 Bulawayo, high-density).

“There should be absolute faithfulness from both partners. It will not work if one partner is faithful and the other is not” (FGD6 Bulawayo, high-density).

“People should abstain from sex before marriage” (FGD2 Harare, high-density).

“Retire from sex” (FGD1 Harare, high-density).

“Before we did not have female condoms, but nowadays they are available so a woman can use them” (FGD3 Harare, low-density).

“...I think there should be constant educative forums where people are always reminded about HIV and AIDS virus, it could help behaviour change. For example, for teenagers and single people abstinence should be encouraged. Single mothers should be encouraged to use condoms and those in marriage should also insist on protection. Protection might be problematic for elderly couples though. We all have friends and relatives who died due to the virus. Before people never wanted to be tested because of stigma. But over the years due to the vigorous HIV and AIDS education in place, we are now going for testing. It's now normal for someone to just go for testing. With all the HIV and AIDS information available, it seems people are still getting involved in risky behaviour. I would want to encourage people to behave and be faithful, they should stick to one partner, especially married couples. I believe married women may be faithful to their husbands but their husbands may be involved in extra-marital affairs.” (FGD4 Harare, medium-density).

“...There is need for more HIV and AIDS information directed at men so that they know the consequences of the virus. Maybe if they get to know the risks associated with being promiscuous they may change their ways” (FGD4 Harare, medium-density).

“I think the chances of married women being infected by the virus are much higher compared to other women. A teenage girl can abstain, a single woman has the power to negotiate for safe sex whereas a married woman is powerless, she is not in a position to ask her husband to use condoms. Imagine your husband attending a workshop for a week in another city and then on his return you ask your husband to go for an HIV test? That is unheard of” (FGD4 Harare, medium-density).

“I agree men should also have such discussions as we are having right now. Maybe the constant HIV and AIDS education can have an effect and they can change their behaviour. Often husbands also discriminate their wives...” (FGD4 Harare, medium-density).

“Chirwere ichi hachidziviririke condom rinoputika [You cannot protect yourself from this disease because the condom can burst]” (FGD6 Bulawayo, high-density).

- Category: Transmission of HIV

There were several ways that women described as facilitators of HIV transmission, a few of which were inaccurate: unprotected sexual intercourse with an infected partner; open wounds such as when cleaning the open wounds of an HIV infected person without gloves; kissing an infected person with open wound on the lips and or in the mouth including oral sex; sharp objects such as contaminated needles, razor, nails; blood transfusion in the event that the blood is contaminated; mother to child that is, when an HIV positive mother is not treated, she can infect the unborn baby; having sex with multiple sexual partners; combining sex and alcohol; sex work; through bleeding gums and sharing a cup used by that person. One respondent said that HIV can be transmitted through the shaking of hands; the rest of the group disagreed with this. A few believed clothes, food and eating utensils can spread the disease when an infected person uses these and shares with others. One said that transmission can occur by bathing someone who is infected, if you have an open wound:

“In the rural areas, people use one razor to shave children’s hair. If there is one child who is HIV, that razor can aid the spread of the HIV virus to all the other children” (FGD2 Harare, high-density).

“You can have a situation where someone who is infected with HIV and AIDS has bleeding gums or cracked bleeding lips. If this person uses a cup and leaves blood stains on the cup, you can be infected if you share the same cup when you also have bleeding gums or cracked lips” (FGD2 Harare, high-density).

“If an expectant mother gets to know that she is HIV positive, she is put on treatment, but she must take the medication early because she can infect the baby if she delays. She has to take that medication before six months into the pregnancy otherwise the baby will be infected. The medication is called Nevirapine. When you go, and register at the clinic for the first time, you are tested for HIV. Once it is established that you are infected, you will start getting treatment” (FGD7 Bulawayo, medium-density).

“If you step on a nail that has already pricked an HIV and AIDS person, you can be infected. I heard this from a nurse at the clinic” (FGD1 Harare, high-density).

“I still believe you can get infected through an infected person’s clothes. You know the deceased person clothes that a distributed to relatives after the funeral, I understand you can get infected if you put them on” (FGD6 Bulawayo, high-density).

“Haven’t you all heard that even handshakes are no longer allowed. When we were playing, we were told that even greeting someone with a handshake is not allowed” (FGD6 Bulawayo, high-density).

“What you are saying used to happen a long time ago. When we first got to know about HIV/IDS, this is how we were taught by the village health workers. There was inadequate information then there was a lot of misinformation. A lot of research was done since then and this is when it was realized that HIV and AIDS was not spread the way you alluded to earlier. They then realised that the virus was spread through bodily fluids like blood and unprotected sex” (FGD6 Bulawayo, high-density).

“If I am infected and have sores in my mouth and I use a drinking glass, when I pass that glass to the next person to also drink from it, that person will get infected too if they have sores in their mouth. But if I don’t have any sores in my mouth, I will not pass on the virus to the next person, even when they use the same glass” (FGD6 Bulawayo, high-density).

“We would just be showing love and affection towards the infected person, but the truth is we will get infected by using those utensils. The infected person also knows that the utensils that they are using are no longer being used by those he/she is staying with” (FGD6 Bulawayo, high-density).

“But you are talking about something that used to happen when HIV and AIDS was still was a frightening disease. But right now, I don’t think it is of any consequence if you stay with someone who is infected because we are now well informed about the transmission of the virus” (FGD6 Bulawayo, high-density).

“You can also be infected by having oral sex if you have open sores in your mouth” (FGD4 Harare, medium-density).

“This is when one partner uses their mouth to perform sex on the other partner’s sex organ. From my understanding, the virus is not in the sperm but it is found in

body fluids, so when the one using their mouth has open sores, they can be infected by the virus. You can also get infected if you are cut by a sharp object that is contaminated by the HIV virus although I understand the chances of getting it that way are slim. I have also heard that nurses too are at risk. If a nurse is injecting a patient who is HIV positive and she/he accidentally pricks her/himself, they can get infected' (FGD4 Harare, medium-density).

- Category: HIV status

All women, except for one, felt that it is important for someone to know their HIV status. The key motivation for knowing one's status was that if you are found to be HIV negative, you can take necessary precautions to protect yourself and maintain your status, while if you are found HIV positive, you can seek treatment in time before the immunity system deteriorates. It was felt that the earlier one is aware, the better.

One respondent felt that knowing your status is not necessary because if you turn out to be HIV positive you may not be able to accept the outcome, become depressed and suicidal. She felt that it depended on the ability to be able to manage grave news of being HIV positive. A second respondent did not think it was important to know one's status:

"I believe it is important for one to know their status so they are able to look after themselves. Once someone knows their status, they should change their lifestyle accordingly" (FGD1 Harare, high-density).

"Knowing your status is not necessary because, in the event that you are tested positive, you may not be able to contain and accept the reality. Now if you fail to accept it, you can even commit suicide and or you will get into depression which can negatively affect you. So, it depends, if you know you cannot handle the results especially if found positive, it is best not to know your status" (FGD1 Harare, high-density).

"When you know that your status is positive, you can then seek treatment at the clinic. But when you don't know your status you are not going to go to the clinic and the virus will keep ravaging your body" (FGD8 Bulawayo, high-density).

"It is important to know your status because once you know you are positive you are able to start taking medication. However, if you are ignorant of your status,

your health will deteriorate to such an extent you will fall ill and that is when you will get tested for HIV and it might be late” (FGD4 Harare, medium-density).

“...but it’s not everyone who is able to handle their HIV positive status. Knowing one’s status is good but others may end up dead because of stress and yet others may easily take it in their stride and take steps to properly look after themselves. I wouldn’t want to know my status; I don’t think I would be able to handle it” (FGD2 Harare, high-density).

“I would want to talk about not wanting to know one’s status. Yes, you might not want to know, but HIV and AIDS will eat you up till you are wasted away. When you have wasted away, you might start losing self-esteem. It’s better to know your status so that you know what to do in good time. If you start taking medication early you can look healthy and no one will know you are HIV positive. These days, people take one pill a day. Knowing you are HIV positive is not frightening as before” (FGD2 Harare, high-density).

“You do not suddenly lose weight because you have just found out you are HIV positive. I have seen people who are HIV positive and they look healthy. If I still feel healthy, haaa, I am not ready for testing. I would rather delay knowing my status until I begin showing signs of ill health” (FGD2 Harare, high-density).

“...it all depends on how a person handles the news, it can even lead to their death. I still think it’s better to go for a test when you know there is something wrong with you. Being tested or not is okay as far as I am concerned, it depends on each individual” (FGD2 Harare, high-density).

“Ukanorapwa warwara haumuki [if you delay treatment and start taking medication when feeling sick, you will not recover]” (FGD7 Bulawayo, medium-density).

4.5.3.2 Sub-theme: HIV and AIDS champions

Several media personalities were acknowledged by the women, as championing HIV and AIDS awareness in the media. The most well-known were musicians Jah Prayzah and Oliver Mtukudzi together with talk show host, Tariro Chikumbirike, who hosts ‘Positive Talk’ on ZTV and Mai Chisamba, a television personality who has a Shona talk show on ZTV, and poet Albert Nyathi followed by other musicians Sulumani Chimbetu and Winky D. Others were mentioned, but were not as well known for HIV and AIDS issues: musicians - Victor Kunonga, Sniper, Clament Magwaza; actor/actress – ‘Paraffin’ (ZTV),

Mama Azuka (Nigerian actress), television presenters - Ruvheneko Parirenyatwa, Hazvinei Sakarombe (the latter is also a radio DJ); radio presenters - Taurai Muswere, Patricia Jacob, Tilda, Richmond Siyakurima; journalist – Busi Bhebhe. Male circumcision was the only specific HIV area that was specifically mentioned in relation to a champion:

“I know of an educative programme hosted by Tilda from Star FM. The programme teaches people about HIV and AIDS. It’s a very helpful programme as we learn a lot” (FGD1 Harare, high-density).

“Richmond Siyakurima has a programme too, where he encourages men to stay faithful to their partners. The programme is aired on Radio Zimbabwe” (FGD1 Harare, high-density).

“There is Tariro, she hosts a talk show called ‘Positive Talk’ on television. It’s a television talk show with an HIV and AIDS theme. It is an awareness programme targeting teenagers, women, etc. Some episodes of the programme involve the host going to people’s houses and discussing about HIV and AIDS. At times, they also go into the streets to talk to people about the virus” (FGD4 Harare, medium-density).

“Oliver Mtukudzi sang, ‘Kunechirwere, chirwere, chisingarapike’ [There is a disease, a disease, that is incurable]” (FGD1 Harare, high-density).

“I know of one young musician called Jah Prayzah. He did a song that encourages men to get circumcised. I understand, circumcision minimises the chances of HIV infection” (FGD2 Harare, high-density).

“Oliver Mtukudzi did a song called ‘Todini?’ [What shall we do?]” (FGD4 Harare, medium-density).

“I don’t remember the name of Ruvheneko’s show, but she discusses various topics including positive living and how to take ARVs” (FGD3 Harare, low-density).

“I have seen street theatre although I don’t the name of group” (FGD3 Harare, low-density).

“Busi Bhebhe, a journalist. She used to host a lot of programmes on ZBC, way back...she is now under NYDT (National Youth Development T). NYDT runs so many HIV and AIDS programmes...” (FGD5 Bulawayo, low-density).

“A musician called Clement Magwaza...the song is Take, take, take, isiqede abantu [HIV and AIDS is killing people]” (FGD6 Bulawayo, high-density).

“Taurayi Muswere who does a programme called Mopani Junction, which talks about HIV and AIDS issues” (FGD5 Bulawayo, low-density).

“Patricia Jacob of Radio Zimbabwe also comes to mind” (FGD4 Bulawayo, medium-density).

4.5.4 Theme 3: Perceptions and beliefs

Perceptions and belief describe a certain way the women view issues, and is divided into Epidemic drivers, Information sensitivity to needs, Vulnerability and Blame/fault perception.

4.5.4.1 Sub-theme: Epidemic drivers

Epidemic drivers were explained to the respondents as anything that promotes the spread of HIV and AIDS. Unprotected sex, sex work (including street children, and parents endorsing this for their children), unfaithfulness, promiscuity or loose morals and ignoring the dangers of reckless behaviour and multiple sexual partners, were said to promote the spread of HIV. Pornography and strippers were also highlighted by one respondent. Other reasons given were partying (including *Vuzu* parties), drugs and alcohol abuse, the fast life, the refusal to go for HIV testing (including fear of testing positive), especially by men, inconsistent use of condoms, denial, rape, long distance truck drivers and religion. Poverty, unemployment and lack of money was singled out for leading to hardships which in turn force women to resort to prostitution as a means of survival. The oppression of women, young women going out with older men as well as child marriages were also said to be epidemic drivers. The lack of access to information was mentioned by one respondent as an epidemic driver:

“People are now reckless because they know if they are found to be HIV positive, they can take medication. I think this is the reason, there is some many cases of HIV and AIDS infected people” (FGD1 Harare, high-density).

“Our peers seem to be overwhelmed by wanting to live an upmarket life, hence they end up getting involved with older men. Some of these older men are usually already infected and these girls get infected as a result. These girls in turn end up in relationships with boys of their age and the virus is spread this way” (FGD1 Harare, high-density).

“Poverty. Due to poverty at home, the girl child may turn into prostitution as a means of survival. She may find men giving her more money for unprotected sex. Because there is no food at home, she is forced to engage in unprotected sex and as a result she will get infected” (FGD 2 Harare, high-density).

“Religion also promotes the spread of the virus. There are some churches that promote polygamy. In the apostolic sects, a Madzibaba can have a number of wives. The first three wives may be free of the virus and the fourth wife may be brought in when she is already infected by HIV. So Madzibaba will unknowingly spread the virus to his other unsuspecting wives” (FGD2 Harare, high-density).

“Child marriages also promote the spread of HIV and AIDS. An underage girl can be married off to an older man and she is helpless in terms of negotiating for safe sex. She wouldn’t dare and request her elderly husband to go for testing” (FGD2 Harare, high-density).

“There are some men who discriminate their wives in order to control them. They don’t even allow them to work. As a result, a woman is helpless and can be infected with STIs or the HIV virus as she cannot even negotiate for safe sex or suggest that they go for testing. She is forced to do whatever the man pleases” (FGD 2 Harare, high-density).

“I believe the reason the virus is spreading is because a lot of women are living in poverty. As a result, they decide to go to pubs and engage in prostitution so as to generate income for their survival. They get infected in the process” (FGD 3 Harare, low-density).

“Children are no longer following tradition, they getting involved in sexual activities whilst they are still young” (FGD6 Bulawayo, high-density).

“Even religion sometimes. Some religions can cause people to be in denial. There are some pastors who will tell you that you are a Christian and you cannot be sick because the bible says, or the Quran says, or whatever the belief system is, says you cannot be sick. As a result, you hold on to that belief and you go on to live without medication, you also don’t go to hospital” (FGD5 Bulawayo, low-density).

“Poverty promotes the spread of HIV and AIDS when youngsters who are staying with their parents, or even those who are not staying with their parents, and are

not working seek someone who will buy you basic food stuffs in exchange of sex. The following day, you meet someone else who will again food and the same thing happens” (FGD8 Bulawayo, high-density).

4.5.4.2 Sub-theme: Information sensitivity to needs

Most women felt that the information that is relayed is sensitive to the needs of the age group and addresses their needs, is accurate, simple to understand and is not offensive. The information was said to be helpful if one is willing to protect yourself. One respondent agreed partially, whilst a few indicated that there could be some improvements to increase sensitivity to those found to be HIV positive:

“It is sensitive, because the way it is said. The message is, ‘If you are HIV positive, it does not mean that it is the end of the world’” (FGD2 Harare, high-density).

“To a less extent no, because as much as we get all the necessary information, as married women the information does not help us because our husbands do not want to cooperate. For instance, if you fall pregnant, on your first visit to the clinic you are tested for the HIV virus. When you get your results, you go home and inform your partner. If your status is negative, your husband then sits back and relaxes because as far as he is concerned he interprets that my negative status means he is also negative. However, we all know about discordant couples where one partner is negative and the other is positive. When you go to the clinic to be treated for STI infections, you are advised to bring your partner. I wish the same could be done for HIV, men should go to the clinic with their partners for the test. By so doing both partners go through HIV counselling together before being tested. Being tested as a couple has its advantages because if you are a discordant couple you can start using protection and the partner who is positive can start taking medication. The other advantage of being tested together is that you are both taught on how to look after each other in the event that you are found to be positive. Unfortunately, it’s always the woman who knows more about HIV and AIDS than the man. This is the reason the virus is still spreading because men are ignorant of HIV and AIDS. Men should also be encouraged to attend baby clinics” (FGD4 Harare, medium-density).

“I think the language that is used, I will talk about pamphlets, for me its ok, it’s not explicit but at the end of the day you get to understand what is being said. It’s just simple language, it doesn’t offend you. It’s just simple accurate language. You can

understand what is being said without being offended” (FGD5 Bulawayo, low-density).

“Most of the information is about HIV and AIDS statistics. If you look at the available adverts, it’s all about encouraging people to go and test so that at the end of the day it’s about each testing centre reporting HIV and AIDS statistics. I don’t believe people are being helped. Once you are tested and found to be positive these people then don’t come back to follow you up on treatment” (FGD5 Bulawayo, low-density).

“Most people are not going for testing because they don’t know how the test is done. They assume the test is an injection and it’s painful, so they get reluctant to go for the test. It could be an idea to tell people what it entails to be tested. It’s just a prick on a finger, that’s all not the injection that people assume is used to test for HIV” (FGD7 Bulawayo, medium).

“The other thing that makes people to be reluctant to go for testing is that once you are tested and found to be positive, those who are positive are then advised to form a queue. Those who are negative also form their own queue. I don’t think this is right. People should just form one queue and they will then get their medication in a secluded room. Not the way it is currently done, you will find those who are positive being given distinctive green coloured cards. It’s discriminatory” (FGD7 Bulawayo, medium).

4.5.4.3 Sub-theme: Vulnerability

The women cited several issues to which they attributed their vulnerability to HIV and AIDS: love of money, sex work, peer pressure and indecent dressing; engaging in extramarital affairs; lust in women and men; the lifestyle of ‘clubbing’ and partying; taking drugs; long distance relationships; lack of self-discipline; men using male circumcision as an excuse to be promiscuous; *Vuzu* parties, blessers; family planning; rushed marriages; lack of negotiating skills; proliferation of beer halls and night clubs; HIV positive men concealing status from their wives; poverty:

“Women tend to be envious of other women’s lifestyles. For example, I may envy your dressing and go on to ask my husband to buy me the same outfit. My husband may say he is not able to afford buying the outfit for me. This may lead me to be involved in an extra-marital affair with a sugar daddy at my work place.

Sleeping with that sugar daddy just once without protection can result in me being infected, simple because I want money to buy that outfit. It's all about being envious of other people" (FGD2 Harare, high-density).

"Your background too can influence you to be vulnerable to being infected by HIV and AIDS. You may have grown up seeing your female relatives involved in prostitution. This can result in you also deciding not to get married and prostituting yourself for survival. You will however end up being infected by the virus. So, your upbringing can influence the way you lead your life later on in life, what you see as you are growing up may become your way of life" (FGD2 Harare, high-density).

"There are cases where the husband can convince her wife to prostitute herself in order to generate income for the sustenance of the family" (FGD Harare, low-density).

"The other reason women are at risk is because men who are circumcised believe that they are not capable of transmitting the virus. They claim that when one is circumcised there is that chance/percentage that protects them from getting infected. Circumcision is also now making men to be careless as they now know there is medication for HIV and AIDS" (FGD4 Harare, medium-density).

"Even when a woman has not been badly influenced by friends, her husband can go to a pub and he will sleep with other women. Men have this belief that a man cannot sleep with one woman all the time, 'a man can't eat the same meat everyday' so they say. So, that husband will have those different types of meat (that is, women)" (FGD7 Bulawayo, medium-density).

"Dressing can also be a contributor. Women are going around without being properly dressed. They move about scantily dressed with their underwear showing, surely men get tempted" (FGD1 Harare, high-density).

"Poverty can influence women to be vulnerable too. You can be in a situation where you have no husband or your husband may be there but they are not working. The family will be in abject poverty. This situation can force a woman to get into prostitution so she and her family can survive. She is also easily lured into having unprotected sex in order to get more money to buy groceries for the family" (FGD2 Harare, high-density).

“There are ‘blessers’ too. These are rich guys who bless you financially in exchange of sex. These men will buy you whatever you want. So, there is this married man, you don’t even know what he has been up to for the past years in his life, he comes and buys you a phone, clothes, we are always driving in his expensive cars and he takes me for shopping. So, there you are drowning in this life of luxury. And so, for me to tell him or ask him to go for testing, it becomes impossible because I am thinking maybe he will leave me for someone else. So, you will find these girls are stuck there and just enjoy being pampered and can’t even ask the blesser to go and get tested” (FGD5 Bulawayo, low-density).

“Long distance relationships/marriages may also put women in a vulnerable situation. Your partner/husband can be away in the diaspora for long periods of time at any given time. We are but just human too. I have needs/feelings and this may lead me to have a boyfriend. After a while you can gain trust with that boyfriend and end up having unprotected sex” (FGD2 Harare, high-density).

4.5.4.4 Sub-theme: Blame/fault perception

Blame or fault perception was an attempt to consolidate the women’s perceptions on who was to blame for the HIV epidemic. Responses were varied, with most blaming women or holding the belief that everyone is at fault. A few felt it was men’s fault. Some singled out specific populations, such as those living in border towns, HIV positive mothers, young women, young boys and the Apostolic sect who encourage child marriages. The need for money and lack of employment was mentioned also as an underlying factor driving women to pursue transactional sex; social media was also blamed, as well as poor communication between couples:

“The apostolic sects for example have this culture of marrying off young girls to older men. You can find 11 or 12-year olds being married off. The man is told that they can have the girl grow in their care. You will find that, the man that this girl is being married off to was not even tested for HIV. Even when the man knows his status, he will not disclose it and continue to marry the young girl. I believe these churches are also responsible for the spread of HIV and AIDS” (FGD7 Bulawayo, medium-density).

“People living in border towns, for example Beitbridge, Plumtree, Gwanda, Nyamapanda, Victoria Falls, etc. are responsible for the spread of HIV and AIDS.

It's easy to get money in these towns, you can even find school children staying at lodges with married men" (FGD7 Bulawayo, medium-density).

"Sometimes it's the mother's fault. Because when she is expecting and she is HIV positive, she does not go to doctors so they can help her prevent the virus infecting the unborn child" (FGD8 Bulawayo, high-density).

"This is my opinion; I think it's us young women who are responsible for the spread of HIV in Zimbabwe especially those girls who are chasing for money from blessers. I may be 21 and the blesser can be 45 years old, so you can imagine the age difference. All these years, I don't know what he was doing, how many people he has been sleeping with and I will get infected by him. The blesser will have more than one woman that he sponsors and will infect these women. Besides the blesser, I may also have a boyfriend who is 22 years old and I in turn will infect him" (FGD5 Bulawayo, low-density).

"I think everyone is at fault. You can't point a finger and say it you and you. At the end of the day I can defend myself and say I am young lady and I saw this man who happens to be older and he just happened to propose to me and I accepted. So, I think it's all of us. Everyone is responsible for their actions" (FGD5 Bulawayo, low-density).

"Both women and men are at fault because they are capable of cheating. An innocent partner can be infected by a cheating partner" (FGD1 Harare, high-density).

"Women are denying their partners conjugal benefits due to an assortment of reasons. As a result, men will go and find other willing sexual partners to satisfy their needs" (FGD1 Harare, high-density).

"There are more women than men and I believe it's the women's fault that HIV and AIDS is spreading. The way women dress leaves a lot to be desired. They don't seem to want to formally work lately preferring to stand by street corners. They are just after money" (FGD1 Harare, high-density).

"If the government could intervene so that we can get jobs or have projects that we can be involved in to as to generate income. If these women that we suspect

are going out with our husbands could be involved in some kind of projects too, maybe they could stop sleeping with our husbands” (FGD1 Harare, high-density).

“I think it’s the sugar daddies’ fault. They are the ones who are getting involved with young girls. These girls are vulnerable because they are lured by money to buy all sorts of goodies. Their poor backgrounds make them vulnerable. Some of the sugar daddies are already infected and they can give large sums of money to these poor girls in exchange of unprotected sex. These girls end up unknowingly getting infected with HIV. By the time they get married, they are already infected and will go on to give birth to an infected child. These girls will also infect their husbands, that is, if she does not go for testing before getting married” (FGD2 Harare, high-density).

“These days there is what is called “shama time”. This is when young women dress scantily during summer. You will find young women putting on bikini like shorts, the kind of shorts that are put on by Beyonce when she is on stage. Others will put on very short dresses which are supposed to be put on with tights. So, indeed, the women’s suggestive dressing is at fault” (FGD2 Harare, high-density).

“The new “WhatsApp and Facebook craze” too is at fault. It can lead women into rekindling old affairs. The woman will end up cheating with an old flame. This new technology is at fault if it is misused” (FGD2 Harare, high-density).

“It’s difficult to put blame on anyone because the young wives are also now promiscuous, some to the extent of turning to prostitution. There is this attitude whereby wives are now saying, if men are capable of having extra-marital affairs what also stops them from doing the same. In fact, it was very rare to hear of wives having affairs. You also have men claiming that it is a known fact that men cannot have one partner. The men claim that even in the Bible, Samson and David had multiple wives. So, wives are supposed to accept this situation and they should be grateful that they are the ones in marriage” (FGD4 Harare, medium-density).

“Haaaa, it’s difficult to fault anyone because everyone is capable of spreading the virus. If it were possible to blame the woman and say a man is not capable of spreading the virus, then we would have the woman to blame. A single woman is capable of spreading the virus just like a single man is also able to spread the

virus. Married people are also capable of spreading the virus. So, everyone is to blame” (FGD4 Harare, medium-density).

4.5.5 Theme 4: Context

The context theme is divided into sub-themes of Community involvement, Spirituality, Socioeconomic status, Culture, Government policy and Young urban women’s context.

4.5.5.1 Sub-theme: Community involvement

The respondents felt that the community has a vital role to play in communicating HIV and AIDS issues. Clinics were the most frequently mentioned member of the community named as playing a pivotal role. PLHIV and pregnant women are given teachings and lessons, free HIV treatment at local clinics and at times food assistance for HIV positive people, and this was commended. New Start Centre staff have been seen at soccer matches offering free testing and counselling. An organisation called Youth for Today and Tomorrow (YTT) as also said to be active in the community from time to time with regard to HIV and AIDS awareness. Several women felt that the community is not involved in anything related to HIV and AIDS.

Recommendations for community involvement included forming support groups which meet regularly. These platforms can then be used to teach women on how to use the female condom, and be given other necessary information. The need for occasional community gatherings, whereby people share information and are taught on issues related to HIV and AIDS, was highlighted, including making use of available community halls and organizing workshops. Churches were also seen as being able to play a significant role in communicating HIV and AIDS matters, as the religious part of a community: The reason given was that most of the population are church-goers. In addition, platforms such as youth meetings in churches could be used to communicate information related to HIV and AIDS.

It was suggested that the municipality could put condoms in public toilets so that access to them is facilitated. The community was encouraged to desist from despising PLHIV, which includes discrimination and stigma.

One respondent felt that here is more being done in rural communities than in urban communities.

Door-to-door awareness, education and HIV testing was another recommendation to cater for the shy ones in the population, who find it challenging to walk in New Start Centres:

“The clinics might be playing a role, but it may only benefit those who go to the clinic for treatment or baby clinic” (FGD2 Harare, high-density).

“Communities or people in general, there is still need for people to change the way they treat people with HIV and AIDS. I think discrimination and stigma is still there and we have to find ways as communities to get rid of it” (FGD5 Bulawayo, low-density).

“There is this other day when I went to the local community clinic, I was going to get my daughter immunized. I noted something unsettling when I got to the clinic, I would want to equate it to discrimination. Those who come to the clinic to collect HIV and AIDS treatment are given distinct medical cards, they are green/blue in colour. If you see someone at the clinic carrying a green or blue card, you immediately know that they are taking ARVS or TB medication. I think, there should be uniform cards for all patients who visit the clinic so that there is no discrimination of people with HIV and AIDS or TB. At the end of the day, it should be an individual’s prerogative to divulge their HIV status. Those blue/green cards should not be imposed on people so that everyone knows that they are taking ARVs, I don’t think it’s fair” (FGD5 Bulawayo, low-density).

“I have also seen that when I visit my mom at the local clinic. I have seen people carrying the green/blue cards. But when I gave birth at United Bulawayo Hospitals (UBH), everyone got their medication from the same room. Infect the distribution of ARVs at UBH is done discretely, the medical cards are kept in a room and the health worker in that room is the only one who will access your card, in the privacy of that room. Patients queue outside that room and they go in one by one, by so doing no one will know what you are being treated for” (FGD5 Bulawayo, low-density).

“Of late I am not seeing the community playing any role because we no longer see them doing anything” (FGD7 Bulawayo, medium-density).

“The community should call and address people in different age groups and gender. People will just stay indoors if they are not invited to these meetings” (FGD7 Bulawayo, medium-density).

“Yes, we have seen people campaigning. I am not sure from which organization they were representing. I have seen these women come into the community and mainly targeting expecting mothers at their homes” (FGD8 Bulawayo, high-density).

“An organization called YTT- ‘Youths for Today and Tomorrow’ organises some camps. This organization holds workshops and arranges camp meetings for young people. And so, during the workshops and camps, they teach the youth about HIV and AIDS” (FGD8 Bulawayo, high-density).

“Of late I don’t see the community playing any role because we no longer see them doing anything (FGD7 Bulawayo, medium-density).

“They should call and address people in different age groups and gender. People will just stay indoors if they are not invited to these meetings” (FGD7 Bulawayo, medium-density).

“But most of the time if you are not sick or expecting, I will not go to the clinic. If no one approaches me with that information or even if I am given a pamphlet, I will not bother” (FGD6 Bulawayo, high-density).

“I would want to see more information in the streets, protection should be availed everywhere including public toilets. Asking or buying condoms can put one in an embarrassing situation, it gives the perception that you are a prostitute. So, by putting condoms at public toilets, no one can claim to have been embarrassed to ask for or buy a condom” (FGD4 Harare, medium-density).

“We have seen those who are already on treatment going to the community hall for educative programmes where they are also given food, etc.” (FGD1 Harare, high-density).

4.5.5.2 Sub-theme: Spirituality

Spirituality was seen as having a role in HIV and AIDS, by all respondents. The contention was that some religions and pastors have a negative impact while others have a positive one. The general perception is that most people are church-goers. A recommendation

was made that youth meetings, men's and women's in churches could be used to communicate information related to HIV and AIDS, and that churches should organise workshops on HIV and AIDS teaching their congregants. Another suggestion was for the curriculum at Bible schools where pastors are trained, to include modules on HIV and AIDS and counselling such that they are trained to deal with these issues at church with their congregants:

"I think that people should understand we are Christian, yes, we teach abstinence, yes. But the reality is we are people with flesh and blood and I can't tell someone to abstain. It's one's choice to abstain. I can't force you to abstain. Then if you choose to abstain, how can I help you? What attitude should one have? At the end of the day, we chase people away from church and yet the church is supposed to welcome everyone" (FGD5 Bulawayo, low-density).

"Churches do teach people about HIV and AIDS although the only challenge is that church leaders at times encourage those on treatment to stop taking medication and trust the Lord to heal them. But we all know that it is written in the bible that there is a disease that will infect people and that disease will not be curable. So, you will find someone who was on treatment heeding the church leader's advice and end up stopping to take their medication and the consequences are fatal. They end up dying. I would have preferred a situation where church leaders encourage people to continue with their medication as they continue with their gospel" (FGD1 Harare, high-density).

"But there are different kinds of Apostolic sects. I saw that "Positive Talk" show hosted by Tariro where this one apostolic sect discourages polygamy, they go to the clinic and they forbid child marriages" (FGD2 Harare low-density).

"The Johanne Marange apostolic church is the one that is known for polygamy, child marriages and their members do not go to the clinic. The women have a lot of children. The sect leaders are known to be promiscuous, they can sleep with female patients in the pretext that they are healing them. Resultantly, women are easily infected with HIV" (FGD2 Harare low-density).

"It is possible that the pastors may not have enough information because to them they will be thinking that maybe it's a disease or it's an illness that is not supposed to attack a Christian. They even say the disease is associated with demons...so,

at the end of the day, if I am exposed to the virus, it then becomes hard for me to go to the New Start Centre because if I were to be found to be HIV positive, then it means I have a demon” (FGD5 Bulawayo, low-density).

“The other thing is I think churches should hold HIV and AIDS workshops and not only concentrate on the bible only. I remember when I was at a youth camp, there was an HIV and AIDS workshop held. They shared on how to live positively and stuff like that. I think churches should adapt to that mode” FGD5 Bulawayo, low-density).

“I also think pastors should be counsellors. Some people are comfortable confiding in the pastor than going to a professional counsellor” (FGD5 Bulawayo, low-density).

“I believe the church is taking a leading role in explaining and teaching people about HIV and AIDS. At church, you are encouraged to behave well and not commit sin. So, if a pastor continuously preaches this, the message may get through and change people’s behaviour. Even those in prostitution could fear the word of God and mend their ways. So, if people go to church more often, they may end up putting their energy on church business and avoid such earthly stuff as clubbing. If you continue going to church you will fear God and the more you fear God the more you will desist from doing those unholy things” (FGD4 Harare, medium-density).

“The other good thing about attending church is that there are different sessions for the youth, couples, men and women. At the couples’ sessions, a husband gets to discuss the challenges that he is facing with his wife. This is done in front of other couples and as a result the wife will be taken to task. This helps to change her ways because you cannot have a situation where you are the topic at every church service. A wife too can talk about the challenges she faces with her husband and the problem is discussed and those present may suggest the way forward and encourage good behaviour because surely a husband cannot, for example, come home late every night and say he was with friends. This is where the problem starts and this is where infections come from” (FGD4 Harare, medium-density).

“...The youth are also taught about good behaviour at church. The church discourages fornication and adultery. Most of the time people get infected by the virus because of their loose morals, although of course there are those who still get infected even though they don't have loose morals. So, if the church could continue preaching the word of God, it will help us to even look after our HIV and AIDS ill relatives. The church teaches us to love one another including those who are not well and to support those who have ill relatives” (FGD4 Harare, medium-density).

“My recommendation for religious groups or churches is that as much as they are teaching abstinence, they should also accept the fact that not everyone is going to abstain. So, at the end of the day, let us not discriminate against those that are not abstaining, but instead, help them to protect themselves from HIV. Because as long as we are acting as if everyone is abstaining and then at the end of the day we get people who are positive when we could have given them information about protecting themselves. That is my recommendation” (FGD5 Bulawayo, low-density).

“My comment is similar to what has been already mentioned. I have noted that a lot of people in the church are dying because they are in denial. You can hear someone saying my husband died of a headache, it can't have been HIV and AIDS. The wife can even go on to claim that her husband was bewitched. I know of a woman who died due to denial. We encouraged her to go for testing but she would refuse because she thought that once she went for testing everyone at church would know that she was HIV positive. As a result, she preferred to just die. It was so sad. It seems people are so afraid to go for testing. There is this fear” (FGD5 Bulawayo, low-density).

“I think I would recommend that, religious leaders, the pastors, be trained on how to handle HIV and AIDS and protection” (FGD5 Bulawayo, low-density).

“Although you are carrying out a scholastic research, I wish the government would also carry out such research where people would go into the community so that they hear what are people's expectations in terms of HIV and AIDS reduction” (FGD6 Bulawayo, high-density).

4.5.5.3 Sub-theme: Socioeconomic status

The socioeconomic status of women in the urban areas was seen by almost all the respondents as being relevant in relation to HIV and AIDS matters. Life was said to be very hard for women because of the lack of jobs and no money. For those working, some companies were failing to pay their workers their salaries while some bosses were demanding sex in exchange for a job. In as much as there is women empowerment, men were viewed as still having greater opportunities and making more money than women. Due to these reasons, women were said to be resorting to sex work in search for income, making them at high risk of contracting the HIV virus. Some women look for blessers. Income-generating projects for young urban women was suggested as a solution:

“You can have a situation too where some of the young girls who are not yet working are put under pressure by parents when they are told to bring food home. This will drive that young girl to now go out there to look for blessers in order to bring food for the family. Instead of encouraging the young girl to find descent ways of making money, for example dressing making, hair dressing, etc., parents drive these young girls to go out there and get into prostitution” (FGD1 Harare, high-density).

“There is a shortage of money these days. Even when you try to start a vegetable market you face challenges because people have no money to buy the vegetables and the produce will end up rotting. We are at a loss as to what to do” (FGD1 Harare, high-density).

“I think it drives people to do things that they later on regret in life. Poverty can drive anyone to do silly things. If you want money, you would have to find ways of getting it to survive one way or the other...someone once said if she lost her job and had no money, she would go into prostitution because it doesn't need any capital to start whereas selling tomatoes needs capital” (FGD5 Bulawayo, low-density).

“The socioeconomic situation prevailing at the moment has forced women to find other means of making a living. Lack of financial resources leads to HIV and AIDS. If the financial situation in this country was stable, women would not be tempted to prostitute themselves in order to survive” (FGD2 Harare, high-density).

“In my opinion, I do not think it’s about whether someone is able to sustain themselves or not, it’s about upholding your morals as an individual” (FGD3 Harare, low-density).

“If you look at the urban woman here in Southerton, you will find that most of them are not working. Women have personal needs and these include even sanitary ware. This is the reason you will find women of our age group going out with sugar daddies in order to get some kind of income. Financial challenges are putting women in vulnerable situations. If we could find projects to do and be able to look after ourselves, we could minimise our chances of being infected by the virus” (FGD4 Harare, medium-density).

“A woman can get a part time job as a maid, but again you can get into a situation where the man you want to work for lures you with a higher wage if you have unprotected sex with him. Because of poverty, you may end up submitting to his demands and in the process, get infected” (FGD5 Bulawayo, low-density).

“...And then economically men generally earn more. They make more money. Nowadays there is “women empowerment”, but we are not yet there. We do not have equal opportunities. Even in a family set up, if there is a boy and a girl, who gets to have their school fees paid for first? A mother will think about paying her son’s fees first because there is that thinking that the daughter will eventually get married and the husband will take care of her. Economically we are challenged and this puts us at the weak end, as a result we are then not able to negotiate. More so, if you are a housewife and your husband is taking care of you. When your husband comes back home, can you then say, “Let us use condoms”. The husband would then quiz the wife and say “So you want to use condoms in my house? This is my house, I am the man of this house”” (FGD5 Bulawayo, low-density).

“Young girls may fail to go to school because they are poor or don’t have the resources to go to school. That child may stay at home and she will have an idle mind and the next thing she thinks is to look for men. By looking for men she may end up in prostitution and spreading the virus” (FGD6 Bulawayo, high-density).

4.5.5.4 Sub-theme: Culture

There were some cultural practices in Zimbabwe identified as either harmful and promoting the spreading of HIV, while others were deemed good, for HIV and AIDS. The former dominated.

The good practices, according to the women, were: abstinence; *kudyisa murume* (use of love enhancing concoctions usually put in the husband's food without the knowledge of the husband) so that the husband loses affection for any other woman except for his wife only; *kusunga-rukahu/runyoka* (commonly referred to as central locking system, whereby the wife uses herbs from witchdoctors such that her husband fails to get an erection when he wants to get intimate with any woman other than his wife; *chinamwari*, (this is when adolescent girls are taken away from their homes for some time to some place in the bush where they are taught various things related to how to treat a husband); male circumcision in certain areas in Zimbabwe; upholding of good morals; discouraging sex before marriage as well as discouraging cohabiting; being education oriented.

The harmful cultural practices were: witchcraft ideology - the idea of thinking that witchcraft is always the cause of sickness even if it is purely HIV; *chimutsa mapfihwa* - when a young sister or niece inherits her late elder sister's or aunt's husband; *kugara nhaka* - a young brother inheriting his late brother's wife (widow inheritance); submission of the woman in the sense of always having to do what the man wants; polygamy (*barika*); arranged marriages including child marriages; incisions (*kutemwa nyora*), group ear piercing using one pair of needle; *chiramu* (uncles caressing their nieces and or man caressing the young sister of his wife); pressures from parents, home, church and society exerted on women to get married at a certain "cut off" age such as at 25 years; a culture of the Kalanga people in Plumtree area where the new daughter-in-law is made to have sexual intercourse first with the father in law before sleeping with her own husband; prolonged periods of not engaging in sex for reasons such as abstaining during some of the pregnancy period and just after a wife gives birth, and a practice where the husband lives in the urban area while wives stay in the rural area, thus separating married couples; going out with older men for money and/or material things (transactional sex); relatives looking after children.

Some of the women were aware of cultural aspects being incorporated in HIV and AIDS communication through dramas and talk shows, whereby HIV and AIDS issues are discussed to a considerable extent. One such show is *Chakafukidza Dzimba Matenga* on

Radio Zimbabwe. It was recommended that the time allocated to these programmes be increased. Some did not know to what extent cultural aspects are incorporated in HIV and AIDS communication:

“Yes, these are some of our traditional cultural habits that we learnt as we were growing up. We were advised to give our husbands love portions and “lock” them. The portions are called ‘rukawu’. If your husband went on to have an affair, they would not be able to perform in bed with the other woman and it would force them to go back to their wife. If another girl/woman slept with your “locked” husband, she would fall ill. She would have what is called ‘runyoka’” (FGD1 Harare, high-density).

“The cultural customs that are incorporated in these dramas/programmes are shown for a short time” (FGD2 Harare, high-density).

“The other cultural custom is when my daughter goes to stay with my aunt (Tete). My uncle may be attracted to my daughter and go on to rape her and be promised marriage upon the death of my aunt. Unfortunately, my uncle may already be infected with HIV and AIDS and could infect my daughter. I think this culture of having one’s children being looked after by relatives because of poverty should be discouraged as it also promotes child abuse and the spread of HIV and AIDS” (FGD4 Harare, medium-density).

“While ‘Chinamware’ is good in terms of making sure that young girls remain virgins until they get married. As girls turn to be young women they are also taken to the bush where they are taught about womanhood among other things. After their initiation, they come back and a ceremony is held on their behalf. At the ceremony, it is announced that the girls are still virgins and the parents of these girls feel proud of their daughters. However, it is not all the girls that go for the initiation and are found to be virgins. Those girls who are found no longer virgins, they shy away from the ceremony and their parents to stay away in shame. As a result, girls were forced to abstain and remain virgins. A cow was then given to the girl’s parents in recognition of her virginity when she got married. Today’s girl child is maturing too early, is cleverer and some of her behaviour is influenced by what she sees on social/mass media. So, if these girls go through ‘Chinamware’, they may end up practising what they would have learnt during initiation due to peer pressure. Because of this, I now have reservations about this ‘Chinamware’

custom. I went through 'Chinamware', my grandparents are of Zambian and Malawian origin. I think this practise is making those girls who went through the initiation want to indulge in sex because they want to practise what they would have learnt. They may end up being infected and as a result the virus continues to spread" (FGD4 Harare, medium-density).

"The 'Chinamware' culture is incorporated in the mass media because abstinence is incorporated in the HIV and AIDS information. On television, you can see messages where it is said abstinence is the only sure way of making sure you do not get infected with HIV and AIDS" (FGD4 Harare, medium-density).

"There are incorporated in some of the dramas. An example is where they talk about a widow being inherited by the late husband's brother, 'kugarwa nhaka'. By so doing the widow may be inherited by someone who is already infected by HIV and AIDS" (FGD1 Harare, high-density).

"Once I saw a drama on ZBC, I however have forgotten the name of the drama. The main theme of the drama was HIV and AIDS. There were sugar daddies in the drama. They portrayed this girl who was descent and was from a poor family. She ended up getting a blesser because all her friends also had blessers. Unfortunately, she was the only one who got infected with HIV because she did not know what to do. The girl died and her friends survived. At the end of the drama they would then say if you don't protect yourself this is what is going to happen to you. There was also a message that said, "HIV and AIDS, stop spreading it. Take care of yourself, condomise and do not date sugar daddies" (FGD5 Bulawayo, low-density).

4.5.5.5 Sub-theme: Government policy

Most policy and government involvement was work being done through health institutions such as public-sector hospitals and clinics, and through collaboration with NGOs and donors. Some organizations were said to donate food hampers and handouts to HIV positive people, and to distribute condoms. Others could identify with Government partnering with organizations to do free HIV counselling and testing, treatment at clinics and awareness programmes such as road shows campaigns to reach communities. Awareness activities were said to be carried out at primary, secondary and tertiary level. One of the respondents highlighted at times seeing police moving around in the community and schools doing door-to-door awareness education. A few alluded to laws

that were passed and which help counter the spread of HIV. One respondent suggested the passing of a law banning sex work.

Recommendations included that government, though helping a lot, should decrease the lead time from the stage of getting tested and onset of treatment as it is currently too long, and that they should continue assisting patients with free medication and food handouts since most of the population is unemployed and has no money:

“The government initiated that condoms be distributed for free at clinics. UN agencies such as UNICEF donate condoms to the government for free distributions at health institutions. UNICEF also donates family planning pills to the government. I am however not so sure about the government’s interventions in terms of HIV and AIDS. The government should encourage people to go for HIV testing after every three months. Children should be encouraged to abstain from sex until they get married” (FGD2 Harare, high-density).

“Government should also deploy people trained in the field of HIV and AIDS into the community so that they educate us on HIV and AIDS. By so doing they also get to know the living conditions of people” (FGD2 Harare, high-density).

“I am not sure if AIDS awareness is still there at schools because these were available at schools when I was still at school. This was another way by government to educate pupils about HIV and AIDS so that by the time I went to high school, I was already aware of HIV and AIDS. I also joined a HIV and AIDS group at school because I was already empowered and had knowledge about HIV and AIDS” (FGD5 Bulawayo, low-density).

“The police, magistrates, prosecutors etc. do not help us. They are actually responsible for spreading the virus” (FGD7 Bulawayo, medium-density).

“She is saying it seems prostitution is now being allowed because they are not being arrested. Although the law says they must be arrested, the law agents, however, are not arresting those engaging in prostitution” (FGD8 Bulawayo, low-density).

“The police move around our schools and residential areas passing on information through loud speakers” (FGD6 Bulawayo, high-density).

"I am not sure if you can say its communication, but I understand if you infect someone with HIV you can go to jail" (FGD5 Bulawayo, low-density).

"I know the government has banned early child marriages. Those involved in early child marriages are arrested. This minimises the spread of HIV. That act has made people not to practise this culture of early child marriages" (FGD4 Harare, medium-density).

"I would want to find out what the constitution says in terms of when the girl child can get married? Should they get married at 16 or 18 years of age?" (FGD2 Harare, high-density).

"I have seen awareness campaigns at tertiary institutions. I have also seen personnel from New Start Centre at these institutions conducting free HIV testing. They also educate students on HIV and AIDS. I have however not seen any awareness campaigns targeting urban women of our age group who do not attend college. I think those at tertiary institutions tend to benefit from these campaigns. So, those at home only get HIV and AIDS information through the mass media" (FGD4 Harare, medium-density).

"I have however seen such campaigns in the high-density suburbs. Such campaigns are few in the low and medium density suburbs. There are also road shows in the high-density suburbs. They are done by health workers from clinics and hospitals. Those in the high density seem to benefit more" (FGD4 Harare, medium-density).

"I want to find out if government can't help couples who are HIV positive and are unemployed. They are dying early because of poverty. They are taking the ARVs on empty stomachs. Government should send health workers out to access the situation on the ground so that those in need of food can be helped out" (FGD2 Harare, high-density).

"I am always confused about the visually impaired. Can the government not intervene because I have observed that they keep having babies?" (FGD2 Harare, low-density).

"Children of the visually impaired couples live in the streets and their parents are not able to adequately look after them because they can't see. Their girl child may

end up getting into prostitution for survival because that is their only means of survival as they would not have been able to go to school” (FGD2 Harare, low-density).

“I wanted to say that if government or NGOs could help the communities to hold workshops where people are taught about HIV so that people don’t discriminate each other. I believe this discrimination is the reason people are in denial. People in communities should learn to support each other rather than discriminate each other. I also think that there is need to teach women on how to use the female condom. There are pros and cons on the use of the female condom. There is need for people to live in harmony with those who are HIV positive especially at schools” (FGD5 Bulawayo, low-density).

4.5.5.6 Sub-theme: Young urban women’s context

The young urban women’s context had overlaps with some of the other themes and sub-themes previously mentioned such as Socioeconomic status, Spirituality, Vulnerability and Culture. The environment in which the women live was described as still male chauvinistic with women being inferior to men and being expected to submit to their husbands. This notion was described as making women vulnerable, compromises women’s confidence, and makes it harder to negotiate on certain aspects. Also, in as much as there is women empowerment happening, men still have greater opportunities and making more money than women.

Unemployment leading to poverty was the main reason driving women to engage in sex work, especially given because it has no capital investment like other businesses. Those not work become idle and begin relationships with older men – blessers or becoming ‘small houses’. Some are resorting to prostitution, whilst some get into early and or rushed marriages seeking economic refuge. Some women are even thinking of going back to rural areas because of the hardships and stress being faced.

One of the hardships cited is not being allowed to work despite some husband’s income being inadequate. Some households are struggling to take care of basic needs such as food, clothing and school fees. At the same time, competition and peer pressure is rampant. At the same time, it was also said that young urban women are more education-oriented and are empowered and venturing into the business world. Unfortunately, related to education, at colleges, some students are using sex to pass their examinations, including at times for all qualifications. Those with jobs may also use sex to secure a job

and stay at the job. The challenge comes when some are not educated and do not have a career, making marriage the last option. Some women are hardworking and resort to vending and buying and selling. But in general, the life of a young urban woman is very hard.

The competition also comes in the form of attracting boyfriends, which entails in part early sexual debuts among young women:

“At times, our husbands do not want us to work. They want us to stay at home looking after the children and doing household chores. It gets to a point where I don’t even have money to buy my children clothing and the food is not enough” (FGD1 Harare, high-density).

Seeing other women prosper makes us envy their lifestyles and this puts us in risky situations as we try to emulate their fancy lifestyles (FGD3 Harare, low-density).

“I can give you mine. I think that the generation that we have now, most of us are now more educated and more career driven. Of course, the pressure is there, the society exerts pressure on us to get married but now we know that I have to get my Master’s degree, my PhD. These are the things that we are now looking forward to. It’s not like before when you just got a diploma and you are done. Nowadays when you get your degree you start thinking about getting a Masters, a PhD. Women are now pushing more and I think that we are more empowered than the women before us. Not that there was anything wrong with them, but I am just saying that women are getting more and more empowered as young woman. Even businesswise, women are now running flea markets, etc., women are running businesses at 25. So, I think that we are now more empowered” (FGD5 Bulawayo, low-density).

“When you didn’t get the chance to finish school, you are expected to be pretty enough to score a rich guy. That’s basically the point, because you are not going to bring bread on the table. All you are going to do is household chores, have beautiful hair, nails, in fact you will be like a “trophy wife”. You are nothing without the husband. That’s the life you would probably lead” (FGD5 Bulawayo, low-density).

“Nowadays you have to use your body to get a job. It’s not a good thing to do though. I don’t know how the issue of bosses and the sugar daddies can all be

handled. You can find a job but if you do not sleep with the boss, you will not get that job. So, at times you might find that just being seated at home is better” (FGD7 Harare, medium-density).

“Women in this age group are very sexually active. She enjoys having a lot of sex. If she fails to control herself, she can end up sleeping around. When women of this age group start sleeping with men they will not stop, when they break up with the first man they sleep with, they will go on to look for another sexual partner. Older are different, they are able to control themselves and will abstain from sex and just look after her children. It’s difficult for women in my age group to just forget about sex” (FGD4, medium-density).

“Many of us are unemployed. There are university graduates amongst us and they are not employed. We have needs ranging from clothing, food, cosmetics, etc. and this results in us getting involved with all sorts of men. There is peer pressure too. Our age mates are getting involved with men so as to survive. A woman can have a boyfriend and still go on to have an affair with a sugar-daddy or a married man. All these men financially support her. In other words, she is the small-house. I will end up copying my friend’s lifestyle and also start having affairs just like my friend. This puts us at risk as we will end up being infected with HIV” (FGD4, medium-density).

“Haaa life is good!” (FGD8 Bulawayo, high-density).

“We run around for men a lot” (FGD8 Bulawayo, high-density).

“The other thing is money. You know us women at times we are lazy to work and we are attracted to money... I believe women should be independent and not depend solely on men” (FGD5 Bulawayo, low-density).

4.6 Key informant organizations

Five key informants were interviewed from different organizations; three NGOs and two government bodies. The NGOs were PSI, SAfAIDS and Organization for Public Health Interventions and Development (OPHID). The government bodies were NAC and MoHCC (AIDS & TB Unit).

4.7 Results for key informant interviews

The key informant interviews were of a face-to-face and in-depth nature, after first obtaining the necessary permissions. No recordings were carried out for these interviews, and a structured open-ended interview guide was used. Accuracy for these interviews was established through member-checking, and where necessary, via emails by asking for clarity (asynchronously) as well as synchronously (using WhatsApp) and using the telephone (Onwuegbuzie 2016:14). Quotes from emails from one NGO and from one government entity are shown later in this section. This was all done by the researcher. There were three themes that guided the interviews, and the same themes were used for data analysis – unlike for individual interviews and FGDs; Perceptions and beliefs was the only theme excluded from the key informant interviews.

Table 4.10 shows the themes and sub-themes resulting from the key informant interviews. There were no categories for the sub-themes.

Table 4.10: Themes and sub-themes for key informants

Theme	Sub-theme
1. Communication	Role of NGOs and Government
	Communication channels
	Interpersonal communication
	Population with highest HIV prevalence
	Research
	Barriers to information dissemination
2. HIV and AIDS knowledge	HIV and AIDS information and knowledge
	HIV and AIDS champions
	Epidemic drivers
3. Context	Young urban women's context
	Government & policy
	Regional cooperation
	Spirituality
	Gender
	Socioeconomic status
	Culture
Community involvement	

4.7.1 Theme 1: Communication

Communication is the first theme that is classified from the key informant interviews. It is divided into six sub-themes: The role of NGOs and Government; Communication channels; IPC; Population with highest HIV Prevalence; Research; Barriers to information dissemination.

4.7.1.1 Sub-theme: Government and NGO roles

- Government

The GoZ relies on a structure whereby there is a Health Promotions Unit (housed within MoHCC) at central level, headed by the Deputy Director, and health promotion officers at provincial and district level. The unit's role is to carry out health promotion, coordinate at community levels such things as awareness campaigns and training of health/village workers/behaviour change workers. These community level workers are the ones who translate health issues and mobilize the community.

There is a public relations office at central level (headquarters), headed by the Public Relations Manager, with no provincial and district representation. At the central level, media relations and event management occurs for all health issues. The Public Relations Manager is the link between the MoHCC and the media; they don't do programme work. However, there is some overlap between the work of the Health Promotions Unit and the Public relations Office.

It became clear in MoHCC that many issues related to HIV were present, therefore there was the formation of the Communications and Advocacy Officer post, to focus on HIV, in the AIDS and TB Unit, a directorate within MoHCC. This person works together with the Health Promotions Unit and the Publics Relations Office.

The role of the Communications and Advocacy Officer is to coordinate all communication in the HIV unit, and this includes working with partners. Their responsibility includes demand creation of HIV services, for example, compiling manuals for Village Health Workers (VHWs); formulating the strategy for demand creation; development of message concepts; designing IEC materials such as posters – they do preliminary designs and then take them for professional design after giving the colours, text, photos etc. This officer handles media relations for events and functions such as inviting journalists, updating them on HIV-related issues, and coordinating media sensitization trips with editors and journalists.

Other responsibilities involve coordinating communications to ensure accuracy, that it is factual and that it is up to date. MoHCC chairs the Advocacy and Communication Technical Working Groups and Policy Committees for HTC, PMTCT and VMMC. This is because partners such as donors and implementing partners cannot be left to coordinate communications on their own.

This position's role is broadening – it was initially HIV prevention-focused but now with new WHO policies, MoHCC is trying to secure funding for adherence communication, to handle such issues as the introduction of PrEP, and to dispel miscommunications. One key role is that the MoHCC encourages journalists to run stories through MoHCC to enhance and endorse them. A second government entity, NAC, was interviewed, one that, unlike MoHCC which has a broader role in health, is focused on HIV and AIDS.

NAC plays a coordination role in HIV and AIDS communication. It is part of the communication technical groups in MoHCC, which have subcommittees. Although it does not chair (stakeholders do), it is the Secretariat. NAC is in an informed position and finds out how a community understands topics. The Media and Publicity Committee, of which it is a part of, is informed by resources available, for example, it is known that adverts are expensive. NAC also runs programmes, and has its own strategy. Districts within the country do situational analyses and come up with priorities, that are then aligned to the available resources; hotspot mapping is done to determine the areas to focus on for HIV and AIDS interventions. NAC has previously met with the Chief's Council (represents each province), faith-based leaders such as pastors, the mining sector (through the Zimbabwe International Trade Fair), and with focal people in organizations. The meetings were with a view to share updates on HIV and AIDS issues and advocacy issues to focus on. Meetings have been held with parliamentarians, where they are asked about their plans and agreements on the way forward are reached. The budget is an issue, but where possible, the parliamentarians are given a 'sitting allowance', so that they are incentivized and asked what they will do in parliament for HIV and AIDS issues. Previously, workshops for Zimbabwe Parliamentarians Against AIDS (ZIPA) were held but they are no longer active. According to the Communication Director, this will need resuscitation. The role of the key informant interviewed (Director of Communication), is advocacy and communication, to facilitate publicity, networking and relations, and oversee programme communication.

- NGOs

Two of the UN family and one other NGO had agreed to be interviewed but were unable to meet for an interview because of competing engagements. Of the five key informants interviewed, three were NGOs who work within the communications domain, in addition to other responsibilities that they have in HIV and AIDS as well as in other areas, such as family planning. All of them work in partnership with government departments. The NGOs interviewed play a variety of roles in HIV and AIDS communication in Zimbabwe. Some of the roles are found in more than one NGO and will be described.

One responsibility is to design communications to create demand for products and services to increase uptake. It was highlighted that communication must be linked to behaviour, and translate into behaviour. NGOs form part of communication technical working groups for areas such as condoms, VMMC and gender-violence. Another role of NGOs is in giving technical support in communications, developing brand/communication strategies and goals for advertisements as well as guiding advertising agencies working with the ministry.

Research is a focus area for some, with an emphasis on identifying gaps and producing HIV and AIDS information that is evidence-based. NGOs work with donors, disseminate information through mainstream media and social media, conferences and workshops, and package information in different forms. The Media, Marketing and Public Relations Team Leader, who was one of the key informant interviewed at one of the NGOs, oversees organizational communication strategy and implementation in six countries: Zimbabwe, Zambia, South Africa, Malawi, Swaziland, Lesotho.

One of the NGOs, in addition to being a technical partner in the MoHCC's HIV care and treatment programmes and support communications, led the revival of the PMTCT communication strategy, and is involved in implementation of MoHCC's new communication strategy to compliment revised PMTCT strategy. They are part of PAC (Policy, advocacy and communication Technical Working Group) which strengthens the use and documentation of strategic information used to inform communications. In this organization, the Director of Programmes' responsibilities include overseeing the communication department.

4.7.1.2 Sub-theme: Communication Channels

The government entities interviewed make use of several communication channels for HIV and AIDS communication. It was highlighted though that mass media is expensive and relies heavily on outside funding from partners – it is mostly funded for programmes such as VMMC. Several radio stations are utilized. Radio is used in part to target Shona and Ndebele-speaking rural people on Radio Zimbabwe. Youth are targeted via radio programming on Star FM, Power FM and ZiFM. NAC annually meets health reporters from media houses for updates and emerging issues annually. Such issues include cancer, HIV and policy issues. Diamond FM is in a city called Mutare, and is also involved in HIV and AIDS communication. Music galas and HIV and AIDS launches make use of radio stations. The second commonly used channel is print media in the form of newspapers. All the key newspapers published weekly and daily are used.

The government considers the Zimbabwean All Media and Products Survey (ZAMPS) when doing their communication planning. They work with advertising agents who recommend specific radio stations and timing, for example advertising information at prime times.

Websites information is shown on social media – Twitter, Facebook and the government can interact with people there. Billboard usage is limited. Billboards are expensive – the rentals are high though the material production is affordable. For one of the government entities - NAC, they do not do posters, as they are more suited to organizations, though they are done in consultation with government. The reasoning is that they fall easily, unlike calendars which are more durable.

The NGOs interviewed also use several modes of communication for HIV and AIDS. Radio was the channel always mentioned first. Shows and sport are incorporated on the radio channels. Other channels are television, newspapers and supplements, posters, reports packaged as booklets, post cards, flyers, stickers on commuter omnibuses and personal cars (print media), in addition to outdoor media such as billboards and rank-impact signs by bus-stops. Social media is picking up, with them making use of WhatsApp, Facebook and Twitter, and websites. They have media briefings with journalists, so that there is accuracy and no sensationalizing – they encourage self-introspection as the goal of communication to the public. Road shows are classified as mid-media and include edutainment, music, dance (including competitions) and drama. Edutainment is a combination of entertainment and information provision. Mobilisers

present key messages. During these shows, service delivery- including HIV testing, STI screening, takes place. Sports functions are another opportunity used to share HIV and AIDS information. T-shirts, bookmarkers, IEC materials such as calendars are used in rural road shows whereby a mobile van goes to a community and stops for a several hours that day.

All the organizations named radio as the most effective mass media channel for young urban women. Reasons given include that this channel has more listenership than any other in Zimbabwe, and that it is also interactive, mobile, it can be listened to at any time, vernacular or a combination of languages can be used (unlike, for example, IEC materials which are expensive to do in all languages), and it is cheap. The interactive part comes about because instant feedback is possible through the link to being able to phone in or send a question or comment via WhatsApp. Put differently, one organization highlighted that it is difficult to attribute behaviour change to one channel and that a combination is required. This is where ZAMPS becomes useful. It reflects how many people are reached by the different media channels. The same organization that highlighted this makes use of this information and allocates adverts accordingly. Mass media is more for raising awareness and knowledge while IPC is needed for behaviour change. In IPC, there is need for strong foot soldiers and interpersonal agents.

The comments about newspapers was that you pay daily unlike with a radio. Currently in Zimbabwe, airways are opening-up more and can target specific areas. Other channels are sound cloud (online data storage space) and YouTube, whereby one can transmit and store, and livestreaming, where one can have a greater reach. Some of these may be donor-funded and cheaper.

There are a variety of radio stations in Zimbabwe. Radio Zimbabwe broadcasts in Shona and Ndebele. The radio stations suited to young urban women were said to be those broadcasting in English such as PowerFM, ZiFM and StarFM. Further to this, the public selects a station depending on the popularity of a given show at that time. The shows on radio work as information provision and there are calls to action.

Social media such as WhatsApp groups, Twitter, Facebook, and Instagram were highlighted as a popular choice that can also reach women who are on these, which would tend to be young urban women rather than those from rural areas

According to the organizations, the drawback of newspapers is said to be that they are no longer bought as they are now available online.

The least effective mass media channel was said to be television. The main drawback was that the ZTV has poor programming, resulting in the public watching just the news. In addition, more people watch digital satellite television (DSTV) rather than local television. In addition, billboards and newspapers were said to be not that effective, according some of the NGOs. Newspapers have the disadvantage of needing to be bought daily, unlike radio which is a once-off purchase. Although low to medium density residents can buy newspapers and can afford it, they mostly look for politics and adverts (their top news) and not health news; high-density residents are less able to afford newspapers, in comparison, and yet the majority live in the high-density suburbs.

The most readily accessible communication channel for young urban women was radio, for reasons similar those cited earlier. Radio is accessible on mobile phones and in commuter omnibuses used for public. Social media was also said to be accessible, through Facebook, Twitter, You-tube, WhatsApp. Television programmes on HIV and AIDS are uploaded onto Facebook and You-tube as short clips, and comments arise.

“Currently, I think viewership influence is low for TV in Zimbabwe because of the poor programming and poor programming content by our national broadcaster, ZTV. There is virtually no variety in the programmes they air and the station seems more interested in politics than responding to content that viewers would like to watch. In this regard, viewers will simply just with off from ZTV. It’s also important to note that the success of a TV station is also measured by the number of viewers and also this eventually also attracts a lot of advertising, thereby creating revenue for the station. the numbers of people who watch ZTV am sure has Significantly dropped - judging by the numbers indicated in the ZAMPS. Their influence as ZTV is also low because they have no local competition in terms of TV broadcasting and hence they have failed to lift their standards and hence they have very influence in the market. if you compare with radio, there are so many players now including private players and hence there is a healthy competition for the market share and hence each station ensures the highest programming content and quality as much as possible” (MoHCC).

Television is not used as much as it is costly and viewership influence low.

4.7.1.3 Sub-theme: Interpersonal communication

There was consensus with the government entities and NGOs that mass media creates hype or awareness, and creates the demand for IPC. Put differently, mass communication does not make people act on what they have seen; change in behaviour is linked to IPC. Adverts that are shown have a call to action or a take home message such as visiting the nearest community health worker (CHW), phoning, visiting a website, email etc. A specific example is that of a television show (later also posted on YouTube) called Positive Talk. At the end of the show, there is an encouragement to send an email to the to a specific email address and to call on phone numbers supplied, for those with further questions.

The government entities are involved in IPC in several ways. VHWs, employed by the government, are empowered to counsel at the community level.

“...community health workers have always been there in urban areas such as Harare, Mutare, Bulawayo, etc. However, they will not be called Village Health Workers - at times they are called City Mobilizers, depending on the type of cadre it is. Their mobilization strategies will also not be the same as in the rural areas, and you are likely to find these in the high-density suburbs than the low-density ones” (MoHCC).

NAC engages in IPC, which involves one-on-one interaction, at such places as the Zimbabwe International Trade Fair and Agricultural Show. NAC also has ‘NAC days’ within the provinces, set aside for interacting with the public.

NGOs also play a role in IPC in diverse ways. In rural areas, community-based communication takes place in the form of IPC agents, namely peer educators. These are the same as community based mobilisation officers – trained to go into the community, including to churches, schools, shops and door-to-door. ‘Mr Smart’ fun days, for HIV prevention through VMMC, take place: the entire community is gathered and community dialogues are held; the Chief and the people, nurse/doctors come and talk about key health issues in that community; HIV prevention services, such as HIV testing, take place. Other cadres employed include counsellors, communication and programme officers.

Urban IPC agents are also there for urban areas. However, community dialogues are difficult to implement in urban areas as these are not as closely-knit as the rural areas.

During conferences/other big events, tents are pitched and materials carried, in preparation for one-on-one interactions.

OPHID said it had 140 Clinical Referral Facilitators (CRFs) and is aiming at having one male and one female of each of these per facility, covering 700 facilities (in 11 districts) in conjunction with the Zimbabwe National Network of PLHIV. These people counsel and talk with people. Nurses are overworked and overburdened, so they refer people to the CRFs, who themselves are HIV positive. Questions asked cover such issues as whether the person has been tested for HIV, and whether if they are taking ARVs, they are having challenges. They are trained in counselling for new people who are HIV positive.

4.7.1.4 Sub-theme: Population with highest prevalence

There was consensus with all those interviewed, that the population with the highest HIV prevalence is that of adolescents and young women in urban areas. The most affected age group is women who are 15-24-year olds, followed by older men of 30-45 years. This trend is there because of inter-generational sex between these two age groups. Girls are engaging in sex when they are young. There is also a massive drive by this same age group of women of running away from rural areas and flocking to mining towns in a bid to look for money.

NAC is addressing this in part by promoting tertiary level and even Grade 4 – Form 6 (9-18 years) covers sexual reproductive programmes. Behaviour change programmes are also there and the Young People's Network (a district initiative) is coordinated and facilitated by NAC. NAC has also met with Ministries of Tertiary and Higher Education and Primary and Secondary Education to train teachers and focal people in schools. NAC comes up with the strategies while the education ministries are the implementers.

4.7.1.5 Sub-theme: Targeting of young urban women

Clarity was sought on what organizations are doing to specifically target the urban Zimbabwean woman aged 20-29 in terms of HIV and AIDS communication.

One of the NGOs stated that this population of young urban women is the most neglected population and that most interventions are for rural areas and hard to reach areas. Interventions are fund determined. At events in the urban areas, high density is where these tend to be held as they become high volume – in addition, they encourage income-generating projects and target those with HIV already, then they in turn invite the whole community including those without HIV; medium to low density women are not targeted

because of the thinking that those in the low densities have initiatives like reading from newspapers. Another organization explained their strategy of formulating messaging for HIV prevention targeted at gender violence experienced by women. In this case, they encourage rapes as well as sexual abuse to be reported within 72 hours so that they can use post-exposure prophylaxis (PEP) and to increase the chances of success for the intervention. The same organization has been instrumental in HIV and AIDS communications for the promotion of female condoms, although they acknowledge that this is mostly aimed at sex workers, due to nature of the job which does not pay well and consists mainly of single women from the high-density areas. Related to this, they arrange 'Condom Nights', which is edutainment targeted at sex workers and men.

One of the NGOs, OPHID, has always been active in PMTCT, and has made use of existing communication strategies, hence they have quickly managed to communicate with pregnant women, providing them with required information. An example is targeting HIV positive pregnant women and asking them to bring children for testing using 92 radio spots.

MoHCC explained that they don't have something specific for women of this age group but generally mainstream women and gender issues in their communications. An example is that in VMMC programming they ensure that women are viewed positively and not portrayed negatively. In their use of IPC, they try and balance the numbers of mobilizers so that women are represented. They also encourage women to be champions of issues. Social media is being used but they want to increase the usage. Initially MoHCC was not keen on the use of social media and partners took the lead. Now MoHCC has a Facebook page, Twitter etc. and the AIDS and TB Unit hope to have their own. These efforts will reach people though not specifically young women. There is a pilot with the biggest mobile telecommunication network and their subsidiary, EcoHealth, for geo-fencing. This is a technology that uses text messages linked to a database from a specific area and targeting specific ages. This could be used in future for young urban women of a certain age group.

WhatsApp is being used informally. One social media challenge is that it is mostly not paid for, therefore it is harder to control; lies can spread quickly and go viral. Ministry ignores some of these and do not necessarily address each one brought to their attention; some miscommunications they address indirectly, even from print media like newspaper.

NAC acknowledged that they are seeing a lot of infections going up in the age group 15-29. They are engaging in deliberate communications by focusing more on them, and holding discussions, for example after showing short films and through one-on-one counselling for rape, child abuse and condom use. They highlighted that men over 40 are having an increase in new infections. This implies that that this sub-population should also be targeted. There are Young People's Friendly Corners for example at clinics, within districts, where discussions are facilitated, including for young urban women.

4.7.1.6 Sub-theme: Languages used in communication materials

All interviewees use the three key languages in Zimbabwe, namely English, Shona and Ndebele, in their communications. It appears that minority languages, of which there are several, are rarely used, unless there is a specific request.

One of the organizations uses Tonga in Binga and Hwange, in the western part of Zimbabwe, as this is more suitable. The same organization uses Shangani for print media such as t-shirt and other IEC materials in Chiredzi, to the south of Zimbabwe. One of the radio stations was said to do translations in minority languages. Another organization said that its Board has asked that the use of Braille be considered. However, in the organization's opinion, at an implementation level, demand for Braille may not be there.

4.7.1.7 Sub-theme: Research done by organizations: to obtain women's perspectives on HIV and AIDS communication

One NGO said that it undertakes both qualitative and quantitative research to better understand needs of different target populations, with all the programmes within MoHCC. This helps to then align with both NAC and MoHCC strategic plans. In addition, the organization is moving away from usual health promotion and is using human-centred design thinking. With this, one gets to understand the population, observes, and ask questions on various issues – the solutions come from the population themselves many times. However, this takes time as one needs to collect the information, generate prototype solutions, test the solutions and then adapt communications according to what resonates with the people.

Carrying out research was echoed by a second NGO which explained that before sharing any communication materials, they first sound out the target population and solicit feedback. The example they gave was that after every 13 programmes on television (uploaded also on YouTube), they check for knowledge levels, actions taken after watching (behaviour change), number of episodes watched and information obtained.

They do not specifically target young urban women as they are trying to be inclusive and include men.

MoHCC was unaware of any research targeting a specific group, except for one done for VMCC, which was an attempt to adopt marketing principles and apply them to health. This was done by Ipsos – it was thought men are the same, but it became clear that they are not. The information revealed helps in targeting certain men. The results inform innovative approaches for demand creation at both an IPC and mass communication level: for IPC clients, are segmented using a paper and electronic tool that was developed from the research by Ipsos; for mass media, insights are being used on a campaign planned for men dubbed *Ka Lyf kema Boss* (A boss's life).

NAC carried out a rapid evaluation of the NAC Radio and TV Programmes – then disaggregated the findings for specific groups. They expressed budgetary constraints for specific research. The budget is very limited as half goes to procuring ARVs; the rest is allocated for all other activities which are not funded by partners. However, they do give general encouragement to do research that is evidence-based. There is low uptake for research. Provinces and districts are being encouraged to do research.

The third NGO does not do this type of research. They explained that of late people moved away from testing messages, as it is hard to prove that behaviour change comes about from just one communication or method, even if a woman may think so (influenced when not aware). It is also time consuming. Layering of communication is what is the current strategy and seem to be working. This involves using methods such as WhatsApp, radio and a 'hair salon approach' (a type of IPC, detailed in Chapter 5); this way people are likely to act.

4.7.1.8 Sub-theme: Barriers to HIV and AIDS information dissemination

Various issues were said to be barriers to HIV and AIDS information dissemination. Contradicting and/or confusing messages was highlighted as one of these. This is in terms of which messages are credible and should be taken seriously, as there are several being promoted. One example of a contradictory message is that of being encouraged to adhere to treatment while some religious sectors promote divine healing and the stopping of medicine.

A second barrier is competing interests and busyness. There is competition for information attention, whereby popular topics currently include fashion, motivational talks

and how to make money. Young urban women have a high demand on their attention, so there is a need to pitch higher than others. They need to be understood and messages must be packaged appropriately. Life being fast, people are too impatient to sit and listen; they are busy looking for money and food. People also go out, and so one strategy is to therefore target popular events, such as music galas, and aim to motivate people to go into tents and talk to service providers. If this is not done, the people come and dance and leave.

The third barrier is low coverage for IPC. Manpower to go out and do IPC as well as to monitor the quality thereof is proving to be a challenge. Some people would rather have health workers do this, but this presents a budgetary challenge as these workers need to be paid.

To minimise confusion of messages, MoHCC recommends that ideally all HIV areas should be integrated, be they VMMC, condoms or others, so that a series of adverts results, instead of a handful promoting one area.

4.7.2 Theme 2: HIV and AIDS knowledge

HIV and AIDS knowledge is the second theme and it is divided into four sub-themes: HIV and AIDS information; HIV and AIDS champions; Epidemic drivers; Vulnerability.

4.7.2.1 Sub-theme: HIV and AIDS information and knowledge

All the organizations interviewed agreed that in Zimbabwe the quality of HIV and AIDS information available to young urban women is high and it is adequate. The percentage given was “About 80-100% for quantity and quality”, with one organization saying over 90% for knowledge levels, according to research, which is how it was measured. The ZDHS indicated an elevated level of knowledge. This is attributable to different media channels such as billboards in urban areas, a variety of radio stations, the internet, television and newspapers which are mainly distributed in urban areas, and electronic and hardcopy newsletters. Information is accessible in multiple languages, and this makes it easier for information to be available.

The urban woman in Zimbabwe has adequate, high quality information about HIV and AIDS but knowledge does not translate into behaviour change. The challenge, from the organizations perspective, appears to be translating knowledge into action, and discerning inaccurate information. What drives the action are activities such as exhibitions where people are tested or VMMC procedures are performed. VMMC is currently the

most audible voice for HIV. However, it was said that at community level, the women may not have as much knowledge, and there is therefore room to improve and strengthen the quality and coverage of information dissemination at that level.

4.7.2.2 Sub-theme: HIV and AIDS champions

Some of the organizations have formal champions while others do not have formal ones. Some of the champions are targeted for specific communities, for example, chiefs, traditional leaders like *Sabhukus* (Village head) and headmasters at schools. Local celebrities or personalities in local communities (those who are prominent and acceptable) focus on their own community. One organization elaborated saying that they had a buy-in from the chiefs through the Chiefs Council, which is part of parliament. Other champions are PLHIV, sex workers, of which some are not necessarily leaders but people passionate about HIV issues. Examples of some HIV and AIDS champions are DJ Hazvineyi Sakarombe, Power FM's Rumbi Moyo and presenter/producer Patricia Jacob. Some double up championing wholesome adolescent sexual and reproductive rights, family planning and gender, in addition to HIV issues.

Currently, the most visible HIV and AIDS champions are the ones for VMMC, including Jah Prayzah, Winky D, Fungisayi (musicians), Albert Nyathi (poet), Hardlife Zvirekwi (soccer player) and Thabani Gambiza (radio DJ).

NAC does not use formal champions but rather uses policy makers and traditional leaders. They motivate them to go out and lead. Some of these have since said that they already have bad reputations to lead from the front, and have suggested that the young generation come up with leaders. For this reason, some are finding it difficult to be role models and champions, although they are prepared to talk about the issues at hand. This strategy has somewhat been implemented through the Young People's Network. Young people are trained to be leaders and to speak out, for example a news reader in Bulawayo city, junior parliamentarians within the provinces and the child president. The child president is given a platform to speak.

Parliamentarians then work by influencing parliament and their constituencies.

4.7.2.3 Sub-theme: Epidemic drivers

Various areas came up in response to what the epidemic drivers for urban Zimbabwean women were. Culture-wise, women were said to be subservient in sexual issues and therefore not empowered, when they should be at par with men. In addition, the economic

situation has resulted in girls dropping out of school and rising unemployment. The economic situation has promoted poverty and a survival mentality, which means adopting an “I can die now of hunger or later of HIV”, meaning that people would rather address present issues of hunger that have an immediate impact, than HIV, which has a delayed effect. The challenge is also the lack of sustainable income-generating programmes.

Multiple concurrent partnerships were highlighted as a high driver of the epidemic (married women also have multiple concurrent partners). It was noted that a married woman is at the ‘greatest’ risk because of the gender inequalities which restrict her ability to access prevention, care and support. Though not an epidemic driver, married women are a population at risk.

Intergenerational relationships, of mostly the 15-24 age group women with older men, is also an epidemic driver. There is a promotion of the idea of getting married to someone much older and who owns their own things. Related to intergenerational sex is the concept of ‘blessers’, whereby a younger woman and older man have no formal relationship – girls look for someone to ‘bless’ them with for example school fees for a week. Girls advertise that they are looking for a blesser and their show their photo. The concept started in South Africa because of poverty. In addition, child marriages exist and contribute to intergenerational relationships.

Young urban women are more marketable compared to rural women, and there are multiple platforms to meet men, especially as the environment is conducive.

It has also been identified that there is an emphasis on knowledge not on behaviour, which presents a challenge.

4.7.3 Theme 3: Context

4.7.3.1 Sub-theme: Young urban women’s context

Generally, it is a difficult environment for most of these women in the 20-29 age group. The life is rushed life, confusing, demanding, with competing needs and it is competitive. There is pressure to fit in and women will do all sorts of things to fit in.

There is a diversity of women in the urban areas for this age group, ranging from those who are degreed and have attended university (higher economic bracket), to those in the lower-middle class who tend to be married by 20 years; there is pressure to get married and have kids. Most people live in high density areas, including women. Life is stressful for these women and they tend to be the bread winners -vending, hustling and informally

employed, while the men have taken a back seat and not working but are instead depressed. Further to this, opportunities are not great for women in Zimbabwe: families do not support education or careers; they would rather encourage turning to a man to provide for the young women.

There is urban poverty such that even married women are doing sex work as husbands are not working; husbands look for work while wives go to brothel all day, as their children must eat.

At the same time, these women have goals such as anticipating growth even when vending. They are dreamers and want to be married. Some who have resorted to sex work want to leave that line of work and pursue childhood dreams.

4.7.3.2 Sub-theme: Government policy

Each Ministry in GoZ has an HIV focal person, including the President's office, which has asked for training in HIV and AIDS from NAC. The Ministry of Finance allocates resources for HIV to each Ministry. NAC receives the AIDS levy and are flexible in its use, for example, they give support to uniformed forces and their programmes.

The DREAMS programme specifically caters for young women.

MoHCC is indirectly promoting HIV and AIDS in mass media, while GBV issues are championed from line ministries - the MoWADCD is active in its own programmes. This impacts on child marriages, which are closely related to HIV.

Other government activities include the Zimbabwe Youth Council doing a survey on child marriages, and the start of police victim-friendly units (such as in the case of rape).

Two NGOs explained that the MoWAGCD is working with UNFPA on gender violence whereby Behaviour Change Communication Officers will go into the community after being trained. The city council is also training some behaviour change communicators in the towns, in HIV and product services.

NGOs are supporting MoHCC in mass media and guidance on messaging.

MoHCC has shared a strategic plan with partners, including NGOs. This provides a guide to communication issues. One NGO said that it has its own communication products through mainstream media such as billboards, radio, television and newspapers; they

hold press conferences to address key issues. They provide resources to address the issues, for example, they pay money to journalists to go and report on the issues.

4.7.3.3 Sub-theme: Regional cooperation

There has not been much in terms of regional cooperation. There was a regional SADC strategy on behaviour change, communication and programmes, and country visits, however funding no longer exists. There was a behaviour change communication strategy for the region. Programmes were targeted at sex workers and truck drivers in border towns. The programmes covered services such as HTC, STI screening and treatment, condoms, etc. In the past, NAC had the Boystomen campaign for 2-3 years, which UNICEF sponsored. All SADC countries were part of OneLove. There is currently talk of a cross-border initiative.

The Soul City initiative (shows in South Africa and several neighbouring countries) is no longer there; it highlighted information on HIV and AIDS.

It seems that generally donors are not funding regional programmes but rather country-specific ones. Cross-learning and cross-sharing is a challenge, because of this.

Other opportunities for regional collaboration (though not specific to HIV and AIDS communication) arise at regional functions such as the ICASA where countries take part regionally and then go and implement.

One NGO said that for their organization, each country designs work according to the context. They are trying to see if they can come up with regional and global brands. A second NGO that is involved in PMTCT work, meets regionally and internationally on common issues.

4.7.3.4 Sub-theme: Spirituality

One of the NGOs said that spirituality is not their focus. Previously, they worked with religious leaders but have since stopped. They noted that the religious sector was not saying much about the issues. However, the NGO highlights that religion does take centre stage in young women's lives.

The key informant interviewees highlighted negative aspects of religion, such as women on ART being prayed for and stopping medication. This is negatively affecting progress in HIV interventions; young urban women have gone to Pentecostal churches and been told they are healed. Stopping the medicines encourages drug resistance and some end

up experiencing treatment failure on first line ARVs and moving towards second and third ones, which are the more expensive alternatives. Some only start taking these when they are sick again. Life is difficult, money is low, so sick people are looking at alternatives such as spiritual leaders and witch doctors, especially in urban areas and white garment churches in the rural areas.

On the positive side, PLHIV in the churches can be given hope and encouraged to stay on ARVs. Church can and should do more – especially as there are more women who go to church compared to men. Champions, like white garment pastors, and a group from mainstream churches have been selected – but it is a struggle because those speaking out have been shunned.

NAC has met with some traditional and faith-based leaders. The need to continue taking ARVs and that a low viral load doesn't mean that someone does not have HIV, was explained to them. NAC is encouraging the thinking that whoever said that the medication should be taken, should also be the one to tell them to stop taking. NAC encourages HIV positive people to check viral load before going to faith healers, as they may already have low and undetectable viral load even before being 'healed'.

The consensus was that religion is only a problem when negatively communicating information. If the opposite is being done, then it would be great because of the influence leaders such as pastors and traditional healers yield. One NGO organised policy and advocacy for religious leaders for the Treat All campaign.

4.7.3.5 Sub-theme: Gender

There has been movement toward equality and empowerment; generally, there has been progress. Progress has been made through the provision of women-initiated prevention initiatives like PrEP, PMTCT and to more easily access female condoms. For example, for PMTCT, previously there was nothing much for mothers that were pregnant; the focus was on the child. However, now Option B+ takes care of Mothers' health – this is an example of a great policy shift. The age of consent has been changed from 12 years of age to 16. Child marriages are now outlawed. It is necessary to have repeal of some laws, for example the one that states that at 18 years of age girls can get married (yet age of consent is 16 constitutionally).

One NGO felt that government has done a lot –more can be done at an earlier stage to empower young girls – build self-esteem and confidence especially in public schools,

unlike at private schools. Men still harass women like at bus-stops – they need physical protection in all aspects of life; Government should be more vocal and at the highest level.

The sentiment was that this generation is educated and advanced. Before, men could be promiscuous, but the tables have turned. Demand creation training materials are now designed to empower women and for them to know it. The Government is attempting to link health and gender as cross-cutting issues in every area.

4.7.3.6 Sub-theme: Socioeconomic status

The state of the economy has made young urban women very vulnerable because the available options to choose from for survival are undesirable. Their position in society influences how they make relationship decisions, because accessing resources is difficult even at work – sex is offered for promotion.

The socioeconomic status of young urban women is also covered in parts (social aspect and/or economic aspects) under the theme ‘Context’ where issues are cross-cutting, and sub-themes: Epidemic drivers; Population with highest prevalence.

4.7.3.7 Sub-theme: Culture

One NGO highlighted that culture is relevant and must be considered in communication efforts, otherwise there will be a back-lash from the public, especially for mass communication. Therefore, they do pre-tests and get feedback from the target population, and adjust to where it will be culturally inappropriate.

“Culture is the core of our existence and hence our communication efforts must be within the confines of our cultural values. For our messages to have impact, we must base them on the cultural values and roles that women play. If we disregard these issues our messages will appear donor- driven and hence communities can easily dismiss our campaigns and communication efforts” (MoHCC).

Other interviewees felt that certain issues or words cannot be communicated directly in Shona and Ndebele, hence at times, the meaning may be lost. It was also felt that there are some who still hold onto aspects of culture such as widow inheritance, polygamy and multiple concurrent partners. Urban practices seem less affected than rural ones by culture, but Zimbabwe is a patriarchal society and interventions are required to be promoted, for example, condom use in an environment where usually men are the ones who initiate sex. The best way to address such issues must be considered, with culture being considered.

Cultural issues can also clash with human rights, for example even if it may be better for a man to accompany his wife to the clinic in HIV-related health, the man may refuse and it is his right to do so.

One NGO said that it did not consider culture much in its communications. The NGO elaborated by saying that HIV has been adopted as a medical issue.

“We do not shift the ‘content’ of our HIV messages, but the medium in which we communicate. Urban women are more likely to use social media and radio. Rural women tend to participate in community dialogues and roadshows.”

4.7.3.8 Sub-theme: Community involvement

Individuals were said to be instrumental in sharing information, but urban areas are individualistic. Dialogues/conversations are held in rural areas. Health care workers and the community gather, divide in small groups and brainstorm on health issues sexual, reproductive health and HIV. Coverage of these is low, and should be increased, and introduced to urban areas.

Ideas from NGOs on community involvement included that urban areas could learn from rural areas where, at funerals and in the churches, HIV is openly talked about, even if a person died of HIV. In addition, government could highlight HIV-related issues at rallies and not focus only on politics. Other ways in which communities are involved in HIV awareness are through peer to peer education, expert patients, and through the help of VHWs (MoHCC cadres) who are mobile in the community, though they must cover large distances. There are several community cadres supporting HIV communications: VHW; Behaviour Change Facilitator (BCF); S2S; Peer Educator; Community and home-based care giver; traditional leader as a community cadre; community committees.

Community-driven initiatives are more effective and sustainable because, for example, a chief in HTC will be in that position for years even when funding ceases; people will believe what he is saying and he is coming from within the community. One challenge though is that some of these leaders have benefited from funding and may slow down efforts when funding ceases.

NAC has been involved in such things as pre-launch activities (for HIV programmes and campaigns), Mr and Mrs ARV. Community leaders and chiefs have expressed an interest in becoming team leaders for health and want the materials’ package to use and give to schools and they also want to be involved in day to day work.

4.8 Conclusion

Chapter 4 was a presentation and analysis of results. The pilot or pretesting phase was described in detail, followed by the data collection phase. The demographics were first described, to have an overview of the background and context of the young urban women being interviewed; the different demographics were presented in table and/or graph form. The results for the in-depth interviews were presented, followed by those of the FGDs. Most of the results came in the form of direct quotes so that the voice of the respondents could be heard. The key informants' results were presented at the end, including a few quotes from organizations that were part of the in-depth interviews. For the in-depth interviews and FGDs, the themes followed were pre-determined and guided the study – Communication, HIV and AIDS knowledge, Perceptions and beliefs, and Context. These were further presented as sub-themes and categories, where appropriate.

CHAPTER 5

5 DISCUSSION, CONCLUSIONS, CHALLENGES & LIMITATIONS

5.1 Introduction

The demographic data are first discussed, in detail, to get a description of the respondents' background, and trends were noted for each demographic element. The discussion is then continued, according to the themes that guided the study, with some of the sub-themes and categories of the findings being rearranged, to fit the discussion: Communication, HIV and AIDS knowledge, Perceptions and belief, and Young urban women's context. For each theme, the conclusions are also presented. The challenges and limitations of the study are then explained, with the conclusion of the chapter being the last part of the chapter.

5.2 Demographic data

The low, medium and high-density areas in Harare and Bulawayo were well represented in the study, with most of respondents coming from high-density suburbs, where it is easier to mobilize people. About the same number of women from each city participated in the study.

Most of the women originate from Mashonaland East, followed by Matabeleland North, Manicaland, Matabeleland South (each above 17%), with the rest being from the remaining three provinces, except for Mashonaland Central, where there was no representation. Harare and Bulawayo cities make up the ninth and tenth provinces, as they are considered provinces as well. Malawi and South Africa were the only two countries where non-Zimbabwean respondents originated from.

In both Bulawayo and Harare, most of the women were 25-29 years of age. Most were single, followed by those who were married. Divorced, widowed or separated, had a combined percentage of 12.

Pentecostal religions dominated, with the Apostolic sect being the second most popular religion, then Seventh Day Adventist. The remaining percentage is comprised of other Christian religions; 7% indicated that they have no religion.

The educational level attained saw most having at least reached Form 4 (Ordinary or 'O' Level) in both cities. However, Bulawayo dominated in those who are college or university graduates.

Most of the women were unemployed, with being self-employed being the next highest category, then some were employed by someone. More than half of those residing in Harare were unemployed.

In Harare, as expected, 100% were fluent in Shona; all the respondents in Harare were also fluent in English. In Bulawayo, it changed significantly, with 93,2% fluent in Ndebele, the local language, and 88.6% fluent in English.

These demographics are worth noting, as they give a good profile of young urban women. The discussion of the results is by theme.

5.3 Theme 1: Communication

5.3.1 *Mass communication*

The women who were interviewed have heard about HIV and AIDS through a wide range of mass media channels. Radio and television had the most forms or presentations such as advertisements, talk shows etc., followed by newspapers. Print media came in many forms; billboards, social media and t-shirts and music were also mentioned.

MoHCC and the NAC, the government organizations that were interviewed, between them said that they made much use of radio stations. After radio, they made use of all major newspapers the most. They said that television is of limited use as it is costly and viewership low due to inferior quality of programmes; billboards were also said to be expensive and limited. They also make use of websites and social media.

NGOs use radio the most, make use of sporting events and use a range of print media and television. Innovation could be seen in the way NGOs use mass media as stickers on commuter omnibuses are used, as well as mid-media in the form of edutainment, music, dance, drama linked to health service delivery, and the use of bookmarkers and sporting activities.

Radio was named as the most suitable mass media channel in terms of effectiveness and accessible: radios are mobile and can be found in public transport; there are a growing number of radio stations to choose from in Zimbabwe; radio uses English, Shona and Ndebele; it is affordable, can be interactive and bought once. Newspapers are costly to

buy daily or weekly. Social media was also said to be accessible to young urban Zimbabwean women.

From the organizations perspective, radio stands out as the most suitable mass medium for HIV and AIDS communication as it is accessible and has many advantages. According to the organizations, other mass media can be made use of, although this may call for finding a way to increase accessibility as well as being innovative to capture the required audience. This contrasts with the women who were interviewed, who prioritised television over radio in terms of both effectiveness and accessibility.

According to the findings of the Rapid Evaluation of the NAC Radio and TV Programme, in urban settings, about 70% owned a radio and 80% television sets (NAC 2016:5). This implies that in Zimbabwe television is more accessible to the public as compared to radio. Here is an example of an innovation in mass media HIV and AIDS communication:

The 'Hands up for #HIVPrevention' campaign was aimed at exploring various aspects of HIV prevention and how to relate to specific groups such as PLHIV, key populations and adolescent girls and young women (UNAIDS 2016c:1). The campaign involved the public – a space was availed for people to express their views on what they think needs to be done for HIV prevention efforts to strengthen. Guidance was given in the form of questions to think about as well as topics. They had to submit either a 30-second video explaining what could be done to reduce HIV infections in their community or a photograph of a word or short phrase written on a palm, for example 'more condoms', 'no violence', 'empowerment' etc. They then had to go to the UNAIDS Facebook page and upload the video/photo and then share it to their own Facebook wall (UNAIDS 2016c:1). This innovation has a wide scope of HIV prevention topics and it also involves the public. Lessons can be learnt and borrowed from such innovations, which make use of technologies of photography/video and social media.

Broadcast media is the most accessible to young urban women, according to them, with television taking the lead, followed by radio. Reference was made to the radio being on mobile phones, which almost everyone has, particularly in urban areas. Mobile phones are also linked to easy access to the internet and social media. As a result, social media was the next most accessible mass media channel after broadcast media.

Whichever channels are used for HIV and AIDS messages, one of the national priorities for SBCC, is that messages and approaches across programme areas should be clear

and consistent so that demand for services can be created. Another priority area is for the use of technological innovations especially for the younger generation (GoZ 2015a:30).

One of the ways these technological innovations could be effected is by using social media, accessible easily through mobile phones which most people have in urban Zimbabwe.

While the channel of HIV and AIDS communication is important, the content is also very key and needs to be communicated in such a manner as to be understood, to be consistent, and ultimately to ensure uptake of various HIV services such as testing and using condoms. The messages must ensure that young urban women are able to articulate and act on them.

Television viewing results from ZAMPS indicated that 66% watch satellite television (for example DSTV) while 58% watch ZBCTV. There was also an indication of peak times for viewership and the only time ZBCTV viewership overtook satellite television viewership was around 8-8.30pm, which is when the time of the main news bulletin is flighted. Mai Chisamba, a local talk show, that holds discussions on social issues, was named amongst the most popular programmes on television. Some programmes were more popular in urban settings while others were preferred in rural settings. There was a variety of popular channels on satellite television with the key ones being some sports channels, South African television, Zee World, Telemundo, ZBCTV, gospel and wildlife; these also showed differences depending on the respondents' location (ZARF 2017:58-64).

Research has shown that most of the people in Zimbabwe watch satellite television more than the local ZBCTV. Organizations involved in HIV and AIDS do not have control of the programmes shown on television (presuming that the audience watch television stations that are of the best quality and most interesting, in their view). The strategy that can be used is for organizations to either come up with programmes of their own to put on either satellite or local television, or to target inserting HIV - related adverts between popular programmes in the urban areas (to accommodate young urban women) at peak times.

Radio stations were rated, after asking which ones were listened into in the last four weeks, with Radio Zimbabwe leading by a huge margin (39%) out of ten radio stations. In the urban areas, most people listened to Star FM. Each of the radio stations had

variations in what time they were listened to, show peaks throughout the day (ZARF 2017:68-71).

According to a recent NAC Rapid Evaluation, 90% owned a cell phone, although they did not listen to radio programmes using their mobile phone. Of the urban population, 10% had DSTV (compared to 2% in the rural population). Zvishavane had a radio station named YAFM. Women preferred radio as it allowed them to listen while they carried out their chores in the day time, and television was preferred for the night (NAC 2016:6).

As in an analogous manner to television, organizations can target popular radio stations, including community radio stations, considering the popular listenership times, in the provinces or towns they are targeting for the different HIV awareness campaigns.

Recommendations from the Rapid Evaluation were: identify gaps that NAC programmes can fill, after analysing current radio and TV programmes; beyond awareness, focus on action-orientated information particularly lived experiences which people can relate to while others who are not yet affected and infected can learn lessons; innovate using media the audience prefer, such as road shows and music shows; advertise the programmes so as to ensure that the public are knowledgeable about the days and the times they are flighted; community radio stations should be made use of (NAC 2016:8-9).

Other media consumption which was experienced by the public personally were road shows, mobile promotion and outdoor advertising. Outdoor advertising was disaggregated with billboards dominating, followed by posters and several others (ZARF 2017:96-98).

On viewing the NAC and ZAMPS research, in addition to the conventional mass media channels, HIV and AIDS needs to utilize other methods that are available and are preferred by the public, for example outdoor advertising, road shows and music shows.

The print media were also rated in ZAMPS in terms of readership. In the last three months preceding the survey, The Herald (31%) was the most read daily newspaper in urban areas, followed by H-Metro, Daily News, and The Chronicle; provincial differences were very noticeable, with Bulawayo and surrounding provinces reading mainly The Chronicle. Details were also available of which sections within the newspapers people were most drawn to, with local news dominating followed by entertainment then sports. Weekly publications in urban areas, monthly, bimonthly and quarterly publications also had statistics, as did regional and international publications including magazines (ZARF

2017:82-93). However, in the current study, the print media were not a popular communication channels for the respondents, and it therefore has a limited role in HIV and AIDS communication.

Broadcast media prevailed when it came to effectiveness, with print media coming out as the least effective channel for HIV and AIDS communication, particularly newspapers. Television was the most effective, followed by radio. Television has the advantage of being visual and auditory while radio is just auditory.

There was agreement between the key informants and the women interviewed that the three main languages in Zimbabwe are used for HIV and AIDS communication. Some of the minority languages are used at times.

Young urban women perceive the information being communicated to them via various channels as being sensitive to them as it is not offensive to them, they understand it simply and it considers their age.

Most of the champions identified by the women and the organizations are male and are musicians, both young and old. Some are international stars (such as Oliver Mtukudzi and Jah Prayzah). One female musician was mentioned. Some of the champions are talk show hosts, DJs, radio and T.V. personalities, one soccer player, one journalist, one actress, one poet, and parliamentarians while some mentioned by the organizations were more relevant to rural areas, such as traditional leaders. The most visible champions currently are for VMMC, as evidenced by this being mentioned by both organizations and the women. Some of the women could not name any HIV and AIDS champions while others were unable to explain what the HIV focus area of the champion was. One of the organizations used ordinary people to champion HIV AIDS issues, namely sex workers and PLHIV.

In the last decade, there has been integration of Traditional Leaders/Village Heads in community health and systems strengthening. The reasoning was that these are mostly men with influence particularly regarding mobilizing and encouraging men to participate in health and development issues. Some have been assigned to work with champions by various NGOs. Some are BCFs. Traditional Leaders are used to disseminate information and mobilise communities into action (MoHCC & UNFPA 2016:36).

This principle of local leaders can be extended to urban areas whereby MPs for various constituencies and Councillors can be used in a comparable manner, with some strategically positioned to focus on young urban women.

One of the strengths of traditional leaders and other people who are influential in the community have is they can be used for health promotion, advocacy, mass campaigns and mobilization (MoHCC 2016c:11).

Leaders of any type, are expected to be influential, and using their influence to advocate for and communicate HIV and AIDS issues is a strategic move. Many people in their area of influence can be reached and much HIV awareness achieved.

Both the organizations interviewed and the young urban women themselves agree that the information on HIV and AIDS available to them is of high quality and that it is plentiful. This can be confirmed by the feedback given by the respondents, both women and organizations, when asked to elaborate on various aspects about mass and IPC. The study is showing that there is a wide range of mass media channels and individuals who disseminate the information. Quality-wise the women have shown a very good understanding of HIV and AIDS knowledge (see HIV and AIDS knowledge theme), although there are some gaps and lack of knowledge on some areas such as PrEP (it was not mentioned by anyone as an HIV prevention method). The challenge does not therefore lie with the level of knowledge but with translating this to behaviour that discourages the spread of HIV. According to organizations, more can still be done at the community level, in addition to mass media efforts.

The Lancet reported that Zimbabwe has been involved in implementing research projects to investigate the uptake and impact of PrEP. PrEP utilizes antiretroviral medicines to protect those who are HIV negative from HIV before potential virus exposure. Young women and girls among whom HIV prevalence is high, have been targeted for PrEP specifically (Avert 2017).

PrEP is, therefore, one of the HIV prevention methods women should be knowledgeable about as this gives them a measure of control regarding HIV infection; it is an empowering and life-changing initiative. More needs to be done to specifically impart PrEP knowledge.

The Afrobarometer comprises a comparative series of public attitude surveys on governance, democracy, markets and living conditions. The sample is of 1,200 randomly selected adults aged 18 years or more. In the survey, over 80% expressed satisfaction

with the information provided on HIV and AIDS prevention and treatment and their ability to apply it (Ismail 2011:1-2).

These results agree with the findings from the current study where the respondents (as well as the key informant' organizations), express satisfaction with the information that they have been exposed to, as well as the ability to process and understand it.

Confusing or conflicting information on HIV and AIDS is a barrier that was observed by organizations, and appears to be based on the source of the information. Organizations and personnel who generate accurate information and are therefore the custodians of correct information, have the responsibility of doing more in terms of information sharing to different sectors, such as the religious sector, in a bid to have everyone hearing the same message, regardless of source.

HIV and AIDS information, is competing for space, because there are so many competing priorities for the young urban women. Organizations must come up with innovations to be able to obtain the desired results of attracting young urban women's attention.

Lack of personnel to adequately carry out HIV and AIDS interpersonal information is a barrier that is challenging, especially because these communicators need to be paid, and budgetary constraints are there for organizations – both NGOs and the Government. The current economic situation in Zimbabwe dictates that more than ever before, workers would need to be paid rather to volunteer services for no remuneration.

ZINASP III states that communication channels for HIV and AIDS include social media, mass media, interactive materials and IPC, though there are several bottlenecks. These bottle necks include: limited SBCC programmes tailored for specific people – the recommendation is that SBCC should be designed for young people especially HIV exposure and prevention options; expand SBCC to the young at community level and through mass and social media. Another barrier is skilled teachers delivering relevant HIV and life skills education – the recommendation is to equip teachers with HIV and life skills education; avail to schools, HIV IEC materials (GoZ 2015b:29).

All the barriers or bottle-necks should be considered and mitigated. Measures that can be taken include ensuring that all HIV and AIDS communications are accurate, that they are innovative and more creative, that there are more people undertaking IPC, that they are tailored for various groups such as young urban women and that there is adequate resourcing in the education sector.

Other information dissemination challenges overlap with other areas in the study and can be found under IPC, Community involvement, Gender roles and Research.

5.3.2 Interpersonal communication

The organizations highlighted that while mass communication raises awareness, it is the IPC that helps with the translation into behaviour change. In Zimbabwe, there appears to be more being done in the rural areas than in the urban areas, in terms of IPC. Strategies employed by the government and organizations in urban areas include firstly, the organizations attend or organise big events, pitching tents or stands and promoting HIV awareness in such a manner as to attract audiences, and then engaging in one-on-one IPC, in addition to offering HIV-related service delivery. Secondly, there is door-to-door IPC through CHWs/City Mobilizers. The IPC efforts focus on high rather than low-density areas. This is because this is where the masses are concentrated (see Community involvement).

In the interface with young urban women there was no mention by them of CHWs or the one-on-one interactions at big events. They have heard about HIV and AIDS from mostly teachers and health workers, as well as a range of other people in the community. This underscores the role of the education sector which is where most of these teachers are found.

An exercise for Community Cadre Mapping was carried out with several objectives (MoHCC & UNFPA 2016:13). One of the objectives was to develop an inventory of the health and gender-related community-based volunteers in Zimbabwe. A second objective was to determine what the advantages of these volunteers in responding to community health and gender-related needs is. A third one was to document the work these cadres are doing and their target population (MoHCC & UNFPA 2016:13). This exercise is an important one because some of these cadres are the agents for interpersonal HIV and AIDS communication in the various communities. The community needs to identify suitable people to take-up such positions. It is on a volunteer basis though there are some allowances.

One of the benefits of door-to-door communication, a type of IPC, is that responses and solutions to challenges can be an outcome through discussion, and feedback is immediate. Linked to this, is the fact that reserved people tend to want to speak out in the privacy of their homes, as opposed to mass communication situations. Key populations can be accessed more easily through IPC, for example sex workers (Chikanya 2016:2).

The interactive part of IPC is confirmed as a reason why the women prefer it to mass communication, as stated later in the study discussion.

In the latest ZAMPS survey done in Zimbabwe, phone ownership shows that 94% of the public had working cell phone lines. The network providers were shown by popularity, with Econet taking the lead. Disaggregation was also done for use as voice/messaging and data/internet, with preferences by urban and rural populations also being seen (ZARF 2017:121-123).

It was clear from the percentages that some people own more than one line from a network provider (ZARF 2017:119). This information on mobile phones could be made use of by Government and NGOs, who could partner with network providers and target specific messages to certain different populations, such as young urban women, using SMSs and/or WhatsApp. The fact that most people have phones could also be used to link with mass communication channels - an opportunity for IPC whereby further questions or probing on HIV and AIDS could be done.

Email and internet access was also recorded by ZAMPS, and was higher in urban areas. In addition, purpose for internet was ranked and showed that personal communication was the most popular reason for using the internet, followed by personal research. The most accessed website was Facebook, then there were also search engines, other social media and news sites (ZARF 2017:100-102).

Social media, internet use and emails appear to overlap with both mass communication and IPC and can be leveraged with either, depending on what the focus at the time is. Here is an example of how the internet can be used for IPC in an innovative manner:

A study was carried out at the University of Cape Town to answer whether a digital interactive platform can be used for stimulating IPC on HIV and AIDS-related issues. The findings showed that other tertiary education institutions could benefit from similar projects. The discussion forum is a useful tool to stimulate IPC related to HIV and AIDS issues, although its success seemed to be very dependent on the extent to which it is integrated into the curriculum (see Education). Barriers included time, perception of HIV and AIDS as tedious topics leading to 'AIDS-fatigue', and infrastructural problems. It appeared that anonymity can lead to greater democratic participation. Interactivity was also an important trigger for students to engage on-line (Baelden et al 2012:174).

A second example of IPC and innovation is the 'hair salon approach': PSI is investing in local heroines in the form of hairdressers. These reach out to women (see Champions). One example is Tears Wenzira in Chitungwiza, a city in Zimbabwe. She is one of 1,900 hairdressers and barbers who partnered with PSI. Tears talks to clients with whom she has developed a relationship about the female condom and about how HIV is transmitted, and the role the female condom can play. She sells them and in addition she refers clients to clinics for HIV-testing and treatment and for health issues. In 2016, over 1, 5 million female condoms were distributed in this manner, in hair salons across Zimbabwe (PSI 2017).

Health professionals such as nurses, doctors and counsellors were viewed by young urban women as being the ones who are most likely to pass on the most accurate information. However, not all health professionals are educated about HIV and AIDS; this is an opportunity for a deliberate drive by policy implementers to educate as many types of health professionals as possible because of public perceptions and expectations such as those of young urban women. PLHIV have a very crucial role to play in IPC (as well as in mass communication – see Champions), even if they are not opinion leaders and are ordinary people; the young urban women perceive that they have accurate information as they are living with HIV.

An initiative by MoHCC through the Zimbabwe Health Transition Fund, to mitigate the shortage of human resources in the health sector, was to recruit and deploy CHWs. This strategy is recognized globally for overcoming staff shortages, according to a document entitled 'Strengthening Primary Health Care through CHWs: Investment Case and Financing Recommendations 2015' (MoHCC & UNFPA 2016:18). A CHW embraces a wide range of community-based health cadres, selected by their own community, trained and deployed within the communities they live in (MoHCC & UNFPA:19). 77 community-based cadres were identified in an exercise carried out in Zimbabwe (MOHCC & UNFPA 2016:26). There were 20 key focus areas for the 77, including HIV/STI prevention (77%), which was the highest (MoHCC & UNFPA: 37).

The VHW, accountable to the MoHCC and getting their allowance from them, is a part-time volunteer who carries out health promotion and care activities; they are multi-skilled. The BCF's focus area is that of enhancing the delivery of a broad range of integrated HIV prevention, SRH, and GBV mitigation messages and services, approaching families, individuals and couples using a door-to-door approach. These cadres are supported by NAC and donors (MoHCC & UNFPA 2016:33-36).

The VHW and BCF are well positioned to be involved in HIV and AIDS IPC activities, within communities, and these are the cadres that have been put in place by the MoHCC to carry out structured IPC.

IPC came out as the preferred means of receiving information about HIV and AIDS. Its advantage over mass communication is that it is interactive – the recipients can ask questions and seek understanding and clarity on issues. While mass communication has the advantage of reaching the masses at one point in time, and is favourable for its impersonal nature for those uncomfortable with one-on-one communication, it has the main disadvantage of presenting information that cannot be probed; it assumes the recipients will understand what is being communicated.

Most of the women in the study have never educated anyone about HIV and AIDS.

Sista to Sista (S2S) mentors, support vulnerable girls with information and skills concerning sexual reproductive health and rights. This is done through clubs and mentoring; these CHWs are found in selected districts and wards in Zimbabwe. They are taken from pools of BCF's (see IPC). Peer Educators exist in the communities in Zimbabwe. Some are in school while others are not. An example of peer educators is 'Young People We Care', supported technically by various organizations. Other examples are 'Peer Educators for Informal and Formal Workplaces' and 'Sister with a Voice Peer Educators' (MoHCC & UNFPA 2016:35).

There are opportunities for young urban women to seek out, such as being Peer Educators or S2S mentors. They need to make themselves available and go for training, so that they either become involved in HIV and AIDS communication formally or informally (see IPC and Community Involvement). This will go a long way in being positioned to educate others.

5.3.3 Conclusions

- The women feel that television, followed by radio, is the most accessible form of mass communication; the internet and social media though mobile phone technology followed. Other less conventional mass media channels should also be used.
- Broadcast media is viewed by young urban women as the most effective means of communicating HIV and AIDS issues, with television taking the lead over radio. Print media is viewed as least effective.
- According to the organizations involved in HIV and AIDS, radio is the mass media channel that is the most effective for HIV and AIDS communication for young urban

women. It is also the most accessible. Print media, billboards, television and other forms of mass media have limited use and effectiveness for myriad reasons. Social media is also accessible to young urban women. There is room for innovation in mass media communication.

- English, Shona and Ndebele are used appropriately in HIV and AIDS communication in Zimbabwe. The minority languages have a role to play in certain instances.
- From the young urban women's perspective, the HIV and AIDS information is being communicated in a sensitive manner.
- From the women's perspective, most of the HIV and AIDS champions are male and musicians, with few female ones represented. Most women can identify at least one HIV and AIDS champion. VMMC is the most visible HIV area to the women and the organizations.
- Zimbabwean young urban women have high quality and adequate amounts of HIV and AIDS information available and accessible to them, through various means. Therefore, communication efforts have been good, though there is room for improvement, including in closing some knowledge gaps.
- From organizations perspective, the barriers to HIV and AIDS information dissemination to young urban women are: conflicting or confusing information that comes from sources that are not credible; competing interests that also attract the women's attention; inadequate IPC personnel to disseminate this information. Additional barriers may include limited programmes targeting young urban women, as well as teachers not fully equipped to impart HIV education.
- There is some IPC taking place in urban areas both from the organizations and the young urban women's perspective. More can still be done, as is happening in the rural areas. Teachers and health workers are the people most young urban women are hearing about HIV and AIDS from. The women singled out health workers as the people they were most comfortable hearing from about HIV and AIDS issues. IPC is essential for behaviour change, although mass communication is strategic for raising awareness. Innovation will be instrumental in making HIV and AIDS communication effective.
- Health professionals followed by PLHIV are perceived to have the most accurate information about HIV and AIDS. The public was viewed as being the least likely to give accurate information about HIV and AIDS.

- Those viewed as likely to pass on the least accurate information, according to most of the women, are the public including friends and neighbours in the community. Others singled out were: those who have never gone for HIV testing; people who are not HIV-infected; people who are not affected by HIV in any way; old people; teenagers; witch doctors; false prophets; teachers.
- IPC is the preferred means of HIV and AIDS communication for young urban women. Mass communication also has a role to play in raising awareness.
- Most of the women have not shared information on HIV and AIDS with anyone.

5.4 Theme 2: HIV and AIDS knowledge

5.4.1 Distinguishing between HIV and AIDS

The respondents distinguished between HIV and AIDS and many even had above average details. They understand that if there is no medical intervention then HIV progresses to AIDS; they also understand that the treatment is not a cure but it enables one to lead a healthy normal life.

5.4.2 HIV prevention

The women showed an elevated level of knowledge about HIV prevention as evidenced by their responses which in most cases explained more than one form of prevention, including ABC, PMTCT and VMMC. PrEP, and female condoms, ART for prevention were not mentioned by the women as contributors to HIV prevention. Most women did not talk about PMTCT or male circumcision until asked about them later in the interview. There was a very good understanding of PMTCT. Male circumcision is quite well understood though some are not sure how this works to prevent HIV infection.

Knowledge of ways to reduce transmission of HIV is vital in addressing the HIV epidemic. In Zimbabwe the knowledge of prevention methods, though the questions were prompted, was high with women between the ages of 20-24 as well as those aged 25-29. They named use of condoms and limiting sexual intercourse to one uninfected partner as an HIV prevention method (GoZ 2016b:33). Compared to rural residents, the urban ones were more knowledgeable about prevention methods. The ZDHS confirms that women and men who have higher levels of education are more likely than those with lower levels of education, to have awareness of HIV prevention methods (GoZ 2016b:34).

The 2015 ZDHS also shows that of young women in Zimbabwe (aged 15-24), only 46% were found to have comprehensive HIV knowledge, while their male counterparts stand at 47% (Avert 2017). These figures show that there is room for HIV knowledge

improvement among the younger generation, as less than half of them have comprehensive HIV knowledge.

In the context of the study it can therefore be extrapolated to mean that the more educated young urban women will therefore be more aware of prevention methods and to therefore be better positioned to use them, than those less educated. This can be linked to promoting education for the girl child (see Education level).

Dr Stamps, Health Advisor in the Office of the president and Cabinet, stated that “mutually faithful life-long partnerships, abstinence and correct condom use”, together with right financing were pivotal to major success in the HIV epidemic. He added that continuing to educate the public on prevention and treatment was important (Nyanyiwa 2017:4). Thus, educating the public is part of HIV and AIDS communication.

One SBCC priority in Zimbabwe, states that all SBCC interventions focussing on partner reduction and faithfulness should incorporate promotion of ART for prevention, VMMC, PMTCT and condom uptake (GoZ 2015a:30). According to the Zimbabwe 2011-2015 Communications Strategy document concerning PMTCT, the strategy assumes no current significant resource is available for mass media. Nevertheless, the role of PMTCT is acknowledged, especially in reaching large numbers of people. Funding is assumed to come from partners. Television is singled out for being expensive. However, several future programmes are planned, depending on the availability of funds. Other media-related aspects include regular briefings for journalists, news releases by MoHCW as well as dramas and programmes on radio (MoHCW 2011:20).

The ZDHS showed that there are still some misconceptions about HIV transmission whereby some still believe transmission occurs through mosquito bites (16%), through sharing food with an HIV positive person (7%) and by supernatural means (5%) (GoZ 2016b:35).

It is evident that knowledge levels in Zimbabwe, including for young urban women, is high. However, misconceptions need to continually be identified and dispelled using HIV and AIDS communication.

5.4.3 HIV treatment

The women understood ARVs in the context of medication for HIV infection to manage the infection so that it does not progress to AIDS

5.4.4 Knowledge vs behaviour

The women have gained knowledge over time and this has influenced them in a positive manner in terms of their behaviour. The information has encouraged the majority to take part in HIV prevention.

5.4.5 Conclusions

- Young urban Zimbabwean women have a high knowledge level of HIV and AIDS and can explain the difference between HIV and AIDS. Most could identify the diverse ways HIV is transmitted, though there were a few misconceptions.
- Indications from the study suggest that the level of knowledge on HIV prevention among young urban women is high. This, however, is offset to some extent by the apparent low level of awareness in terms of newer prevention methods such as PrEP, female condoms, and ART for prevention.
- The women are well informed about medication being available for HIV infection. They understand that HIV does not have a cure.
- Women have been able to translate the knowledge they gain into behaviour change.

5.5 Theme 3: Perceptions and beliefs

5.5.1 HIV prevalence

The women's perception was that the prevalence of HIV in Zimbabwe is high. The organizations all agreed that among the various groups, adolescents and young women in urban area have the highest HIV prevalence in Zimbabwe.

In the 2015 ZDHS, the HIV prevalence was found to be the same in urban and rural settings, but higher among women (17%) than men (11%), and overall 14% (GoZ 2015b).

Although the prevalence rate has gone down from the last demographic survey in 2005/6, it is still high and the young urban women therefore have an accurate perception.

The HIV prevalence is not only high in Zimbabwe, but higher among women and among those in urban areas. This highlights how young urban women are greatly affected by the HIV epidemic and why HIV and AIDS communication plays such a prominent role. According to key informants, the highest HIV prevalence is in 15-24-year olds followed by older men 30-45 years old.

5.5.2 HIV Status

The women have a good perspective about knowing their HIV status – they understand that once they are aware of their status, then they are empowered to make an informed

decision, be it to remain HIV negative or to get assistance should they be HIV positive. Considering the 90-90-90 HIV strategy referred to earlier, the women, if they act on what they believe, are headed in the right direction. Testing is the entry point to curb the HIV epidemic; those who are positive can be referred for further counselling and treatment while the negative ones have an incentive to participate in HIV prevention.

In the ZDHS it was found that the trend in Zimbabwe is increasing for HIV testing – 7% (2005/6 survey), 34% (2010/11 survey), to 49% (2015 survey) (GoZ 2015b). The figures indicate percent of women 15-49 years old who were tested for HIV and received their results (GoZ 2015b). The trend shows that increasingly more women are being tested for HIV and becoming aware of their status.

MoHCC in 2016 reported that the estimated PLHIV in Zimbabwe who know their status, is only 66% (Avert 2017).

When individuals know their HIV status, they can make informed decisions that is, reducing risk and increasing safe sex practices to remain HIV negative; HIV positive individuals can act to protect their sexual partners, can access treatment and can plan (GoZ 2016b:28). In addition, an innovation that can assist with increasing HIV testing, is self-testing:

The findings of a study on HIV self-testing delivery carried out in Malawi and Zimbabwe, indicates that there are potential implications for reducing current testing gaps among the age-group 16-25 years, a range viewed as hard to reach. The uptake of HIV self-testing among young people is most promising if distribution of test kits is convenient, which is provided through home-based distribution at no cost, with respect for them as autonomous individuals (Indravudh, Sibanda, d'Elbée, Kumwenda, Ringwald, Maringwa, Simwinga, Nyirenda, Johnson, Hatzold, Terris-Prestholt & Taegtmeyer 2017).

In 2015, PR News Wire reported that PSI and UNITAID, as a strategy to increase testing rates, initiated a two-year project to scale-up self-testing in Malawi, Zimbabwe and Zambia: sex workers are one of the targeted populations, as they have testing restrictions (Avert 2017). HIV self-testing is, therefore, a strategy that can be used for young urban women to increase HIV status awareness.

It is important to note the people young urban women are comfortable confiding their HIV positive status to. Mothers, sisters and husbands, having been identified as the most

popular confidantes, should be targeted for HIV and AIDS communications and made use of, should a young woman want to confide in someone.

Should an urban woman become HIV positive, she is most comfortable disclosing her status to someone who is close, can be trusted, who will not judge and who is most likely to be able to assist them in some way. This is often an immediate family member.

5.5.3 Risk perception

Most women feel that they are not at risk of acquiring HIV because of either not being sexually active or because they are currently HIV negative and faithful to their partners. Those who are sexually active and seeing no risk held the belief that their partner is faithful. A few understood that if they are sexually active, this puts them at risk, as it cannot be guaranteed that their partners are HIV negative or that if they are, that they will stay that way; it is also not guaranteed that if their partners are HIV positive, they will successfully be able to negotiate for condom use. Knowing their status as women would reduce their risk, whether negative or positive – if negative, this should motivate them to use protection, if positive this should motivate them to get ARVs for minimizing the risk of acquiring AIDS.

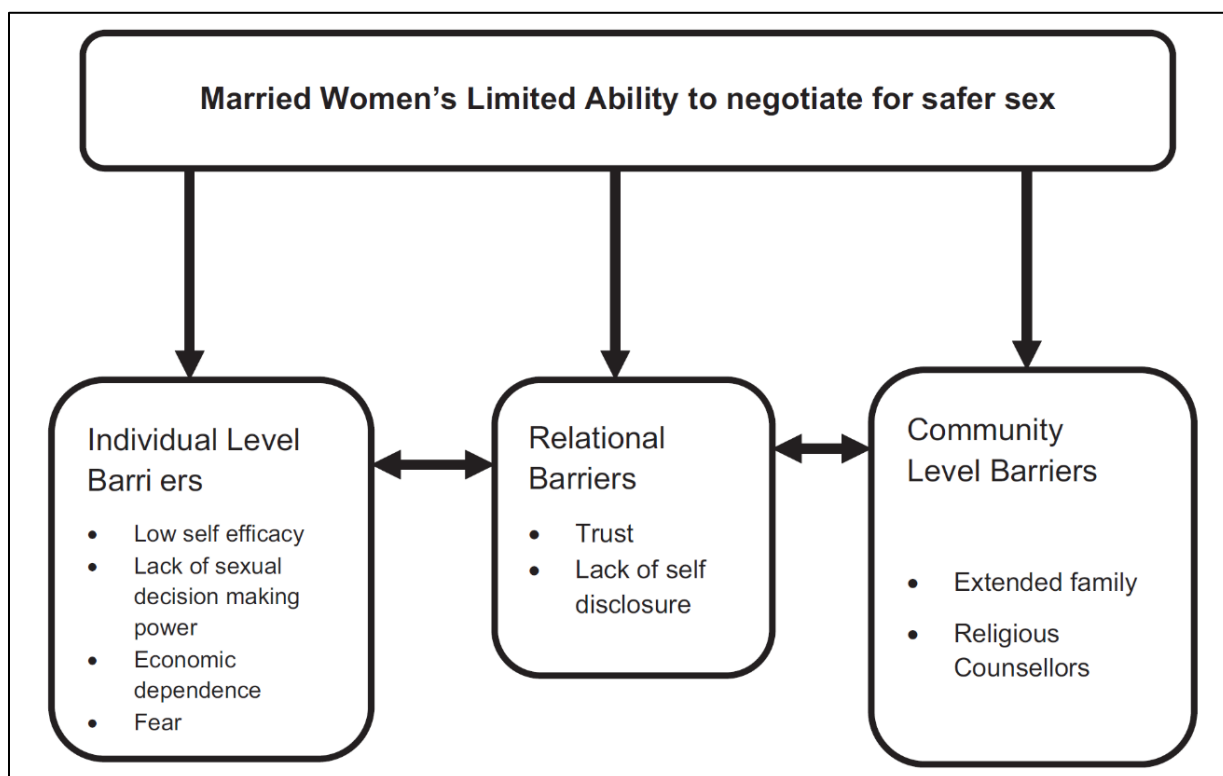
Risk in the HIV context, is defined as “The probability that a person may acquire HIV infection. Certain behaviours create and promote HIV infection, for example, multiple concurrent sexual partners where unprotected sex is practised” (UNAIDS 2008).

The epidemic in Zimbabwe has been described as remaining feminized, with girls and women taking on most of the burden and risk. The prevalence for females is higher than for males (GoZ 2015b:20).

Though the women indicated during the study that the HIV prevalence is high in Zimbabwe and that they are generally very vulnerable, they have not linked this to them being at considerable risk of acquiring HIV. This lack of awareness has given them the low risk perception. Of interest is that a substantial number of the respondents (41%), were married or co-habiting. The 2015 ZDHS showed that 62% of women interviewed were either married or co-habiting (GOZ 2016b:7).

A study was done that looked at barriers to safer sex practice in Zimbabwean marriages. Figure 5.1 summarizes the findings of the study. These barriers increase the risk of HIV for married or co-habiting women. This is of relevance to the researcher’s findings as Zimbabwe has a sizable percentage of married or co-habiting women and these are

largely vulnerable (as the study found) and therefore at risk, despite the respondents' low perception of risk. Therefore, mitigatory measures against risk of HIV, can in part be addressed by reviewing some of the barriers confronting married women.



(Mugweni, Omar and Pearson 2015:391)

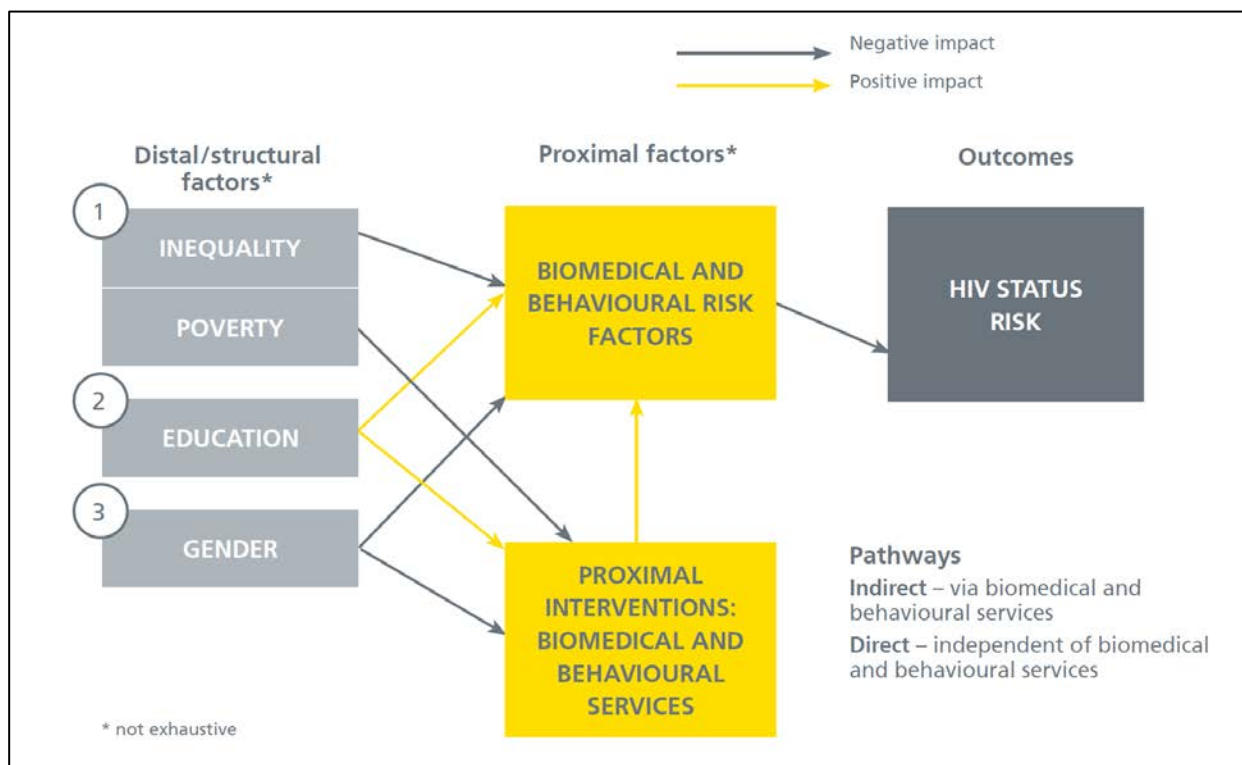
Figure 5.1: Barriers to safer sex practice faced by married women

The conclusion of the study was that safer sex in marriage is negotiated in a wider sociocultural context. “Effective prevention strategies must address this sociocultural context by targeting married women, married couples and community members to strengthen women’s ability to negotiate for safer sex” (Mugweni, Omar & Pearson 2015:397).

HIV and AIDS communication is a key tool for this targeting to take place for young urban women, some of whom are married. This will help mitigate the risk of acquiring HIV.

Gender affects HIV risk, particularly in countries with generalized epidemics. The risk pathways are direct and indirect as shown in Figure 5.2. Gender inequalities overlap and interact with structural factors such as economic inequalities and laws, policies and norms, reinforcing the risk of HIV, according to Byron et al (2006), Kim et al (2008) and

Weiser et al (2007) (UNESCO 2012:40). The pathways in Figure 5.2 emphasize that women are generally at a substantial risk of HIV.



(UNESCO 2012:38)

Figure 5.2: Simplified conceptual framework – risk factors and pathways for HIV

Women are at a higher risk (of being infected by HIV) than men, because of several factors that make them vulnerable: socio-cultural factors such as polygamy; socioeconomic factors such as economic dependence on men, leaving women with limited negotiating power for safer sex; biological factors whereby during penile-vaginal intercourse, women's bodies are more susceptible to HIV than a man's (Chinomona & Mwambi 2015: [15]).

5.5.4 Blame perception

The main perception was that women and men all carry the responsibility when it comes to HIV infection and therefore blame should be given to everybody. A sizable number blamed women. Several groups were highlighted as likely to spread HIV more than others, because of the context they are living in, such as their poor socio - economic situation (some women fell under this group) and some are born HIV infected. Other groups of people seen as at fault and spreading HIV infection, despite being able to avoid

doing so, were for example, promiscuous men and women, those succumbing to peer pressure and religious sectors that encouraged child marriages. It was interesting that the blame was also viewed by some as not being people's but being associated with poor IPC and the presence of social media.

As is the case globally, most women with HIV in Australia were infected through heterosexual sex (Persson 2014). In the media, these women are typically portrayed as having been deceived by men they trust, or in criminal cases against HIV-positive men from high prevalence countries, as victims. In two studies, the victim-culprit picture is challenged by the women's own accounts of acquiring HIV. The women did not see themselves as victims nor did they squarely blame the men, including men who had not disclosed their HIV status. The findings were themes of 'mutual vulnerability' and far more ambivalent allocations of responsibility (Persson 2014). This finding in Australia, agrees with the study findings in that the women do not portray a clear case of blaming anybody for HIV transmission, including men. Instead, they feel that each person, male or female, should take responsibility for their own behaviour.

5.5.5 Conclusions

- The women have the correct perception of HIV prevalence being high in Zimbabwe. The prevalence is highest in young women, followed by older men. This is because of the intergenerational sex between these two groups.
- Women believe that it is important that they be tested for HIV and know their status because this is an empowering decision that guides their next steps in behaviour.
- Should a young urban woman become HIV positive, she is most comfortable disclosing her status to someone who is close, who can be trusted and will not judge and who is most likely to be able to assist them in some way. This is often an immediate family member.
- Young urban Zimbabwean women have a low risk perception of being infected by HIV, which is not the correct perception. Research and a description of the context that they live in demonstrates that they are at a high risk of acquiring HIV.
- The women's sentiments were that no group of people can be blamed or said to be at fault when it comes to the spread of HIV. Everyone has a role to play, be it direct or indirect. Everyone must take responsibility. Certain populations or groups are more at risk of getting HIV infection, through no fault of their own while others increase the risk of being infected by HIV through their behaviour; these root causes are what need to be addressed.

5.6 Theme 4: Young urban women's context

5.6.1 Overview

There is agreement between the women and the organizations that the context in which 20-29-year-old urban Zimbabwean women live in is generally a difficult one. It is very demanding, competitive, one where the women are expected to play many roles including being a bread-winner and one that is very harsh. The women understandably are feeling under pressure, inferior to men and live under vulnerable conditions. This can be understood when their cultural, socioeconomic status, spirituality contexts and vulnerabilities, described elsewhere in this document, are examined; there are many cross-cutting issues. The majority are struggling to make ends meet and have resorted to sex work while others are in rushed and unhappy marriages or are into sugar daddies. Many are hustling and buying and selling goods because Zimbabwe has a very high unemployment rate and the jobs are hard to come by. Many of these women live in the high-density areas. There are some women who are well educated, working or running successful businesses; some are at university still. There is a combination of married and single women, with the single ones feeling the pressure to get married. Society is the one that is prescribing many things expected of these young urban women. There is another breed of woman who has a vibrant social life to the extent that this lifestyle ends up making her vulnerable as well, because of alcohol, drugs and multiple sexual partners.

Most of the people in Zimbabwe live in the rural areas; however, urban migration is ongoing and is resulting in the urban poor population increasing (MoHCC 2016c:6).

5.6.2 Vulnerability

5.6.2.1 Definition

According to UNAIDS, vulnerability “results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection” (UNAIDS 2008). Examples of such factors are: personal factors (such as inadequate knowledge and skills about how to protect oneself); service delivery factors (such as inaccessibility to healthcare facilities because of long distances); societal factors (such as social and cultural norms that stigmatize and disempower certain populations, and act as barriers to vital HIV prevention messages). Vulnerability can arise or be promoted from any combination of such factors, or it can be there because of just one factor (UNAIDS 2008).

In the context of the current study, some personal and societal factors are the ones that were explored. Some of the societal factors were found to contribute significantly to women's vulnerability in Zimbabwe (see Young urban women's context).

There was agreement from the women that their being women made them very vulnerable to HIV infection for an array of reasons. Some of the reasons are through no fault of their own, for example child marriages, lack of negotiating skills, rape, having sugar daddies and engaging in sex work due to economic hardships leading to poverty. Other reasons were more out of choice: rushed marriages (although this is sometimes due to economic pressure), lack of condom use, and promiscuity in the form of multiple sexual partners due to several reasons, rather than faithfulness to one partner.

5.6.2.2 Gender roles

Gendered expectations of girls and boys start early in the life of a child and are formulated through family practices, community norms, school, influence of media, to name some factors (UNESCO 2012:11).

The society in Zimbabwe is patriarchal and the women have identified this. Their role dictates that they be subservient even to their demise. It is permissible for men to have several sexual partners yet this is not the case for women. It is also difficult to negotiate for sex especially in a marriage. The solution, in part, is in engaging the men to change their outlook and to be agents of change, but also in empowering women to mitigate this. The organizations interviewed have explained that many efforts have been and are being made to empower women, for example out-lawing child marriages, promoting education advancement for young girls, together with life skills, and GoZ is attempting to link health and gender as cross-cutting issues in every area. There are also practical steps that can be taken for empowerment using biomedical HIV prevention methods within their control, whereby the women can act to protect themselves from getting HIV infection, for example PrEP (see HIV knowledge).

In young women, HIV prevalence is significantly higher than in males – one example is in the 20-29 age group where 20% of women have HIV compared to 10% (GoZ 2015a:26).

In the ZDHS, HIV prevalence was found to be highest in those who were divorced, separated or widowed, followed by those who are married or living together. It was lowest in those who had never married (GoZ 2015b).

These findings indicate that women have been affected by HIV infection to a greater extent than men. Further to this, the ZDHS finding indicates that women who have been or are married or cohabiting are more at risk of being infected with HIV, than those who

are still single. This could be because of not being able to negotiate for safe sex, and the accepted cultural norm of multiple and concurrent partners by men.

The ZDHS carried out between 2010 and 2011 states that gender inequality manifests within marriages and relationships – only 68% of men believe a woman can refuse sexual intercourse if she is aware that her partner has other sexual partners (Avert 2017). This means that a considerable number of men believe that they have a right to have sex in a relationship even if they have other sexual partners. This is the thinking that needs to be addressed and changed.

In Zimbabwe, the participation of males is low, in addressing gender issues and serving as change agents and role models – the recommendation is to engage key male leaders at all levels, and advocate for them to lead in addressing socio-cultural barriers that stifle safer sex (GoZ 2015a:29).

Men, at community as well as national level, have a key role to play as champions of both HIV and AIDS and socio-cultural issues in mitigation of women vulnerable.

Gender equality in access to education, is a basic human right. It is also central to achieving Education for All (EFA). Out of the 67 million children believed to be out of school in 2011, more than 50% were girls (UNESCO 2012:11).

Formal education can reduce vulnerability to HIV by exposing girls and boys to information, improving economic prospects, building self-esteem and skills, and by influencing the balance of power with sexual relationships. There is an estimation by the Global Campaign for Education that universal primary education alone would prevent 700,000 new HIV infections each year (UNESCO 2012:12).

It has been demonstrated that education is a tool that contributes to HIV prevention. In the long-term.

Most of the young urban women do not see the link between HIV and education level. Their thinking was more short-term: they failed to realize that although biologically everyone has the potential to be infected by HIV, the middle to long-term effect of being well educated is being able to better articulate general and HIV and AIDS information, and better understand women's vulnerabilities, getting better employment, and becoming financially independent and not being forced into situations where one feels their only

choice is to listen to men (for example not being able to negotiate for condom use) or to rely on men for money and material things.

Several measures by the GoZ were introduced as a means of addressing the gender disparities that prevail in the education sector. One of them was an affirmative action policy in 1995, at higher education institutions of learning, where females are encouraged to enrol in university degree programmes with slightly less points than their male counterparts. Barriers to education for girls and young women exist in several forms including discrimination, cultural and patriarchal beliefs, gender stereotyping demotivating girls and young women into following non-traditional study areas (such as scientific and mathematical ones), early unplanned pregnancies leading to school drop-outs, early marriages through harmful religious and traditional practices, and poverty such that boys are chosen over girls for school, when resources are scarce (MoWAGCD 2014:13-14).

Defraying schooling costs to girls and their families through stipends, scholarships and cash transfers, are examples of policies and programmes that need to be actioned on behalf of the girl child (UNESCO 2012:22). Related to this, a few recent studies suggest that cash transfers, especially conditional ones, can be effective for HIV Prevention. Though not a magic bullet, they are one tool that can be used (UNESCO 2012:37).

GoZ has identified barriers to education for girls and young women and have started to address and counter some of these. Lowering requirements for women to enter tertiary institutions is controversial as this may appear as though women are of inferior intelligence, may be unfair, may appear to be discriminatory towards men with lower requirements, or make questionable their resultant qualification or competency. Other options that should be explored fully including conditional cash transfer, stipends and scholarships.

According to UNESCO in 2009, the International Technical Guidance on Sexuality Education (ITGSE) defines CSE as an 'age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information' (UNESCO 2015:12).

CSE is gaining momentum and interest at international, regional and national levels. It may be delivered as a stand-alone subject or integrated across relevant subjects as part of the school curricula (UNESCO 2015:24). There is also the question of whether CSE

should be compulsory or optional. However, in the absence of it being compulsory, there will be no guarantee of it being effective (UNESCO 2015:25).

There is clear evidence that some of the benefits of CSE are HIV prevention, and gender equality. CSE is a critical enabler in responding to HIV and should therefore be part of national HIV responses. To fast-track the HIV response and end the AIDS epidemic among young women and girls across Africa, according to a UNAIDS and AU 2015 document, UNAIDS recently cited comprehensive age-appropriate sexuality education, as one of the five recommendations (UNESCO 2015:38).

The University of Western Cape HIV and AIDS policy recommends that all facilities integrate HIV and AIDS content into the curriculum for both undergraduates and postgraduates (Baelden et al 2012:174).

Integrated curriculum rather than stand-alone HIV curriculum is a recommendation that can be taken up in Zimbabwe, together with CSE.

5.6.2.3 Gender-based violence

The women viewed GBV towards them as a contributing factor to HIV spreading. Violence destroys the relationship between the husband and wife, and whether they stay together, separate or choose to get divorced, both parties may seek other sexual partners and the sexual network widens. If they do stay together, the wife might become afraid to negotiate for safe sex.

The 2010-11 ZDHS reported that young women are more likely to believe that men are justified to beat their wives (for an array of reasons), than even the men – men were found to be less likely to justify wife-beating (Avert 2017). This is of great concern and indicates a need to educate the women and change their mind set concerning GBV.

According to the National Gender-Based Violence Strategy for 2012-2015, the GBV levels, especially on women and girls, is of concern; they are victims of 99% of GBV cases in Zimbabwe. GBV and health outcomes have a widely recognized link (MoHCC & UNFPA 2016:15). The Zimbabwe MoWAGCD supports and trains Ward Development Coordinators, a type of community cadre, in GBV prevention, counselling and paralegal assistance, according to the National Gender-Based Violence Strategy (MoHCC & UNFPA 2016:16). The GoZ is making efforts to GBV prevention, and this is commendable.

5.6.2.4 Epidemic drivers

The women and key informants identified similar HIV epidemic drivers. These are notably related to culture and gender; the disempowerment of women is an important contributor. Poverty driving women to engage in sex work, because of the adverse economic environment, was a key contributor to HIV. Multiple concurrent partnerships, for assorted reasons, were mentioned as a major epidemic driver, as were intergenerational relationships such as sugar daddies and child marriages.

During a media tour of the province of Matabeleland South, in Beitbridge, the NAC Acting Provincial Manager/Monitoring and Evaluation Officer highlighted the high prevalence in the town. He attributed such elevated levels to mainly spousal separation, low and inconsistent use of condoms, low risk perception and intergenerational sex. Beitbridge is the major border post in Zimbabwe and shares a border with South Africa. Sex work is rampant in the town (Kafe 2017:4).

The women's risk perception needs to be high so that they can behave in a manner that reflects their awareness of this (see Risk perception). The young urban women also need to learn negotiation skills for condom because of the wide sex networks they are in the middle of – while men may have many sexual partners, some of the young urban women, particularly those who do sex work, also have many sexual partners, creating a vicious cycle, and heightening their risk of being HIV infected.

The ZDHS indicated that the mean number of sexual partners in a lifetime was 1,6 and 1,8 for females aged 20-24 and 25-29; for males, it was much higher at 4,7 and 6,3 for 20-24 and 25-29 (GoZ 2016b:36-37). The 2015 ZDHS further confirms that men in Zimbabwe are 14 times more likely to have multiple sexual partners than women (Avert 2017).

This clearly puts women in a compromised position. It is evident from these numbers that in the general population, men have significantly more sexual partners than women, and this is one undeniable epidemic driver, as the sexual network becomes very wide.

Some of the epidemic drivers in Zimbabwe, according to ZINASP III, are multiple and concurrent sexual partnerships, inter-generational sex, discordant couples and low circumcision rates (GoZ 2015a:28).

Both contracting and transmitting HIV are increased by having multiple partners (GoZ 2016b:36).

Most of the epidemic drivers are rooted in women's vulnerability, related to harmful sociocultural norms (multiple and concurrent partners as evidenced by sexual partners in a lifetime statistics) and poverty and therefore economic dependence on men (sex work, intergenerational sex), and these culminate in wide sexual networks. This agrees with the fact mentioned earlier that in Zimbabwe the main HIV transmission mode is through heterosexual intercourse.

The HIV and AIDS communications should centre around combination prevention interventions, as this is the national overall strategy. The GoZ, to address the sexual transmission of HIV, has prioritized social and behaviour change, increased condom promotion together with distribution and consistent use of condoms, VMMC and prevention of STI's. These are the strategies that are targeting the epidemic drivers, although other strategies are in place (GoZ 2015a:28).

The variation in HIV prevalence, according to a study done in Zimbabwe, are driven by biological, socioeconomic and socio-cultural factors. Of importance is that sexual contact remains the key driver of HIV transmission among those that are sexually active in SSA (Chinomona & Mwambi 2015: [15]).

5.6.2.5 Sex work

Young urban women see sex work as key to propagating HIV infection. Together with other scenarios, sex work lays the ground for multiple concurrent sexual partners and unprotected sex, though the latter comes at a price. This goes against the one partner and use of condoms teaching.

Provinces in Zimbabwe that house the main border entry points (Beitbridge, Kariba, Plumtree, Victoria Falls, Nyamapanda, Forbes) have shown high risk factors with highest HIV incidences – sex workers' incidence rate was tenfold that of natural incidence data (GoZ 2015a:20).

One innovation by NAC at Beitbridge, a border town in Zimbabwe rampant with sex work, housed in a province with currently the highest prevalence for HIV in Zimbabwe, is the introduction of 'moonlight clinics'. These clinics are mobile clinics where HIV-testing is done. So far, they are held twice a year in Beitbridge at strategic times such as when the community organises cattle auctions. Sex workers and their clients are targeted and any other people who may not want to go for testing during the daytime when they might be

visible. These clinics are held at nightclubs, musical shows, truck stops and other strategic places (Kafe 2017:4).

5.6.2.6 Sugar daddies/blessers

The women acknowledged that sugar daddies have a definite link to HIV infection spreading. The setup is seen to be like polygamy, by the women. Sugar daddies are not a new phenomenon in Zimbabwe; they have long since been there. They now also go by the name 'blessers'. What takes place between these blessers and urban woman or 'blessees' is transactional sex. Because it is across generations, as the men are much older, it is also intergenerational sex. The women get their material goods and/or money in exchange for sex. According to the women, this is often unprotected sex. The unprotected sex, likelihood of multiple concurrent partners by the men, and the fact that the men, being much older, have been having sex for much longer, increases the risks of the women getting infected by HIV infection. In addition, the women involved with sugar daddies may have more than one sugar daddy and/or may have their own boyfriends, hence the sexual network dangerously widens. Poverty has driven most of these women to seek out sugar daddies, to cover their needs. The context they are living in makes them vulnerable.

In SSA, relationships with large age-differences are common; 15% of young women aged 15-19 in Zimbabwe report having had sex with a man at least 10 years older, according to the 2010-11 ZDHS. This sugar daddy culture creates an environment that can elevate the HIV risk, since older men hold the power in the relationship and/or they are likely to have HIV (Avert 2017).

There is a general belief that young females engage in sexual activities with older men, and this was also seen in the HIV study in Zimbabwe, which shows an additional effect of age on the gender effect on HIV prevalence that sees young females being at a higher risk of HIV than their young male counterparts (Chinomona & Mwambi 2015: [15]).

Though blessers are known in South Africa, in Zimbabwe, they are rampant and known more commonly as 'sugar daddies'.

5.6.2.7 Polygamy

Polygamy was viewed as something that drives HIV infection because the scenario involves one man with multiple concurrent partners. There is also no guarantee of the women's faithfulness in such a set-up, whereby they may possibly feel that they are being

short changed or that they also need someone on the side. The moment anyone in the circle is HIV positive, the risk of getting HIV is there, as it is unlikely that the married women would be able to negotiate safe sex. In such a competitive setup, this would be highly unlikely.

Zambian male cultural practices that could lead to HIV transmission, include widow inheritance (see Culture). Most of the time, the women involved have no option of refusal and even if successful, they are likely to be rejected by the husband's family. Polygamy is one of the factors listed as promoting HIV transmission in Zambia. It may be because of sexual cleansing or wife inheritance. Polygamy and extramarital relationships are tolerated culturally but are key to understanding Zambia's high HIV prevalence (Menon 2014:101).

Some African cultures, such as those in Zimbabwe and Zambia, tolerate concurrent and multiple sexual relationships, including polygamy. Whichever form the concurrent and multiple sexual partnerships come in, it is of concern, as the risk of acquiring HIV for the women involved becomes higher.

'Small houses' facilitate the spread of HIV, according to the women. Multiple concurrent sexual partners whereby one man has his official wife and then his 'unofficial' wife that he cares for on the side, maybe even more than one, makes it risky for a woman to be in such a relationship.

Relation dissatisfaction played a key role in the engagement of concurrent sexual partnerships, in a study carried out in Zimbabwe. Depending on the source of the dissatisfaction, four possible types of concurrent sexual relationships were formed: sex worker, casual partner, regular girlfriend or informal polygamy or 'small house'. These had different intimacy levels, which influenced practicing safer sex (Mugweni, Pearson & Omar 2015).

5.6.3 Community involvement

Young urban women see the community playing a significant role in HIV and AIDS communication. Some could describe the community work they were already seeing on the ground, while others gave some recommendations on activities that could be done at community level for possible adoption.

Healthcare workers were viewed as being very central to the community work that was being done, either at clinics or through other ways in street or door-to-door HIV awareness

campaigns. Home-based care workers share information on HIV and AIDS. There are also sporting activities coordinated by some NGOs where service delivered is explained and offered, for example, testing and counselling. New Start Centres are widespread and funded by NGOs. They share HIV and AIDS information and offer service delivery related to HIV such as HIV testing and referral for VMMC.

Schools and colleges are involved in teaching children, adolescents and young adults about HIV and AIDS, and there is peer education.

What became clear in talking to the respondents, was that the level of community involvement needed to be increased. Recommendations on further activities were: support groups for women; the municipality putting condoms in public toilets; using community halls and churches for gatherings to share information and be taught further on HIV and AIDS.

The key informants felt that urban people are very individualistic and it is therefore more challenging to engage the community and bring them together, unlike in rural locations. They feel that dialogues should indeed be happening within the urban community, as is the case in rural Zimbabwe. In the rural areas, funerals and church gatherings are opportunities to share communicate HIV and AIDS issues. In the rural areas, there is peer education taking place, the use of VHWs who are mobile and can spread information on HIV and AIDS. The organizations interviewed feel that community-driven initiatives are more effective and sustainable as they will have the community's buy-in. Community leaders need to be part of these efforts.

Community members are unique in that they can access and address their own people's needs (MoHCC 2016c:12).

Because of this, it is reasonable and expected that community members should be involved in HIV and AIDS communication within their communities. What is required is availability of these people, as well as some level of training in some instances, and at times incentives or at least allowances, to enable them to move around and do their work properly. Community involvement can either be formalized or coordinated through MoHCC or it can be approached in a less structured manner within the community. Much has been done in the form of structured community involvement through volunteers.

Rural and urban community health programmes are designed in an analogous manner. This is despite the health challenges, infrastructures, economic and socio-demographic

conditions being basically different. Health promoters' role in urban settings is similar to that of VHWs, including profiles, trainings and remuneration (MoHCC 2016c:14). VHWs, BCFs and some of the other CHWs, operate in the rural and peri-urban areas; their role is mostly prevention of disease and health promotion (MoHCC 2016c:9) Designing an urban community health programme and implementing one, is enshrined in the Community Systems Strengthening Logical Framework for 2017 – 2021(MoHCC 2016c:33).

Most of the community work being done by health workers is in the rural and peri-urban areas; there is a gap for similar work in urban areas, although efforts do exist.

ZNASP III states that community volunteers have limited capacity to address social and cultural factors that influence behaviour – the recommendation is therefore that community-based volunteers should be identified, recruited, trained and retained to address social and cultural norms. One SBCC priority area is that it may be necessary for minimum packages for social mobilisation to be developed for both professionals and community volunteers (GoZ 2015a:29).

An exercise carried out confirmed the presence of several community committees. They represent the interests of the community and coordinate service providers. They have a monitoring role and are also involved in dissemination of information and community mobilisation. Membership comprises traditional, political, religious leaders and community cadres. An example of a committee is the GBV Committee (MoHCC & UNFPA 2016:36).

Community systems strengthening, in addition to being a way to improve access to and utilization of formal services, is crucially targeted at increasing community engagement. Community engagement is defined as “Meaningful and effective involvement as actors as well as recipients in health care, advocacy, health promotion and health literacy, health monitoring, home-based and community-based care and wider responses to disease burdens” (MoHCC 2016c:11).

Communities should be encouraged to meet and discuss HIV and AIDS issues with a goal of calls to action for the volunteers, who will be the implementers. This way each community member can opt not to be left out, as not all will volunteer to be peer educators, BCFs etc.

A key issue with CHWs, the official cadres tasked by MoHCC to carry out health-related work in the community, is that they have overlapping roles and functions with some community groups. Roles and responsibilities of local and traditional leaders, community mentors, community-based organizations (CBOs) and groups have not been clearly defined to be effective and sustainable. Another issue is that the diverse and dynamic nature of communities is often overlooked during the formulation of community engagement strategies – for example, a person may be part of more than one community, since communities are such because of commonalities such as religion, culture, share experiences, geographical area, values etc. Key and vulnerable populations also need to be included in communities (MoHCC 2016c:12). In the context of this study, young urban women are vulnerable, and female sex workers fall under key populations.

5.6.4 Spirituality

There is agreement between the young women and the organizations' responses that spirituality is central to HIV and AIDS communications. In Zimbabwe spirituality refers mostly to religion, which is Christian for the majority. The Church has always been regarded as a moral compass as it encourages high morals and good behaviour. Other aspects that it is useful for came out as a place where people congregate and therefore the various meetings can be used for discussing and teaching on HIV and AIDS, including by out-sourced professionals as well as through church leaders from within the congregations. Campaigns can be held at churches. The down side is that some religious sectors are miscommunicating HIV and AIDS issues and, for example, encouraging congregants to not take ARVs. Here, lies the danger of spiritual leaders, because they yield such power and influence and most will believe anything they are told by them. The testing for virginity that was mentioned by one of the respondents (carried out by some religions), is not to be adopted as a good practice as it is a human right violation. It does not promote HIV prevention, but if anything, it exposes the girls to men who are looking out for virgins as a preference, including for the belief that having sexual intercourse with a virgin cures HIV infection.

5.6.5 Socioeconomic status

The socioeconomic status for the majority of young urban Zimbabwean women is very dire. Together with the undesirable cultural norms, the socioeconomic status is largely what defines these women (main conclusions). They are struggling to make a living and do not have many options to survive. Therefore, they are resorting to blessers and/or sex work and by so doing, are vulnerable and are at high risk of getting infected by HIV. The

outlook seems to be more short-term so that they can feed themselves and those they are responsible for, and not looking at the long-term effects of being HIV-infected with the possibility of getting AIDS and dying. Most of the women struggling to make a living are not well educated, and here we see an association: the better educated women will generally struggle less; they have more options. Those who are not well educated, end up depending on men (see Educational level). However, even those who get work, may be offered jobs in exchange for sex; some also must exchange sex for promotions. Even at tertiary education level, some lecturers expect sexual favours in exchange for awarding good pass marks.

The Social Services and Poverty Eradication Cluster under Zim Asset, seeks to improve the living standards of the people. It is comprised of programme area that will be integrated to other programmes from other clusters. These programmes include employment creation, alignment of legislation to the New Constitution, gender mainstreaming, human capital development and economic empowerment (GoZ 2013:61-63). “Social Service Delivery” is a key result area in the Social Services and Poverty Eradication Cluster. It encompasses most of the cluster outcomes such as reduced HIV infections among children and adults, reduced financial barriers to health services, for example, increasing the budget allocation to Health to 15% of total government allocation, which is according to the Abuja agreement (GoZ 2013:66-69). “Improved Standard of Living” is another outcome stemming from the same cluster while “Improved gender equality and equity” is the expected outcome for the key result area related to gender development (GoZ 2013:74-75).

However, as will be seen from some aspects of ZAMPS, some of the intentions of Zim Asset do not appear to have materialized on the ground; there has not been any employment creation or improved standard of living for most of Zimbabweans. The jobs available have become less and the standard of living has generally come down. This directly affects young urban women, who are part of the population, and magnifies their already existing dependence on men for a living; women are currently more vulnerable than ever in the prevailing environment in Zimbabwe.

ZAMPS gives an indication of how difficult the economy in Zimbabwe is. The survey was carried out in July 2017. The household income distribution stood at 29%, for those earning up to USD\$100; 55% for those earning between \$101 and \$500; 16% earning

\$501 upwards (ZARF 2017:16). This is showing that the majority of those who were working were earning on the lower end of salaries.

The picture is bleak with a very large portion (45%) of those interviewed in ZAMPS not earning any income: unemployed (16%); house-wife (10%); student (15%); retired (4%) (ZARF 2017:12). Those who were earning money were self-employed, in full-time formal employment, working part-time or in informal employment (ZARF 2017:12). Most of the respondents were aged 21-25 years (18%) followed by 26-30 years (16%) (ZARF 2017:9).

Adolescent girls and young women typically lack access to financial capital and have more limited opportunities to acquire education, knowledge, and skills that can lead to economic advancement, thus making them among the most economically vulnerable group (MoWAGCD 2014:18).

The dire socioeconomic context the young urban Zimbabwe women live in has driven them to seek out intergenerational and transactional sex through sugar daddies or blessers as well as through sex work (see Epidemic drivers, Risk perception and Vulnerability).

5.6.6 Culture

MoHCC felt that culture is a key issue, and confirmed that it is very central to their communication efforts; it was seen as undesirable to not consider culture as this would raise suspicions of being donor-driven rather than getting the local people's buy in. Buy-in is essential if HIV and AIDS communication is to have an impact and make a real difference. Culture was viewed as very tricky by one organization and at times contrary to Human Rights; this means it must be handled wisely.

Some organizations consider culture in designing their HIV and AIDS communications whilst others do not. One of the NGOs pre-tests material and adjusts the final output accordingly. One organization highlighted that rural women are affected more by culture than young urban women. However, they still consider culture because of the general societal expectations where women are subservient.

Many of the women do not seem able to describe the cultural issues that are incorporated in HIV and AIDS communications, with only male circumcision and good morals coming out. Dramas and talk shows are the identifiable platforms where cultural issues come out but it is felt that these platforms should be increased.

A priority area for SBCC is for interventions to address socio-cultural factors that limit adoption of safer sexual practices, for example, gender inequity, inconsistent condom use and VMMC uptake (GoZ 2015a:30).

The GoZ has recognized the seriousness of harmful norms and is cognizant that it pulls in the opposite direction to HIV prevention. It has therefore made this a priority and put strategies in place to counter these harmful socio-cultural norms and these will be highlighted through SBCC, something that is commendable. Harmful socio-cultural norms threaten progress in the HIV epidemic.

5.6.7 Government policy

5.6.7.1 Overview

The most visible work that government is doing in HIV and AIDS communication, according to the young urban women, is in hospitals and clinics, in partnership with NGOs and donors, as well as outside of health institutions on road shows and campaigns. Other Government ministries have been recognized by the women as being involved in HIV and AIDS communication, such as the Ministries of Education and Social Welfare. The MoWAGCD was not mentioned by the women, yet this should have been one of the key ones seen to be communicating HIV and AIDS issues in relation to women in Zimbabwe. Some women are oblivious to any efforts being made or laws being put in to place or already in place that relate to HIV and AIDS. All this is despite the Government having an HIV focal person in each ministry; neither was NAC mentioned by the respondents in terms of what they are doing for HIV and AIDS communication, yet they are the administrators of the AIDS Levy which comes from all formal income tax.

There is a disconnect between the mass media and IPC women talked about elsewhere in the study and Government and policy makers – the women are not linking the two, yet almost all communications are through the Government, at times in partnership with civil society, NGOs and/or donors. For example, many of the billboards, posters and pamphlets have an MoHCC logo. Women do not seem aware of the work the MoWAGCD, Zimbabwe Youth Council, and the Municipality are doing.

Child marriage is a recurring issue under several themes and is also singled out as an issue women see as being addressed and advocated for by government and policy makers. Human rights lawyers and female MPs are policy makers that are visible to the young urban women, and known to be working on child marriages.

The 2016 UNAIDS Gap Report reported that in 2015 Zimbabwe produced a national HIV investment case. By targeting specific locations and populations, it promoted effective, efficient and sustainable investments in the HIV response (Avert 2017). The mainstays of the investment case include community systems strengthening and scaling up existing HIV prevention interventions (UN Zimbabwe 2014).

Community involvement is a key component of HIV and AIDS communication, and SBCC is also a major prevention strategy.

The Government has a national strategy, ZNASP, “designed to bring hope, ensure no one is left behind, be at the right place for the right people and right location most affected by the epidemic, and working together to begin the ending of the AIDS Epidemic” (GoZ 2015a:18). The document succeeds ZNASP II (2011-2015) and aims to align the national response to the 2013-2018 Zim Asset priorities of Government, to contribute to the HIV sector (GoZ 2015a:20).

The “right people and right location most affected by the epidemic” to a considerable extent refers to women, as they are the most infected and affected by the epidemic, particularly those in urban areas, as these are affected by HIV more than rural areas – the strategies such as ZNASP should be simplified so that they can be articulated by ordinary people, and MPs can assist with this.

ZNASP III has outlined national SBCC priorities, one of which is for the availability of advocacy materials for policy makers at all levels to promote an enabling environment and uptake for HIV prevention services (GoZ 2015a:29).

Government is also the main service provider for HIV-related service delivery, mainly in the public sector, and another SBCC priority area is for the existence of clear linkages between SBCC and service provision (GoZ 2015a:30).

In the Afrobarometer, 58% did not want government to prioritise HIV and AIDS above other problems (Ismail 2011:17). Ironically at the same time, AIDS was shown to be the main killer of women and children. In the same study, generally the people are satisfied with Government performance on HIV and AIDS (Ismail 2011:2). The success of the AIDS levy, highlighted earlier, is believed to have influenced the public’s opinion positively (Ismail 2011:17).

If the public focuses on the AIDS Levy, which is one of the more visible efforts related to the HIV epidemic, their outlook is limited because the levy is only one source of finance

for HIV and AIDS programmes. MoHCC and its partners have other financial resources which capacitate them to implement HIV and AIDS communication through various programmes. As mentioned earlier, young urban women do not seem to be preview to this or aware of this. Public awareness needs to be there so that people know that the Government has other responsibilities in the HIV epidemic outside of administering the AIDS levy.

The development of the community systems strengthening framework was an inclusive and participatory process, guided by a technical committee. The first step was the community mapping exercise (see Community involvement and IPC) (MoHCC 2016c:18). Several considerations in the community systems strengthening framework include that health promotion/education and community mobilization are cross-cutting, and that message development and delivery should be based on an integrated approach. Secondly, information and services (for especially HIV), were to be tailored to several groups including adult women and key populations. Thirdly, the minimum packages for urban settings must be developed. These should incorporate health problems, infrastructure, economic and socio-demographics in urban settings (MoHCC 2016c:24).

The Government has put structures in place to strengthen community systems, mainly through community workers. They recognize in the process that there are many overlaps and that integration is required for message development.

The National Girls' and Young Women's Empowerment Framework is the first one of its kind in Zimbabwe. It confirms Government's commitment to empowerment of girls and young women. Prevailing issues include to eliminate discrimination against the girl child, negative cultural attitudes and norms, discrimination in education, skills development and training, to eradicate violence against the girl child and young women, to promote effective participation in decision-making and leadership for the girl child and young women at household level, community and societal levels, and strengthen the family's role in improving the status of the girl child and young women (MoWAGCD 2014:5).

The goal of UNESCO's Strategy for HIV and AIDS is 'Universal Access to HIV prevention, treatment, care and support' (UNESCO 2011:6) Strategic priorities are three: building country capacity for effective and sustainable education response to HIV; strengthen comprehensive HIV and sexuality education; make progress in gender equality and human rights (UNESCO 2011:7).

The global initiative on education and HIV and AIDS (EDUCAIDS), is one of UNESCO's responses to HIV. EDUCAIDS develops, supports and promotes comprehensive education sector responses. Through an independent evaluation of EDUCAIDS in 2009, it was found that there had been progress, for example in the integration of HIV into curricula for teachers and secondary school students and that EDUCAIDS has contributed through availing resources strengthening coordination and sharing best practice (UNESCO 2011:25). The GoZ can work with UNESCO and utilize strategies that are already in place for building capacity for HIV issues in the education sector in Zimbabwe.

HIV education and knowledge is a strategy for wide coverage of HIV issues, especially in Zimbabwe where there is a persistence in a culture of polygamy, gender inequality, patriarchy and sugar daddies (Avert 2017).

5.6.7.2 Role of Government and NGOs

The GoZ and NAC have the joint goal of ensuring that HIV and AIDS communication facilitates behaviour change. These organizations have complimentary and sometimes overlapping roles in HIV and AIDS communication. They are both part of national communication technical working groups and committees. The MoHCC chairs these forums. NAC plays a Secretariat role. NGOs give technical assistance and guidance in programme-related communication including in content design.

All organizations, whether Government entities or NGOs have the common goal of creating demand for HIV services. The MoHCC is rightly so the custodian for formulating the strategy for demand creation, and this falls under HIV and AIDS communication.

There are several departments in the MoHCC involved in HIV and AIDS communication and their roles seem to sometimes overlap. The Health Promotion Unit, Public Relations Office and the office in the AIDS & TB Unit that houses the Communications and Advocacy Officer, work together to coordinate awareness campaigns and media relations' management. Unlike NGOs, MoHCC has the responsibility to ensure that editors and journalists are well educated on HIV and AIDS and that they are reporting accurately. Roles within MoHCC need clear demarcation.

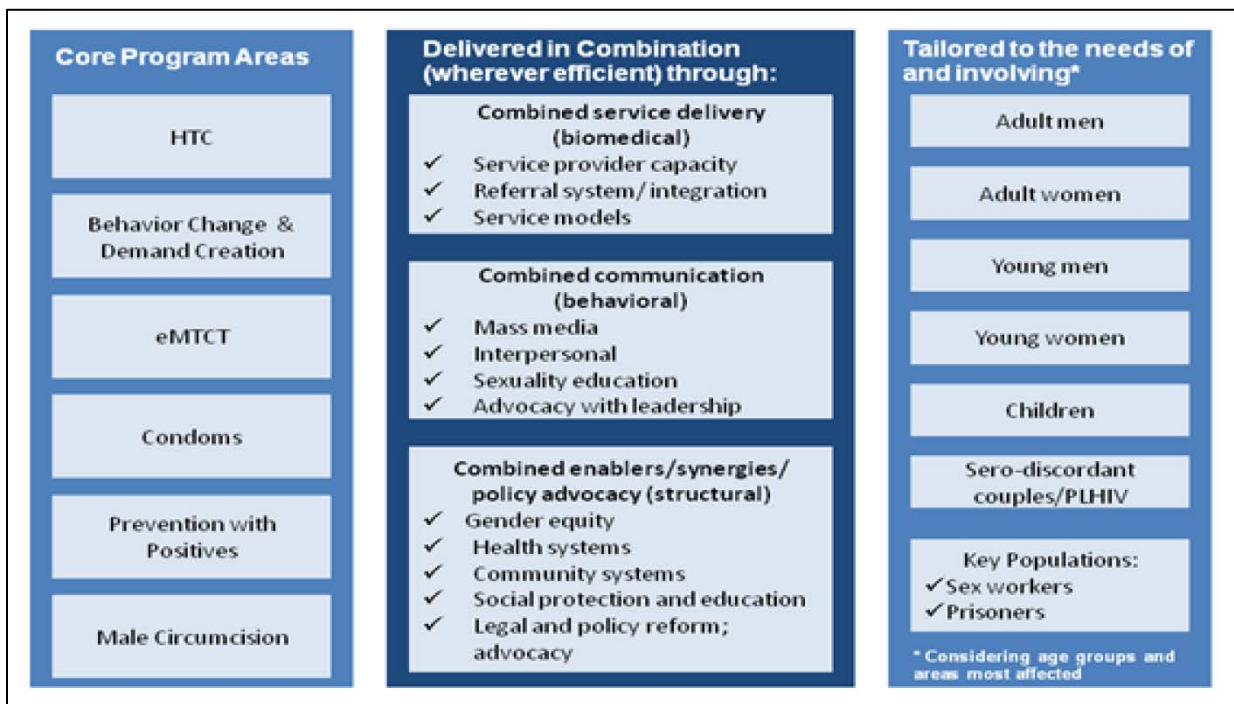
Interestingly, NAC, a parastatal and therefore a government entity, also has a coordination role, and is the organization solely focused on HIV and AIDS, unlike MoHCC which has a broader health responsibility in addition to HIV and AIDS. NAC also runs programmes, as does MoHCC with technical input from NGOs.

ZNASP III states that NAC coordinates and manages the multisector national response through its decentralized structures. It has ensured the inclusion of traditional leadership, faith-based organizations, private sector, for profit companies and partners, non-state-actors, other government sectors, PLHIV, key populations, hard to reach communities (GoZ 2015a:45). Here we see that NAC is well-positioned to address the thematic areas that have come up in the study, especially given that there are many cross-cutting issues. NAC is the organ that brings together all HIV stakeholders.

5.6.7.3 Targeting young urban women

Young urban Zimbabwean women have not been targeted in HIV and AIDS communications as a stand-alone group, with one organization saying it feels this group is neglected and just one organization saying that it did target this group: sub-populations of those living in the urban areas have been covered in the form of pregnant women, HIV positive women, sex workers, victims of GBV, victims of rape, those living in high-density. Rural areas have tended to be targeted more than urban areas, and the young urban women have not been covered as much as they should be, given that they make-up the population with the highest prevalence. It was assumed that they are covered in general communications that target the public at large. The nation-wide strategy encourages the targeting of specific populations, though not by location (urban and rural):

The SBCC being employed nationally, according to ZINASP III, focuses on approaches and messages designed with specific populations in mind (GoZ 2015a:28). The Zimbabwe Combination HIV Prevention Delivery Model shown in Figure 5.3 clearly demonstrates the tailoring for adult women, young women and sex workers, which covers young urban women aged 20-29 to an extent. Combined communication is also acknowledged as being central to the model; behaviour change and demand creation is also shown (GoZ 2015a:67)



(GoZ 2015a:67)

Figure 5.3: Prevention output results matrix

ZNASP III acknowledges that SBCC has the potential to be very effective, if delivered to the appropriate population in combination with other evidence-based HIV prevention and care services. In addition, a strategy is for SBCC to be targeted primarily at those at most risk and key populations (GoZ 2015a:69). In Zimbabwe, women are at great risk, and sex workers, who are primarily women, are one of the most visible key populations.

A survey was carried out by MoHCC, supported by UNFPA (MoHCC & UNFPA 2016:4). The target groups for the 77 types of community health care workers were 25, with the most targeted groups as follows: young men aged 10-24 – 77%; young women aged 10-24 – 71%; adolescent girls aged 10-19 – 71%; adolescent boys aged 10-19 -70%; women above 24 years – 65% and PLHIV – 65%; sex workers were on the lower end at 27%. There is further disaggregation of target groups by cadre type (MoHCC & UNFPA 2016:41).

It is encouraging to see that women were well-catered for in the most targeted groups as young women, adolescent girls, women above 24 years, part of PLHIV and sex workers. However, community cadres are primarily active in rural and peri-urban settings (see Community involvement). Their work needs to be extended to cover urban areas more widely.

5.6.7.4 Regional cooperation

Historically, there have been efforts for countries in the region to come together and work on HIV and AIDS communication aspects. Currently not much is being done. NGOs usually take on the role to coordinate this, but it seems that donors are focusing on country-specific programmes more than regional programmes.

In 2012, the AU Commission and the New Partnership for Africa's Development (NEPAD) had their roadmap endorsed at the 19th AU Summit (GoZ 2015a:45). The roadmap was on shared responsibility and global solidarity for AIDS, TB and Malaria response in Africa. An HIV and AIDS Strategy Framework 7 is maintained by SADC. “The Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in the ESA was affirmed in December 2013 including by Zimbabwe” (GoZ 2015a:45).

In 2016, MoHCC produced a report that stated that as the 2011-2015 Zimbabwe Strategic Plan came to an end, a national consultation was held to plan for the revitalization of the prevention responses. This resulted in developing a regional roadmap with South Africa and Kenya to scale-up HIV prevention services and investment (Avert 2017).

Interestingly, none of these regional efforts and roadmaps were mentioned by any of the key informants interviewed. There needs to be more visibility and talk, and more importantly updates on implementation progress on regional efforts that are on-going, from a government policy level. HIV and AIDS communication would need to part of the regional dialogues, as it is central to HIV prevention (and treatment). It is a means to link mobilization of the public with the HIV service delivery.

5.6.7.5 Research

There are on-going research efforts from organizations, regarding HIV and AIDS. Targeted research has its limitations, including budget constraints, but also the uptake for research has not been high, therefore targeted research has not been done, to a considerable extent. Innovative approaches have been seen in some of the research, which emphasize consideration of the population’s input, such as human-centred design thinking; soliciting for feedback and recommendations from the population has been done by other organizations, and they have gone ahead and modified communication materials in line with the feedback. Approaches to research differ, with some organizations preferring to not focus on one communication type or channel but rather the layering of communication. This implies that there would therefore be no need to do the type of

research that considers preferred channels of messages on populations, since it would already have been decided that several methods and channels will be used. However, it is important for the voice of the public to be heard and for members of the public to be allowed input regarding the identity of channels deemed to be both effective and accessible. The current study is a good example, whereby the organizations name radio as most suitable for the young urban women while the women view television as the most suitable channel (accessibility and effectiveness) to a significant extent (see Mass communication).

One bottle neck documented in ZNASP III is that SBCC research findings that inform HIV prevention programmes currently have limited dissemination. The recommendation from ZNASP III therefore, is to create a platform to inform programme interventions through sharing behaviour change studies (GoZ 2015a:29). Related to this is that it is a priority area for SBCC, for evidence-based communication data to be combined with creativity and innovation (GoZ 2015a:30). The current study is one step towards this, as it is including data from the research findings to formulate HIV and AIDS communication guidelines; this is an innovation as no such guidelines currently exist.

The Zimbabwe Advertising Research Foundation (ZARF) was established in 1997. Its mandate is to carry out independent research on behalf of, but not limited to, advertisers, publishers, the media, advertising agencies, public relations consultants. ZAMPS is the biggest piece of research that is undertaken in Zimbabwe (ZARF 2016). Social programmes by the international community that people are aware of, were found to be food aid (48%), education support (23%), AIDS awareness (20%), healthcare (18%), followed by several others (ZARF 2017:128).

While there is some public awareness of HIV and AIDS programmes, communication efforts need to be stepped up in this area, so that the public is aware of the programmes and efforts on the ground, though they might have a high knowledge of HIV and AIDS itself. This is considering that HIV and AIDS is one of the biggest challenges currently being faced in Zimbabwe.

ZAMPS is a quantitative survey that targets adults (aged 15 years and above, according to the study) and making use of face to face interviews. The most recent ZAMPS, carried out in July 2017, had a sample of 1,500 respondents nationwide, with a skew towards urban areas (ZARF 2017:5).

5.6.8 Conclusions

- Most of young urban women in Zimbabwe are in a very stressful and economically harsh environment, one that is competitive and has an overreliance on men, making them vulnerable. They live in the context of urban poverty.
- The young urban women perceive that they are in a very vulnerable position in Zimbabwe due to an array of reasons mainly because of the context they are living in, which is out of their control and that is primarily the prevailing harsh economic environment.
- Women in Zimbabwe are living in patriarchal environment where they have become vulnerable due to their subservient role. As a result, the HIV prevalence and incidence is higher in women. Furthermore, domestic violence encourages the spread of HIV infection, from the young urban women's perspective.
- Young urban women do not see the link between education and HIV infection. CSE in the education sector and innovative approaches to addressing gender education inequalities need to be explored.
- There are many contributors to the epidemic, and mostly point at the vulnerability of women culturally, in some cases spiritually (as in the case of some religions promoting child marriages) and socioeconomically, which is the context they live in. Many of these epidemic drivers are out of the women's control, because of no alternatives or options. The key epidemic drivers are multiple and concurrent sexual relationships, sex work and intergenerational sexual relationships.
- Sex work is seen to be promoting the spread of the virus as often there is multiple concurrent partners and unprotected sex. Though the sex worker is the most at risk, the partners are also at risk where unprotected sex is involved.
- The women see sugar daddies as a way that HIV infection is spreading; it puts the women at risk. Poverty, fuelled by lack of employment because of the dire economic situation, is an underlying factor as to why women pursue sugar daddies. Poverty therefore makes women vulnerable to getting HIV infection.
- It is the view of the women that polygamy puts them at risk of acquiring HIV.
- The women view small houses as facilitators of the spread of HIV infection.
- The women feel that the community has a significant role to play in HIV and AIDS communication. Efforts are already in existence but more needs to be done in urban areas, including exploring innovative ideas and applying lessons learnt from rural

community involvement in HIV and AIDS communication. More consideration needs to be given as to how communities are defined.

- Spirituality is seen in a positive light as key to HIV and AIDS communication by both the young urban women and the organizations that were interviewed. Significant efforts are being made to share accurate HIV and AIDS information, but there are sects who are abusing their influence and miscommunicating certain aspects of HIV and AIDS.
- Women believe that HIV and AIDS communication incorporates cultural aspects, though many are unable to articulate how. Some organizations incorporate cultural aspects while others do not, in their HIV and AIDS communication.
- The socioeconomic status of young urban women in Zimbabwe is significantly low and has directly put them in a vulnerable position.
- Much work is being done in HIV and AIDS communication in terms of government and policy by the GoZ, its different sectors, and its partners. However, the young urban women need to see and understand this clearly, and more can be done for them as a target population.
- The GoZ, through MoHCC and NAC, is playing a central coordination role in HIV and AIDS communication at central, as well as at implementation level in the provinces and districts. Partners such as donors and NGOs assist Government through financial resources and technical assistance.
- The specific targeting of young urban women in HIV and AIDS communication is low, though there are activities on the ground, especially for sub-populations for the young urban women.
- There appears to not be not much being done specifically for HIV and AIDS communication regionally; strategies are tied more to country programmes. However, some regional agreements and strategies related to HIV programmes have been formulated. However, many of these strategies are not visible.
- Some research related to HIV and AIDS communication has been done, but there appears to be none specifically targeting young urban women in Zimbabwe.

5.7 Challenges and limitations of the study

5.7.1 Challenges

- The respondents were available at varying times of the day due to work, school and other commitments such that it was difficult in some areas, especially the medium and low-density suburbs to gather a group at one point in time, for the FGDs.

- Some of the respondents, who would have confirmed willingness to attend, did not turn up for the group discussion on the agreed date and time. Some FGDs had to be cancelled or postponed following a low turn up of respondents (the range was six to twelve respondents).
- Most of the respondents in the target population were not willing to take part on a volunteer basis. They were demanding payment for participating as respondents. They were therefore not part of the study. Recruitment subsequently took longer.
- Some respondents were not comfortable with being audio recorded and declined to participate on that basis.
- These challenges were peculiar only to the FGDs in Harare and not Bulawayo.

5.7.2 Limitations

- The researcher began an interview with UNDP but could not continue as it became clear that they were not an appropriate key informant as they are not directly involved in HIV programme communication. The researcher later secured permission to interview two UN organizations (UNICEF and UNFPA) as part of the key informant interviews, however in the end it was not possible to secure a mutually agreeable time to interview either. These two UN organizations represent international organizations that have a rich history in HIV. The responses from organizations were limited to the five that were interviewed. Therefore, the exclusion of the UN family from the interviews, may leave a gap on the data information gathered from this study.
- The key informant interviews were not recorded. This was mitigated through member-checking and writing notes throughout, as well as receiving email and phone call responses for follow-up queries. However, even though member checking and note taking was done throughout the study, there may be possibilities of missing some information which could have been mitigated by recording the key informant interviews.
- The researcher secured only one professional who could speak all three key languages (English, Shona and Ndebele) to do the translation simultaneously together with the transcribing from the audio tapes, for both the individual interviews and FGDs. This process took about four months as after the first month, the professional was working in the evenings only due to full-time work commitments. There was therefore reliance on one person for all translations required from the recordings of the young urban women, as well as the assumption that the transcribing done by the same

person was accurate. This was mitigated by the notes that were taken throughout all data collection sessions by the research assistant.

- The volume of data was very high, and as such, the researcher had to decide the quotes to share from the transcripts as findings for the various themes; the full data from the discussions and from the FGDs could not be shared.
- It was not feasible to undertake the study in all urban areas of Zimbabwe, and the study was carried out in Harare and Bulawayo only. It was therefore assumed that the responses from Harare and Bulawayo are representative of all the urban areas in Zimbabwe. The study was not extended to rural areas as this was outside the scope of the research.

5.8 Conclusion

In this chapter, the demographics were described and any key differences between the Harare and Bulawayo respondents were noted and discussed. The discussion followed on from the themes and sub-themes presented in Chapter 4. The discussion incorporated literature review to consider other findings and compare, contrast and/or add to the study findings. Throughout the discussions, conclusions were drawn after considering the findings and reviewing literature. The challenges faced during the study were described, as were the limitations that were there.

CHAPTER 6

6 RECOMMENDATIONS, GUIDELINES AND CONCLUDING REMARKS

6.1 Introduction

This is the concluding chapter of the study and two key recommendations are detailed, while the rest of the recommendations are enshrined in the guidelines. The role of WHO, the leader in public health guideline formulation, is first described, including how they develop guidelines. In the process, several WHO documents over the years are referred to. The recommendations of the study come in the form of guidelines, which is the output of the study. These are guided by the themes, sub-themes and categories outlined in the Results Chapter. The guidelines are compiled after consideration of the literature review including several Zimbabwean policy and strategy documents, the UNAIDS HIV and AIDS Communication Framework, the results of the study and insights from the researcher. The guidelines will be made available to all stakeholders, through the UNISA website. Hard copies will be presented to MoHCC, NAC, UNAIDS Zimbabwe office, WHO Zimbabwe office and MRCZ.

6.2 Recommendations

6.2.1 Research

- Organizations to accommodate HIV and AIDS communication research in their budgets, particularly the most affected populations, including young urban women.
- Encourage the uptake of research by the following: MoHCC – including at central, provincial and district levels and specific HIV-related programmes; line ministries in Government such as MoWAGCD, Ministry of Primary and Secondary Education, Ministry of Tertiary Education, and other relevant ministries; NAC; NGOs; donors; academic institutions such as universities; other organizations.
- Facilitate research findings' dissemination in different forums, for example, by creating a platform where these are shared to inform HIV programme intervention. Include highlighting that evidence-informed communication data is to be combined with creativity and innovation, the goal being to mitigate HIV and AIDS.
- Carry out diverse types of research, including but not limited to: testing of messages and soliciting feedback from target population; design-centred thinking whereby the population comes up with solutions; research for different populations including older men age group, because of the role they play in such issues as intergeneration and

transactional sex, culture and spirituality; exploring HIV and AIDS communication for 10-19-year-old (adolescent) girls and young urban women.

- Duplicate study in other countries to obtain a broader perspective on topic
- Carry out research on HIV and AIDS-related stigma and discrimination for young urban women. Zero stigma and discrimination is one of the HIV epidemic global goals.
- Organizations to make use of ZAMPS survey to inform and plan HIV and AIDS awareness campaigns or communications (see Mass communication).

6.2.2 Education

- Girls and young women to be encouraged to stay in school and complete their education and not drop out, in HIV and AIDS communication (see Government policy).
- Explore options of conditional cash transfer, stipends and scholarships and avail these to girls and young women.
- Clearly communicate link between education, vulnerability and HIV. It must become obvious to girls and women how they are short-changed if they drop out of school.
- Explore CSE and HIV-related content being integrated in the education system at all levels (primary, secondary and tertiary) by being made compulsory (see Government policy).

6.3 The role of World Health Organization (WHO)

WHO has the primary role of directing and coordinating international health within the UN system. WHO works with governments and partners in a bid “to ensure the highest attainable level of health for all people”. This is in line with WHO’s goal of building a better healthier future for all (WHO 2017b).

WHO is well-known for developing guidelines, setting standards and driving quality assurance, for public health. The researcher has reviewed the rationale behind their guideline development and selected key important aspects to focus on.

All WHO guidelines are approved by the Guidelines Review Committee (WHO 2015a). WHO explains how it formulates credible guidelines using evidence, balancing benefits and harm, that are implementable and that have a positive impact on population health (WHO 2014:2).

6.3.1 The need

The most basic question to ask at the beginning of guideline development is whether they are in fact required (WHO 2014:15). This question is addressed by the researcher as a

'Yes', in that the background to the study is motivated by the high HIV prevalence in Zimbabwe, particularly in urban areas, as well as it impacting woman more than men, thereby confirming the need and recommending that efforts to mitigate HIV and AIDS begin with improving HIV and AIDS communication, as this is the starting point to disseminating information.

6.3.2 Existing guidelines

The researcher has not found any existing guidelines of a similar nature in literature, including at WHO. Currently, from what the researcher has been able to find, the following is the only WHO non-clinical official guideline that specifically relates to women and HIV and AIDS: Integrating gender into HIV and AIDS programmes in the health sector. (WHO 2015a).

6.3.3 Purpose

Guidelines should largely have the aim to resolve uncertainty – this should be the focus of most of them. The purpose should be made clear (WHO 2014:16). The researcher's study states that the guidelines are being developed to improve HIV and AIDS communication for women.

6.3.4 Target and Recipients

The target should be a clearly defined audience, which is the end-user or those applying the guidelines. The target is not the recipients of the recommendations or recommended interventions. The recipients are the beneficiaries of the recommendations and WHO urges for them to be clearly defined and for their perspectives and needs to be built into the development process throughout (WHO 2014:17).

The target of the guidelines formulated from the study nationally, is the key policy maker for HIV and AIDS in Zimbabwe, which is the MoHCC, more specifically the AIDS and TB Unit, which coordinates all HIV-related programmes nationally, together with NAC which coordinates the HIV response from all sectors, as well as NGOs, who are the partners that give them technical assistance. Internationally, the guidelines are targeted at WHO for refinement and possible adoption as official guidelines for HIV and AIDS communication. The needs, thoughts and perspective of the young urban women (the recipients) were through the qualitative research, and their perceptions and ideas subsequently recorded and incorporated into the guidelines. This was accomplished through FGDs and in-depth interviews.

6.3.5 Time frame

The timing of developing the guidelines as well as the length they will take to complete is something that needs consideration (WHO 2014:17). Justification of the timing in the study is in the current prevalence rate that is high in Zimbabwe, effecting women disproportionately and in continued incidences – innovative ways to address HIV and AIDS need to be applied until such time the global HIV and AIDS goals have been achieved which focus on universally eliminating new infections, discrimination and HIV-related deaths through antiretroviral treatment. In other words, it is not too late, and the sooner useful and implementable guidelines are developed to assist, the better. In 2017, the researcher completed the study and the main output was the guidelines. There is therefore sufficient time for policy makers to adopt and implement the guidelines, considering the furthest HIV and AIDS goals to mitigate the epidemic have been set for 2030.

6.3.6 Collaboration

The development of the guidelines should not be done in isolation by one party but by wide consultation (WHO 2014:19). The development of the guidelines, by the researcher, were not done in isolation. Various organizations were interviewed and their responses on similar issues summarized and consolidated. The views of the target population of young urban Zimbabwean women were also noted and consolidated, through in-depth interviews as well as FGDs. The views of the organizations and those of the target population were reviewed, literature was consulted, including the UNAIDS HIV and AIDS Communication Framework which guided the study, and the insights of the researcher were also considered. Therefore, there was wide consultation in drafting the guidelines.

6.3.7 Scope

The scope of the guidelines is defined, describing what is and what is not covered by the guidelines. It includes refining the list of priority topics, literature review, formulating key questions and selecting outcomes as well as incorporating equity, human rights and gender (WHO 2014:21-22).

The scope of the guidelines was guided by the UNAIDS HIV and AIDS Communication Framework and attempts to address factors that affect HIV and AIDS communication. The guidelines do not claim to have covered everything that relates to HIV and AIDS communication and factors that may have been left out may be incorporated by the target of the guidelines. The topics covered are presented as themes, sub-themes and

categories. It is outside the scope of the study to prioritize the topics of the guidelines; this should be done by the policy makers.

6.3.8 Evidence

Guidelines need to be evidenced-based and therefore evidence retrieval and synthesis is important to ensure the development of valid recommendations and that high-quality guidelines are produced (WHO 2014:93). This aspect has been adequately covered through the on-going literature review and the design of the study which incorporates engagement of young urban women, who are the recipients of the guidelines and engagement of key informants, who are targeted for the guidelines and the UNAIDS framework.

6.3.9 Writing recommendations

Recommendations should be clear and non-ambiguous, actionable, and include justification as to why certain interventions are endorsed or not. There is also suggested language when writing guidelines (WHO 2014:130-131). As much as possible, the researcher has written clear and actionable guidelines. Although the guidelines were not evaluated by an expert panel, they are evidence-informed, key informants who have expert knowledge gave input, and an HIV specialist reviewed the guidelines, as did the promotor of the study.

6.4 Guidelines

Aside from the areas of education and research, the remaining recommendations from the study are presented in the form of guidelines in Table 6.1:

Table 6.1: Guidelines to improve HIV and AIDS communication for women in Zimbabwe

THEME	SUB-THEME	CATEGORY	GUIDELINE
Communication	Mass communication	Mass media channels use, effectiveness and accessibility	<ol style="list-style-type: none"> 1. Give priority to the most accessible media channels to women, which are broadcast media (television and radio), and social media using mobile phone technology. However, weighting cannot be the same. 2. Radio is the most suitable mass media channel for HIV and AIDS communication as it is cheaper and viewed by organizations as having a wider coverage. This is also considering the growing number of radio stations, including community ones, and it being a preferable mass media channels with women in Zimbabwe as well as with HIV and AIDS organizations. 3. Explore the use of 'Radio diaries' whereby PLHIV share their stories on radio, including as part of a series. 4. Television is expensive and high-quality programmes are required, especially for local television. However, it has a role to play in HIV and AIDS communication because it is accessible to many young urban women. Consider redirecting some of the budget from more expensive mass channels such as television and billboards to cheaper ones such as social media, which may have a greater reach and are also accessible to young urban women. 5. Organizations to formulate high-quality HIV awareness programmes and adverts for local and satellite television. 6. Advertise the programmes flighted on broadcast media (radio and television) to ensure that the public are knowledgeable about the days and the times they are flighted. 7. Link media channels, for example, website and Facebook pages can be highlighted in newspapers, or mentioned on radio. 8. Increase use of mid-media such as edutainment and dance, which links entertainment and information. 9. Make use of road shows. 10. Improve on and increase outdoor innovations, such as placing stickers on public transport vehicles and use of sporting events to share HIV and AIDS information. (innovations, technologies, creativity). 11. Use ZAMPS to inform more specific selection of media channels for HIV and AIDS communication for young urban women, taking into consideration urban area preferences, as well as provincial differences in some cases, in television programmes, radio stations and programmes, most popular time for broadcasting for both radio and television, as well as most popular daily, weekly, monthly and less

			<p>frequent publications, namely magazines and newspapers. Each time ZAMPS is released, review communications and update accordingly.</p> <ol style="list-style-type: none"> 12. Make use of less conventional mass media channels, such as and music shows, mobile promotion and outdoor advertising, according to popularity and location. 13. Make use of technological innovations especially for the younger generation, for example, mobile phones. 14. Whichever mass media channel is chosen, messages and approaches across programme areas should be clear and consistent so that demand for services can be created. 15. Beyond HIV awareness, focus on action-orientated information, particularly lived experiences which people can relate to while others who are not yet affected and infected can learn lessons.
		Language appropriateness	<ol style="list-style-type: none"> 1. Use all three main languages in Zimbabwe that is, English, Shona, Ndebele, for HIV and AIDS communication. 2. Make use of some of the minority languages where appropriate.
		Information sensitivity	<p>Be sensitive in the design and communication of HIV and AIDS material targeted at young urban women aged 20 to 29. This should include consideration and incorporation of issues relevant to their age group, their context and their needs (see Young urban women's context and related sections such as Culture and Community involvement). It should not be offensive or judgemental in any way.</p>
		HIV and AIDS champions	<ol style="list-style-type: none"> 1. Organizations, both Government and non-government, involved in HIV programmes and communication, to engage champions, at a community and/or at a national level, and use them for HIV and AIDS awareness. Examples are musicians, radio and television presenters, talk show hosts etc. 2. Organizations, but in particular NAC, MoHCC and other government departments, to engage political champions, including at the highest levels, to be at the forefront of campaigns. These should be opinion leaders that are acceptable to the public and with a good reputation. 3. Use ordinary people who can champion HIV issues at a community level, such as HIV positive people. This can be a powerful strategy. 4. Collaborate between organizations to ensure that all aspects of HIV are covered between all the champions, and that not just one area is focused on (for example VMMC) or over promoted.

			<ol style="list-style-type: none"> 5. Increase female champions, ones which urban women aged 20-29 years can relate to – ones of their own age. Women have different interests and therefore it is desirable that they not just be musicians but also come from other sectors, such as hair dressers (see Interpersonal communication [IPC]). 6. Maintain male champions.
		Information dissemination	<ol style="list-style-type: none"> 1. Disseminate HIV and AIDS information through various methods. 2. The combination HIV prevention package to cover newer methods such as PrEP, so that there are no knowledge gaps and young urban women are empowered. 3. Use mass media to maintain HIV awareness, ensuring the themes within these guidelines are incorporated. 4. Increase IPC (see IPC) at community level so that no room is left for inaccurate information and questions are addressed. 5. Increase communication efforts within communities. This includes identifying community champions (see Champions) who should be ‘the voice of HIV and AIDS’, who are acceptable, respectable and who people will therefore listen to. 6. Expand from the conventional information-sharing places and or sources such as New Start Centres and clinics to friendlier and/or neutral places (unrelated to health). Ideal places would be places not immediately associated with HIV. These places need to be easily accessible. For instance, an internet online facility could be an option.
		Overcoming the barriers to information dissemination	<ol style="list-style-type: none"> 1. Integrate information on HIV and AIDS, as much as possible, in HIV and AIDS communications, to present a complete picture, including sequentially (PMTCT, VMMC, condom use etc.). This is preferable to emphasizing one area only, in each campaign. This will minimise the chances of receiving incomplete, confusing and/or conflicting messages or messages that young urban women must then try and articulate. 2. Organizations involved in HIV and AIDS to engage the different sectors (for example, the religious sector) and the public, to ensure that these have accurate and adequate information which they in turn will disseminate, including to people the organizations may not be able to reach (see Spirituality, Community involvement). 3. Government and NGOs to collaborate and increase the creativity and innovation in the design of HIV and AIDS information contents and the way it is presented, to be better positioned to capture young urban women’s attention. This includes taking

			<p>note of the need for there to be a wider coverage of popular events, which is where many of the young urban women go, in their busyness, such as music galas. Related to this, Government to partner with music champions (see Champions).</p> <ol style="list-style-type: none"> 4. Design SBCC for young people, especially HIV exposure and prevention options (see Targeting young urban women). 5. Expand SBCC to the young at community level and through mass and social media (see Mass communication) 6. Equip teachers with HIV and life skills education; avail to schools, HIV IEC materials (see Education). 7. MoHCC, NAC, and partners such as donors, to re-look HIV and AIDS communication budgets. Consider increasing allocation for IPC (such as door-to-door visits), and perhaps reviewing downwards mass media allocations, which tend to be high because of the expense involved. An increase in IPC presents an opportunity for attracting young urban women's attention, in an environment where there is competition for attention (see Mass communication and IPC).
	Interpersonal communication	Agents of interpersonal communication	<ol style="list-style-type: none"> 1. Equip teachers in primary and secondary school, lecturers in tertiary institutions, to be well educated about HIV and AIDS and in addition to imparting knowledge, to be ready to engage in on-on-one conversations (see Education). 2. Equip all health workers, including those not working directly in HIV work, to be knowledgeable about HIV and AIDS and confident to talk about it within the community, in addition to at work. The expectation of young urban women is that every health worker knows about HIV, so they look to them for answers – if they the health workers are unprepared, there may be lost opportunities. 3. Target people in the community who interact with young urban women. Educate them, for example, parents, church leaders (see Spirituality), PLHIV, as well as the young urban women themselves (peer educators) (see Educating others and Community involvement). 4. Formulate innovative methods for IPC to target young urban women. Examples include at hair salons, events such as baby and bridal showers, where one-on-one conversations can be facilitated. 5. Step up existing IPC, for example, door-to-door IPC, and the one-on-one interactions at big events, facilitated by mass communication. 6. Mass media communication on HIV and AIDS, as much as possible, should have a call to action and facilitate IPC, for example an email, a phone number for calling or interacting on WhatsApp (see Mass communication). 7. Train PLHIV to engage in IPC in their communities (see Champions).

		Communication method preference	Increase budget allocation for IPC, the preferred communication method by young urban women. The rationale is that it has been established that the Zimbabwean population already has high levels of high-quality information (see HIV and AIDS information) and corresponding HIV and AIDS knowledge levels (see HIV and AIDS knowledge) among urban women aged 20-29, and therefore HIV and AIDS awareness through mass media is being achieved. However, IPC will facilitate the move from knowledge to behaviour change.
		Educating others	<ol style="list-style-type: none"> 1. Encourage women to take up volunteer positions that are involved in structured HIV and AIDS communication, such as BCFs and peer educators. The knowledge and skills gained can be used formally in the community or informally with family and friends. 2. On mass media HIV awareness campaigns, organizations to encourage the sharing of accurate HIV and AIDS information in their spheres of influence. Appropriate encouragements may be, for example, "Go tell someone" or "Now that you know, who are you going to share this with?"
HIV and AIDS knowledge	Distinguishing between HIV and AIDS	-	Reinforce the difference between HIV and AIDS, particularly during IPC, so that misconceptions are dispelled and all the women have an accurate understanding of the two. And no-one is left behind.
	HIV prevention	-	<ol style="list-style-type: none"> 1. Communicate the full spectrum of HIV prevention and options available in HIV combination prevention, including the newer ones such as female condoms and PrEP. 2. Communicate all possible HIV transmission routes, to dispel misconceptions. Also communicate ways in which HIV cannot be transmitted. 3. Increase dialogue on the role of male circumcision in HIV prevention, so that women understand it and its benefits better, rather than for it just to be knowledge without fully understanding.
	Treatment	-	<ol style="list-style-type: none"> 1. Emphasize knowing HIV status, as this is the entry point for ART (see HIV status). 2. Share information on ART including on ART for prevention and updates on treatments as they are implemented.

	Impact of knowledge on behaviour	-	Communicate in a manner that women understand that head knowledge, which is currently very high in Zimbabwe, does not have an impact on their lives unless they use it to inform their daily decisions.
Perceptions and beliefs	HIV prevalence	-	<ol style="list-style-type: none"> 1. Share appropriate HIV statistics with young urban women, including figures related to women, so that they have a correct perception and are aware of the current HIV infection levels, how the epidemic is evolving and what impact HIV and AIDS communication is directly and indirectly making. Information that can be shared includes, incidence and prevalence at a global and at a national level, for everyone and for women. Also share statistics for men, so they can see the difference. 2. Address intergenerational sex in HIV and AIDS communications (see Vulnerability).
	HIV Status	Awareness	<ol style="list-style-type: none"> 1. Make prominent, HIV testing and knowing one's status, in HIV and AIDS communication, so that women have an accurate perspective and understand the full implications of an unknown HIV status, HIV negative and an HIV positive status. This is essential as it is the entry point to the HIV response, and represents the first 90, in the 90-90-90 global strategy. 2. Promote HIV self-testing, an innovation for increasing HIV status awareness.
		Disclosure of positive HIV status	<ol style="list-style-type: none"> 1. Discourage stigma and discrimination in HIV and AIDS communication. This is one of the barriers to people seeking out HIV testing services. 2. In HIV and AIDS communication, in addition to general HIV awareness, empower the public, to be able to deal with HIV positive disclosure, for example enacting "How should I respond once you disclose you are HIV positive?" or "How can I help you live positively?". The public come from communities, and communities are made up of families. HIV positive people are most likely to confide in close family members about their status, before seeking out professional counsellors (see Community involvement). 3. The government and NGOs to design and implement community empowerment activities such as training, for interested family members to do basic counselling and rendering of psychosocial support if someone in their family acquires HIV; to include young urban women in anticipation of them assisting other women (see Educating others).

	Risk perception	-	<ol style="list-style-type: none"> 1. HIV and AIDS communications need to highlight and explain why sexually active women in general are at an elevated risk of acquiring HIV infection, and particularly those who are married or co-habiting, and those economically dependent on men. There should be a clear link to other areas in the guidelines that are indicating their vulnerability as women. This will enable women to gain an accurate and realistic perception of risk. 2. As part of the call to action and mitigation of this risk, there is need to effectively communicate information on HIV combination prevention, including what the women have control over such as knowing their status and taking mitigatory action once the status is known, using the female condom and using PrEP, as means of HIV prevention and minimizing the risk of being infected with HIV (or acquiring AIDS, as in the case of finding out they are HIV positive) for women who are not in a position to negotiate for safe sex using condoms.
	Blame perception	-	<ol style="list-style-type: none"> 1. Ensure all forms of HIV and AIDS communications do not attribute the spread of HIV infection to specific groups, while at the same time they must highlight and accurately address the reasons behind the spread of HIV (see Epidemic drivers, Culture, Socioeconomic status, Risk perception, Vulnerability etc.). 2. Dispel the perception that women are to blame for the spread of HIV, even by women themselves. 3. In HIV and AIDS communication, promote individual responsibility and accountability. Each person should behave in a responsible manner and promote HIV prevention by sharing accurate information and by also participating in combination HIV prevention, for example being faithful to one partner and using condoms.
Young urban women's context	General	-	<p>The young urban women perceive that they are in a very vulnerable position in Zimbabwe due to an array of reasons that are cross-cutting, because of the context they are living in, which is out of their control, that is primarily the prevailing harsh economic environment and patriarchal society.</p> <ol style="list-style-type: none"> 1. Address young urban women's vulnerability. The issues are cross-cutting and should be dealt with at a policy level. 2. Education needs to be underscored and explained so that young urban women see its relevance in addressing their vulnerability and to how good education will give them more and better options in life, in the future (see Education).

			<ol style="list-style-type: none"> 3. Cash transfers is a consideration for some girls of school going age, so that they have an incentive and opportunity to remain in school (see Socioeconomic status). 4. Discourage early sexual debut and encourage abstinence till marriage (see Culture).
	Vulnerability	Epidemic drivers	<ol style="list-style-type: none"> 1. Address the epidemic drivers in the context of the young urban women's lives. The intergenerational relationships (including child marriages) and sex work, are symptoms of deeper issues on the ground (Young urban women's context and related sub-themes such as Culture; Educational level, Risk perception). 2. HIV and AIDS communications to focus on combination prevention interventions, as this is in line with GoZ's overall strategy for countering key epidemic drivers. These interventions include: SBCC; increased condom promotion; distribution and consistent use of condoms; VMMC; prevention of STI's.
		Gender roles	<ol style="list-style-type: none"> 1. MoHCC and NGOs to partner with line ministries such as Women's Affairs, Gender and Community Development, Primary and Secondary Education, and Tertiary Education, to design and prioritize communications for empowerment, including for HIV and AIDS communication. 2. Educate women on issues of vulnerability (see Vulnerability) and risk of acquiring HIV (see Risk perception). 3. Engage key male leaders at all levels across sectors, and advocate for them to lead in addressing socio-cultural barriers that stifle safer sex (see Champions).
		Gender-based violence	<ol style="list-style-type: none"> 1. Discourage GBV. Target communications at men, including highlighting its link to HIV. 2. In HIV and AIDS communication empower women on how to deal with GBV and where to get help. 3. Communication to discourage acceptability of GBV by woman
		Sex workers	<ol style="list-style-type: none"> 1. The use of condoms is a key strategy for sex workers to minimise the spread of HIV. Promote this in communications. 2. Increase in the coverage of interventions such as moonlight clinics, together with them being held more frequently, is a strategy to assist sex workers and their clients to know their status and take-up condom use and other aspects of combination HIV prevention. The moonlight interventions must be held in consultation with the

			<p>community so that they are held at strategic times of the year and at strategic times; the community has a role to flag the key events to NAC and/or their partners (see Community Involvement). Innovations such as moonlight interventions should be visible in HIV and AIDS communication.</p> <p>3. The border provinces should have specific HIV and AIDS communication targeted to their specific context, of high sex work.</p>
		'Sugar daddies'/ 'blessers'	<ol style="list-style-type: none"> 1. In HIV and AIDS communications, highlight to young urban women, the dangers of having sex with sugar daddies, the issue of sexual networks and multiple sexual partners, and discourage this as a solution to women's needs. 2. Discourage early sexual debut and encourage abstinence. 3. Target older men in HIV and AIDS communications, discouraging them seeking out young women for sexual relationships. 4. Address the root cause of sugar daddies, which is economic hardships and propose solutions that will lift women out of poverty without taking risks of getting infected by HIV. (See Socioeconomic status, Education and Government policy).
		Polygamy	<ol style="list-style-type: none"> 1. Discourage multiple and concurrent sexual relationships (this may be a better strategy, as cultural sensitivity is required – polygamy has long been part of some sub-cultures and it is currently acceptable), highlighting the dangers, in HIV and AIDS communication. 2. Target both men and women in communications.
		'Small houses'	<ol style="list-style-type: none"> 1. Discourage multiple concurrent sexual partners, and encourage faithfulness to one partner in HIV and AIDS communications. 2. Target both married men and single women.
	Community involvement	-	<ol style="list-style-type: none"> 1. Maintain what is already working for HIV and AIDS communication, within the community: street campaigns; IPC (such as door-to-door campaigns); NGO-driven initiatives such as New Start Centres; use of teachers and health care workers in different settings to promote communication HIV and AIDS issues. 2. Explore and find a way to incorporate young urban women's ideas. For example, support groups, distributing condoms in municipal public toilets, use of community halls and churches for gatherings (see Spirituality). 3. Apply lessons from rural setting community involvement, such as VHWs (see IPC).

			<ol style="list-style-type: none"> 4. Identify communities in urban areas and their leaders (see Champions) and get their buy-in, then approach Government and NGOs for support including training and allowances (see Government policy). 5. Encourage community members to volunteer for structured community involvement, through the MoHCC and its partners, for example to be BCF's (see IPC) or to be part of community committees. 6. Identify, recruit, train and retain community-based volunteers to address social and cultural norms. 7. Community health workers, community committees, community-based organizations and community leaders need to be brought together and their roles and responsibilities clearly defined, so that synergy is created and duplication minimised. 8. Encourage community engagement in HIV and AIDS communication and innovations for less structured community involvement, also through volunteering. 9. Encourage community conversations whereby the community brainstorms and strategizes with the help of an experienced facilitator. 10. Schools and colleges to promote HIV and AIDS awareness through education system (see Government policy) 11. In HIV and AIDS community involvement and HIV and AIDS communications, be cognisant of, and cater for the diverse and dynamic nature of communities, including the fact that some women may be members of more than one community 12. The vulnerable and key populations to be included and not to be left out in community HIV and AIDS communication, including, as relates to women, the young urban women, adolescents and girls, and sex workers. 13. Target young urban women for peer education (see Educating others and IPC). 14. The community, in the form of the family unit, to be encouraged, through HIV and AIDS communication, to support and counsel family members who disclose their HIV status (see HIV status). 15. Strengthen involvement of families, the smallest community unit, in HIV and AIDS communication. 16. Facilitate workplace HIV and AIDS education programmes, ensuring they consider young urban women.
	Spirituality	-	<ol style="list-style-type: none"> 1. Spiritual leaders, including both religious and traditional leaders (faith-based leaders), yield great power and influence on people. As such, organizations are to engage them, get their buy-in, educate them and use them as HIV and AIDS champions (see Champions). Faith-based leaders to be involved in the following, as well as any other areas linked to HIV and AIDS communication:

			<ol style="list-style-type: none"> 2. Advocate against child marriages (some traditional religions have encouraged this). 3. Promote the seeking of medical attention or treatment, including taking ARVs for those who are HIV positive, and not stopping treatment. 4. Hold or facilitate campaigns with different themes related to HIV. 5. Encourage high morals, including abstinence, delay of sexual debut and faithfulness to one partner; discourage virginity testing. 6. Invite health professionals to speak on HIV and AIDS. 7. In the context of the Christian churches, which are predominant in Zimbabwe - convene or facilitate discussions on HIV and AIDS in meetings for the youth, men, women, couples, leadership and any other meetings. 8. Advocate for HIV modules to be included in Bible school training curriculum. 9. Discourage stigmatization and discrimination of PLHIV.
	Socioeconomic status	-	<ol style="list-style-type: none"> 1. Advocate and facilitate for the girl child to be well educated (see Educational Level): the socioeconomic status is largely dependent on their education level and the relevant guidelines should be followed, particularly for the girl child, who will one day become a young woman. 2. Cash transfers, stipends and scholarships for girls to be promoted, as appropriate, depending on age and need. 3. For women who are already struggling with poverty and therefore dependant on men, Government and its partners to fund various trainings and income-generating projects, together with offering targeted scholarships for women as opportunities for them to complete and/or improve on existing education (Government policy).
	Culture	Good cultural norms	Encourage the good cultural practices publicly through HIV and AIDS communication including: abstinence before marriage, promotion of good morals, male circumcision (in certain settings where this is a culture); faithfulness. Mass communication and IPC both have a role to play here.
		Harmful cultural norms	<ol style="list-style-type: none"> 1. Expose, debate, highlight and discourage harmful cultural norms in the various cultures in Zimbabwe, in HIV and AIDS communication, particularly with mass communication as it is very effective for awareness, followed through with IPC – some messages can be tailored for specific communities where they are relevant. 2. The reasons why harmful cultural norms promote the spread of HIV should be clear (how they translate to promoting HIV). These harmful practices include polygamy, widow inheritance and multiple concurrent partners, blessers or sugar daddies,

			<p>putting pressure on young women to get married, having sex with father-in-law before marriage and partners or spouses living apart for prolonged periods where this is unnecessary.</p>
		<p>Cultural visibility in HIV and AIDS communication</p>	<ol style="list-style-type: none"> 1. HIV and AIDS materials to be culturally sensitive (for example, polygamy is acceptable in some cultures), while at the same time they must highlight and discourage those aspects that promote HIV (see Vulnerability and Epidemic drivers) and not be silent about them, as this could be misconstrued as condoning them. 2. To target men in communications as many of the harmful cultural norms are within the men's control, for example gender inequity, inconsistent condom use and VMMC uptake. Good cultural aspects that deter HIV to also be highlighted and encouraged. 3. Talk shows and dramas to be used, and all other communication channels, including innovative ones, to bring out both good and harmful cultural practices.
	<p>Government policy</p>	<p>General</p>	<ol style="list-style-type: none"> 1. Government, including local government, and policy makers, needs to engage young urban women in such a manner that they the Government are visible and such that the women are aware of their involvement in HIV and AIDS communication. 2. The focal people in each Ministry must be visible and become champions for HIV and AIDS and speak about the relevance and the work of their ministry in the HIV epidemic (see Champions). 3. All MPs and City Councillors, particularly female ones, and those representing urban constituencies, to be a voice for HIV and AIDS communication for women, together with other related issues, for example gender equity and child marriages (See Young urban women's context). This would cover the whole country as they each represent a constituency. 4. Laws, policies and strategies that directly and indirectly relate to HIV and AIDS need to be better publicised and explained in a simplified manner to women, for example ZINASP. This way, women are well informed, empowered, reassured and motivated to be do their part. Innovative methods to achieve this can be formulated, for example there can be a campaign entitled "What the Government and its partners are doing and planning to do to help you in the HIV epidemic". 5. Government to work with UNESCO, including EDUCAIDS to incorporate HIV and AIDS and CSE curricula into the formal education at all levels - primary, secondary and tertiary, including government, mission, private and other institutions (see Education).

			<ol style="list-style-type: none"> 6. Explore how CSE can be implemented in non-formal and informal education setup. 7. Government to train teachers in HIV and AIDS and CSE so that they are competent in imparting the knowledge and skills required (see IPC).
		Role of Government and NGOs	<ol style="list-style-type: none"> 1. Government, through NAC and or MoHCC, to advocate for HIV and AIDS policy formulation and communication strategies, and their implementation in Zimbabwe. 2. Government, though NAC and/or MoHCC, all the while ensuring efficiency and synergies, avoiding duplication of work, to engage in various activities, including but not limited to the following: 3. Coordinate all HIV and AIDS programme communication efforts in Zimbabwe. 4. Coordinate media relations, ensuring that the media understand the HIV epidemic and that they communicate issues to the public accurately. 5. Consolidate roles and responsibilities in the Health Promotions Unit, Public Relations Office and AIDS and TB Unit. 6. Chair national committees and technical working groups. 7. Formulate demand creation strategies for all HIV programmes and implement these. 8. Train community level workers on HIV and AIDS communication so that they are equipped to communicate well and mobilize the community (see IPC and Community involvement). 9. Develop and design content for various mass media and IPC (see Mass communication and IPC). 10. Engage line ministries, opinion leaders such as politicians, faith-based leaders, business people, and others in the HIV response. 11. NGOs to give technical assistance and guidance on HIV and AIDS communication to MOHCC through membership at national forums and through direct engagement with MoHCC. 12. MoHCC to advocate for more money from the national budget, for HIV and AIDS. 13. Donors to assist MoHCC with funding for HIV and AIDS communication. Areas the areas to be considered include, but are not limited to: mass communication; IPC; research targeting young urban women; assist in paying community workers (see Research, Targeting young urban women, Mass communication, IPC and Community Involvement).
		Targeting young urban women	<ol style="list-style-type: none"> 1. Extend some activities carried out by community workers in rural settings to target young urban women (see Community involvement). Examples include Young People's Friendly Corners.

			<ol style="list-style-type: none"> 2. Increase efforts on existing activities that are already in-progress in urban areas, such as discussions, short films. 3. Target all locations of young urban population, including medium and low-density areas, in addition to high-density suburbs. 4. Have communications specifically for young urban women as well as sub-populations, for some of the HIV and AIDS communications, for example, sex workers, HIV positive women, pregnant women, rape victims, GBV victims. 5. In all the targeting – consider the women's perceptions and beliefs, their preferences in terms of mass and IPC, the context they live in, their existing HIV and AIDS knowledge, and their context (the main themes of the guidelines).
		Regional cooperation	Government and NGOs to strengthen regional dialogue and forums that centre specifically on HIV and AIDS communication. Share case studies, lessons learnt and best practices in HIV and AIDS communication on a regular basis.

6.5 Concluding remarks

6.5.1 Contribution of the study

To the researcher's knowledge, there are no existing HIV and AIDS communication guidelines specifically for young urban women. While the contents of the guidelines are not all entirely new, the researcher has consolidated information primarily from the study, as well as literature and has used the UNAIDS Communication Framework as the guiding tool. They are therefore evidence-informed guidelines. The guidelines are for the GoZ's MoHCC, NAC and their partners, including donors, implementing partners and NGOs. Many insights about communication were presented, but also insights about Zimbabwean young urban women's context and the HIV epidemic itself. It is anticipated that the guidelines can be used not only in Zimbabwe, but also in other African countries in similar settings and with whom commonalities of context are shared. Beyond HIV, it is also anticipated that the guidelines can be adapted for other related public health areas in Zimbabwe and beyond, for example, sexual and reproductive health programmes.

6.5.2 Study conclusion

Communication is the tool for information-sharing. Once information is available, informed-decisions can follow. For the HIV epidemic, for as long as new HIV infections, deaths from AIDS and stigma and discrimination exist, communication efforts cannot take a back seat – they must be in the forefront and be the cornerstone of the HIV response. Information needs to be shared appropriately, in a manner accessible for women, who bear the brunt of the epidemic, their context being considered, so that they are empowered to make healthy decisions about HIV prevention or ART. It is therefore strategic to optimize HIV and AIDS communication, as this is ultimately communication for empowerment and development, for women. This communication must be stepped up, making use of IPC, mass communication, education, community involvement, and considering the women's context, while at the same time incorporating new technologies and innovations in the communication world. This is what will be instrumental in translating knowledge into behaviour change. The driving force is the political will from leaders in the country, and government policy is therefore pivotal and sets the tone and pace at which this can be achieved. Government policy has a very audible voice within the guidelines. The study has achieved its four objectives of exploring the HIV and AIDS communication channels through which young urban Zimbabwean women receives their information; examining the HIV and AIDS knowledge and perceptions acquired by young urban Zimbabwean women; describing the context of young urban Zimbabwean women;

drafting guidelines for HIV and AIDS communication providers, for improving the HIV and AIDS information targeted at young urban Zimbabwean women. The study was therefore a success. The researcher will present the findings to several key stakeholders and the remaining HIV and AIDS communication stakeholders will have access to the electronic version of the findings. The researcher will encourage the MoHCC to review and evaluate the guidelines through a panel of experts, adopt and implement them. The researcher will also encourage the MoHCC to set timeframes for their implementation.

6.6 Conclusion

This concluding chapter described two key recommendations from the study. It proceeds to explain the role of WHO, who are the leaders in public health guideline formulation. The recommendations of the study are presented in the form of detailed themed and categorized guidelines; they are the output of the study. In the concluding remarks, how the study contributes to the wider body of knowledge is described, and the study conclusion demonstrates how the objectives of the study have been met, the research questions answered, and the aim has been achieved.

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ANNEXES

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Annexe A - UNISA Ethical Clearance Certificate



**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

REC-012714-039

HSHDC/357/2014

Date: 26 November 2014 Student No: 5577-393-1
Project Title: Guidelines for improving HIV/AIDS communication for women in Zimbabwe.
Researcher: Tsungai Chiwara
Degree: D Litt et Phil Code: DPCHS04
Supervisor: Prof ZZ Nkosi
Qualification: PhD
Joint Supervisor: -

DECISION OF COMMITTEE

Approved Conditionally Approved

for Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Annexe B - MRCZ application to conduct research



MEDICAL RESEARCH COUNCIL OF ZIMBABWE APPLICATION TO CONDUCT RESEARCH

Instructions and Guidelines on Submitting an Application for Registration to Conduct Research INSTRUCTION: Please tick in the applicant column as appropriate

ITEM	Applicant	MRCZ
1. A completed application form.		
2. CATEGORY: REGISTRATION FEES PAID		
A US \$500 for Individual Researcher / studies (Turnaround time: 4 - 6 weeks)		
AE US \$1 000 for Fast Track Review (New Studies) (Turnaround time: 2 weeks)		
E US \$200 for Exempted from Ethics Review (New Studies) (Turnaround time: 2 weeks)		
BP US \$200 for PhD (Turnaround time: 4 - 6 weeks) US \$50 for MSc (Turnaround time: 1 week)	✓	
BU US \$10 for Undergraduates (Turnaround time: 2 days)		
3. Masters & BSc to submit 2 CLEARLY LABELED flat files copies of the following documents:		
a. Research proposal summary (maximum 4 pages)		
b. Full research proposal		
c. Informed consent forms: English & Vernacular Versions. (Shona/ Ndebele/ appropriate language)		
d. Letter of support from supervisor		
e. University Research Ethics Committee /IRB approval		
f. Supplementary information as applicable.		
f. Permission letter from head of institution where data is to be collected (For research in schools, a letter from ministry of Education is a requirement).		
BP (PhD) studies to submit 4 CLEARLY LABELED flat files (1 original plus 3 copies) of the following documents :		
a. Letter from academic supervisor confirming that s/he has authorized submission of proposal to MRCZ	✓	
b. Name, contact details and detailed curriculum vitae of academic supervisor(s)	✓	
c. For candidates registered with foreign institutions, please provide name contact details and letter from proposed local co-supervisor/adviser confirming willingness to supervise/advise	✓	
d. Four Copies of the following documents (1 original plus 3 copies):-		
1. Completed MRCZ application form	✓	
2. Research proposal summary (maximum 4 pages)	✓	
3. Informed consent forms (English and applicable local languages)	✓	
4. Specimen Storage and shipment consent form. (English and applicable local languages)	n/a	
5. Questionnaires & Any other data collection tools (English and applicable local languages)	✓	
6. Full research proposal (hard copy and electronic version)	✓	
7. Drug brochure or supplementary information if applicable	n/a	
8. CVs for the P.I and Co-Investigators	✓	
e. University Research Ethics Committee /IRB approval	✓	
f. Permission letter from head of institution where data is to be collected (For research in schools, a letter from ministry of Education is a requirement).		
5. A, AE & E studies to submit 4 CLEARLY LABELED flat files (1 original plus 3 copies) of the following documents :		
a. Research proposal summary (maximum 4 pages)		
b. Full research proposal and an electronic version as well.		
c. Informed consent forms : English & Vernacular Versions (Appropriate vernacular language)		
d. CVs for the P.I and Co-Investigators		
e. Drug brochure or supplementary information if applicable.		
f. Permission letter from head of institution where data is to be collected (For research in schools, a letter from ministry of Education is a requirement).		
g. Proof of funding on Sponsor's Letterhead		
Registration fees should be paid into the MRCZ Account :		
Account Name	: Medical Research Council of Zimbabwe	
Bank Name	: CBZ	
Branch	: Kwame Nkrumah	
Swift Code	: COBZZWHA	
Branch Sort Code	: 6101	
Account Number	: 01120068040016	



For Office Use Only MRCZ/ <u>A. 2083</u>	Date received...../...../..... FC <input type="checkbox"/> EXP <input type="checkbox"/> XMPT <input type="checkbox"/>
--	--

A. DETAILS OF RESEARCH TEAM

1. Name of Principal Investigator (P.I)	TSUNGAI CHIWARA			
2. Nationality of P.I	ZIMBABWEAN			
3. Existing Qualifications	M. PHIL (HIV/AIDS MANAGEMENT) B. PHARM (HONOURS)			
4. Academic Title	N/a			
5. Institution & Dept.	N/a			
6. Postal address	14228 LEGGATE AVENUE GUNHILL, HARARE			
7. E-mail address	tsungibc@gmail.com			
8. Telephone No.	0772 206155			
9. Is this research expected to lead to the award of a higher degree for the PI or any other research team member? (Yes/No)	YES			
10. Degree Type	Undergraduate (BSc, BA, etc)	MSc/MA/MMed/ MPhil	PhD/DPhil	Other
			✓	
11. Name of student if not the PI	n/a			
12. University/Institution where student is registered	UNIVERSITY OF SOUTH AFRICA (UNISA)			
13. Student # and Year of Study	55773931 THIRD YEAR			
Co-investigators Names	Qualifications	Institution/Department		
14.				
15.	n/a			
16.				

(Add rows if required)

B. DETAILS OF RESEARCH COORDINATOR

1. Name	ANNA MUPAWAENDA
2. Postal Address	14228 LEGGATE AVENUE GUNHILL, HRE
3. E-mail Address	amupawao@zmail.com
4. Telephone Number	0772 515 598
5. Mobile Number	0772 515 598
6. Site where Coordinator is stationed	PENSIONER / AT ABOVE ADDRESS



MEDICAL RESEARCH COUNCIL OF ZIMBABWE APPLICATION TO CONDUCT RESEARCH

C. DETAILS OF THE PROPOSED RESEARCH

1. Title of proposed research	GUIDELINES FOR IMPROVING HIV/AIDS COMMUNICATION FOR WOMEN IN ZIMBABWE
2. Proposed starting date	15/08/16
3. Proposed ending date	31/10/16
4. Performance site(s) in Zimbabwe	HARARE & BULAWAYO
5. Performance sites (outside Zimbabwe)	N/A
6. Total number of study personnel	THREE
7. Budget (state currency & amount)	ZAR 88,790.00
8. Name and address of Funding agency:	UNIVERSITY OF SOUTH AFRICA
9. Status of funding :	a) Submitted for funding <input type="checkbox"/> b) Pending <input checked="" type="checkbox"/> c) Funded <input type="checkbox"/>

D. COLLABORATING INSTITUTIONS

Institution	Contact / Focal Person (Name)	Telephone #	Email
1. UNISA	PROFESSOR NKOSI	12712429659	nkosi@unisa.ac.za

(Add rows if required)

E. POPULATION

F. TYPE OF STUDY

<p>Population : Proposed inclusion criteria (Check all that applies)</p> <p>Males : <input type="checkbox"/></p> <p>Females : <input checked="" type="checkbox"/></p> <p>Adolescents (12 – 17 years) : <input type="checkbox"/></p> <p>Children (Under 12 years of age) : <input type="checkbox"/></p> <p>Pregnant women : <input type="checkbox"/></p> <p>Foetuses : <input type="checkbox"/></p> <p>Elderly (over 65 years) : <input type="checkbox"/></p> <p>Prisoners : <input type="checkbox"/></p> <p>Cognitively impaired : <input type="checkbox"/></p> <p>Hospital inpatients : <input type="checkbox"/></p> <p>Sexual Minorities : <input type="checkbox"/></p> <p>Sex Workers : <input type="checkbox"/></p>	<p>Type of study (check all that applies)</p> <p>Survey : <input type="checkbox"/></p> <p>Secondary data : <input type="checkbox"/></p> <p>Observational Clinical Trials : <input type="checkbox"/></p> <p>Clinical trial : <input type="checkbox"/></p> <p>Lab Based/Biomedical Research : <input type="checkbox"/></p> <p>Record review : <input type="checkbox"/></p> <p>Operations Research : <input type="checkbox"/></p> <p>Qualitative/Social/Behavioural : <input checked="" type="checkbox"/></p> <p>Device Study : <input type="checkbox"/></p> <p>Other (specify) :</p>
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G. DETERMINATION OF RISK (Check all that applies)

Does the research involve any of the following	YES	NO
1. Human exposure to ionizing radiation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Fetal tissue or abortus	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Investigational new drug	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Investigational new device	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Existing data available via public archives/sources	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Existing data not available via public archives	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Observation of public behaviour	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Is the information going to be recorded in such a way that participants can be identified	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Does the research deal with sensitive aspects of the participants behaviour, sexual behavior, alcohol use or illegal conduct such as drug use	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Could the information recorded about the individual if it became known outside of the research, place the participants at risk of criminal prosecution or civil liability	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Could the information recorded about the individual if it became known outside of the research, damage the participant's financial standing, reputation and employability?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

H. FOR OFFICIAL USE ONLY

Risk of proposed research

- A) Minimal risk
- B) Greater than minimal risk
- C) High Risk

Minimal risk is a risk where the probability and magnitude of harm or discomfort anticipated in the proposed research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical, psychological examinations or tests. For example the risk of drawing a small amount of blood from a healthy individual for research purposes is no greater than the risk of doing so as part of routine physical examinations.

I. TRAINING

Has the research team undergone training in the following as appropriate:	YES	NO	If No please give dates when this will be done
1. Research Ethics /Human Subjects Protection	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
2. ICH-GCP	<input type="checkbox"/>	<input type="checkbox"/>	
3. Good Clinical Laboratory Practices	<input type="checkbox"/>	<input type="checkbox"/>	
4. Good Data Management Practices	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
5. Other (Specify if the team has taken any other similar/equivalent training)	<input type="checkbox"/>	<input type="checkbox"/>	



J. CONFLICT OF INTEREST

DECLARATION OF PRINCIPAL INVESTIGATOR

I (name of PI) TSUNGAI CHIWARA declare that all potential conflicts of interest regarding my application for ethics approval to conduct this study have been declared in the protocol/proposal.

Conflict of Interest includes but not limited to reporting :

- Having a financial and/or business interests in the source of funding
- Being a consultant for the source of funding
- Receiving funding from a sponsor that may be affected by the research reported in the study

Yes		No	<input checked="" type="checkbox"/>
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If Yes, please give details in a separate document that show that there is a plan in place for managing any potential conflicts of interest arising

I understand and accept that all information pertaining to this application is a true reflection of the project proposed and I take full responsibility should there be any transgression.

SIGNATURE OF PRINCIPAL INVESTIGATOR.....Blower.....DATE 15/06/16

K. STATISTICAL PLANNING AND DATA ANALYSIS

1. Has this project been reviewed by a professional statistician? If No, please justify below. <u>QUALITATIVE STUDY, BUT AFTER DATA COLLECTION WILL ENGAGE ONE FOR ANALYSIS</u>	Yes		No	<input checked="" type="checkbox"/>
2. If answered "yes" to (1), provide details of the statistician				
3. Proposed sample size :..... <u>FOCUS GROUPS: 85 TOTAL (6-12 IN EACH GROUP)</u> <u>CASE STUDY INDIVIDUAL INTERVIEWS: UNTIL DATA SATURATION REACHED</u>				



L. CONSENT PROCESS

1. Consent Process (Check all that applies)

Written:

Verbal/Oral:

2. Consent Language (Check all that applies)

English:

Local Languages (List them below)

.....
..... SHONA
..... NDEBELA

L. CLINICAL TRIALS											
1. Has Medicines Control Authority of Zimbabwe (MCAZ) approval been applied for?	Yes		No	N/A	<input checked="" type="checkbox"/>						
2. Is the PI presently involved in other research and/or clinical trial activities? (If yes, please provide details and % time allocated to each below)	Yes		No	<input checked="" type="checkbox"/>							
3. Which of the following will be used? <input type="checkbox"/> a) investigational drug(s) <input type="checkbox"/> b) new therapeutic applications of MCAZ approved drug (s) <input type="checkbox"/> c) new combination of any of the above <input type="checkbox"/> d) medical device 4. Briefly describe how this drug or device is a part of the proposed investigation. 5. For each drug or device to be used, please provide the following information: <table border="1"> <thead> <tr> <th>Generic Name</th> <th>Trade or Brand Name</th> <th>Manufacturer</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>						Generic Name	Trade or Brand Name	Manufacturer			
Generic Name	Trade or Brand Name	Manufacturer									
6. Please give the risks, hazards, known contraindications.											
7. Please give reasons for choice of drug(s) for this study. Include pertinent animal clinical tests or appropriate citations.											
8. Please provide dose schedule, route of administration, and duration of therapy.											
9. Please describe assessment of patient while receiving therapy including clinical observations and laboratory tests.											



RESEARCH PROPOSAL SUMMARY

It is the MRCZ requirement that the composition of the Institutional Review Board (IRB) include individuals with varied backgrounds and education. Investigators are therefore required to attach (5) copies of a (maximum 4 pages) Research Proposal Summary using the headings provided below in terminology that is understandable across disciplines.

1. RESEARCH QUESTION TO BE ADDRESSED BY THIS PROPOSAL

2. RATIONALE FOR RESEARCH

- Describe briefly the background of the study, and state reasons for conducting it.
- State objectives of study.

3. METHODS

- Study design and rationale for that design. Explain how the study will be performed.
- Population : Sample size, outline criteria for selection and exclusion of participants, gender, ethnic group, performance sites (provide justification for single gender or group). For larger sample sizes on greater than minimal risk studies, provide justification of the sample size.
- Participants' state of physical health. Indicate if healthy, ill, seriously ill or terminally ill.
- Does the study involve any special populations: Participants will include: minors, fetuses, pregnant women, prisoners, mentally retarded, mentally disabled, or none of the above.
- If participants are from one of the above special populations, explain the necessity for including them.
- Specify source of participating participants, e.g. hospitals, clinics, institutions, prisons, industry, unions, schools, general population, etc. *NOTE: If you plan to advertise for patients, the ad must be submitted to the MRCZ for review and approval prior to its publication and/or posting.*
- List all research procedures and/or interventions involving human participants (when applicable) including tests to be conducted and the analysis of samples (where applicable including where the analysis is to be done – if outside the country, application for biospecimen shipment and Foreign Researcher registration should be made to Research Council of Zimbabwe through MRCZ, please justify including how the samples are to be shipped, *forms obtainable from RCZ website*).
- Distinguish procedures which are part of routine care from those that are part of the study
- Questionnaire/interview instrument (when applicable)
 - If the study includes either of these, a copy of the instrument is to be appended to this application. If the instrument is in development stages, provide an outline of the types of questions to be asked and the expected date of completion and submission to the MRCZ.
- Methods of intervention: Will any new drugs or biologic agents be administered to the participants, or will previously used agents be used in a new manner? If yes, please note that you are also required to file a separate application with the Medicines Control Authority of Zimbabwe (MCAZ) and may not conduct your study without the approval of both the MCAZ and the MRCZ. You are also required to complete the relevant part in this application titled " Studies involving the testing of drugs and medical devices".
- Methods for dealing with adverse events
- Methods for dealing with illegal, reportable activities (e.g child abuse)

RISKS / BENEFITS TO PARTICIPANTS

- Describe in detail any potential risks –
 - physical,
 - psychological,
 - social, legal,
 - ethical (e.g. confidentiality), or other and assess the likelihood and seriousness of such risks (none, low, moderate, and high).
- Include the incidence of complications if known. You may use a narrative description if more appropriate or a table with 3 columns (Potential adverse effects, seriousness and likelihood of complications (Incidence if known.))
- Describe procedures for protecting against or minimizing potential risks.
- If the activity involves women who could become pregnant and is potentially harmful to a fetus, describe steps that will be taken to prevent pregnancy or exclude pregnant women.
- Assess potential benefits to be gained by the individual participants and explain why the benefits outweigh the risks.



MEDICAL RESEARCH COUNCIL OF ZIMBABWE APPLICATION TO CONDUCT RESEARCH

- Assess benefits which may accrue to society in general as a result of the planned work.

COSTS, COMPENSATION AND REIMBURSEMENTS

- Will participants receive any compensation, monetary or other? If monetary, how much? Will participants be asked to assume any out-of-pocket costs for participating in the research? If yes, what? Identify expenses such as additional transportation, laboratory tests, supplies, cost of study drug if it becomes commercially available, etc.

CONFIDENTIALITY ASSURANCES

Describe any means by which the participant's personal privacy is to be protected and confidentiality of data maintained. Include information on the following:

- Any sensitive information that will be gathered.
- Plans for record keeping
- Location of the data
- Data security
- Person responsible and telephone number
- Who will have access to the data
- Plans for disposal of the data upon completion of the study

CONFLICT OF INTEREST (real or apparent)

- Other than the normal scholarly gains, are there any other gains you might receive from taking part in this study?

COLLABORATIVE AGREEMENTS

- Provide letters of approval from collaborating institutions' IRBs and from other local IRBs from other sites.

INTENDED USE OF RESULTS

- Include plans for dissemination and utilization of study results

OTHER INFORMATION:

- Any other information.



FULL RESEARCH PROPOSAL

Attach 5 COPIES of the full research proposal. The full proposal should include the following: Title, objectives, background and literature review, methodology (to include research design, participants and methods, ethical considerations, timetables etc. references, budget etc. Investigators may submit the full proposal in the funding agency format as long as it covers the above headings.

Please also attach copies of **curriculum vitae** for the Principal Investigators and all Co- investigators.

The CVs should include the following:

Name,

Postal address,

Employers name and address,

Qualifications,

Ongoing Research Activities and role or % time allocated for each

Past research experience (relevant) and

Published Papers (relevant)

Principal Investigators or co-investigators who would have already submitted their CVs during the current year are exempted from this requirement.

INFORMED CONSENT

- Any kind of contact with human participants requires a disclosure/consent process.
- Attach a copy of the consent form (template is provided on the website www.mrcz.org.zw).
- Indicate how (written) informed consent will be obtained
- If participants are minors or mentally disabled, describe how and by whom permission will be granted.
- Where will the record of consent be stored? (Consent forms must be kept for three years after the completion of the investigation, unless otherwise stipulated by the MRCZ).

Annexe C - MRCZ approval

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

REF: MRCZ/A/2083

27 September, 2016

Tsungai Chiwara

University Of South Africa
P.O Box 392 UNISA 0003
Harare

RE:- Guidelines For Improving HIV/AIDS Communication For Women In Zimbabwe

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

- Study proposal
- Informed Consent Forms- Individual Interview, Version 1.0 dated 13 June, 2016 2016. (English, Shona and Ndebele)
- Informed Consent Forms- Focus Group Discussions, Version 2.0 dated 04 October, 2016. (English, Shona and Ndebele)
- Key Informant In-Depth Interview Guide. (English)
- FGD Guide. (English, Shona and Ndebele)
- Case study Interview Guide. (English, Shona and Ndebele)
- Individual Interview guide – Demographic Information Guide for participant.(English, Shona and Ndebele)
- Focus Group Discussions – Demographic Information Guide for participant.(English, Shona and Ndebele)

- **APPROVAL NUMBER** : **MRCZ/A/2083**
- This number should be used on all correspondence, consent forms and documents as appropriate.
- **TYPE OF MEETING** : **Normal**
- **EFFECTIVE APPROVAL DATE** : **27 September, 2016**
- **EXPIRATION DATE** : **26 September, 2017**


After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully


MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Annexe D - Key informant request letter

Tsungai Chiwara
14228 Leggate Avenue
Gunhill
Harare
Date

The Head of the Institute
Address
Harare

Re: Request to interview focal person for communication as part of an HIV and AIDS qualitative exploratory study

My name is Tsungai Chiwara and I am a student at The University of South Africa, in The Department of Health Studies. I am studying towards a Doctor of Literature and Philosophy in Health Studies, my area of interest being HIV and AIDS. In fulfilment of the requirements for this, it is required that I undertake research and submit a thesis. My research title is '**Guidelines for improving HIV/AIDS communication for women in Zimbabwe**'.

The study will explore in-depth HIV and AIDS communication from the perspective of young urban Zimbabwean women, thus gaining insights that contribute to the body of knowledge. The exploration will investigate the communication channels through which this sub-group has received its information on HIV and AIDS, the information itself, the extent to which the sub-group's perceptions have been affected or shaped by this information through the various channels. The research will also look into the young urban women's context. The specific objectives of the study, are:

1. To explore the HIV and AIDS communication channels through which young urban Zimbabwean women receives their information
2. To examine the HIV and AIDS knowledge and perceptions acquired by young urban Zimbabwean women
3. To describe the context of young urban Zimbabwean women

4. To draft guidelines for HIV and AIDS communication providers, for improving the HIV and AIDS information targeted at young urban Zimbabwean women.

The method that will be used to gather data for this qualitative study is through in-depth interviews of key informants (such as you) as well as focus-group discussions and in-depth individual interviews comprising urban Zimbabwean women aged 20-29 who have lived in Bulawayo or Harare for at least the last 12 months.

The research has been approved by The Departmental (Health Studies) Higher Degrees Committee, the UNISA Ethics Committee as well as the Medical Research Council of Zimbabwe.

Your organization has been selected for key informant interviews as it is a stakeholder in HIV and AIDS communication in terms of its program/research work for women. Your organization therefore interacts with women and is able to have some insight into their knowledge on HIV and AIDS, their context, and other aspects.

I am requesting for permission to carry out an in-depth interview with the focal person for communication in your organization.

A copy of the thesis will be available for reading, if you so require this.

Yours sincerely

Tsungai Chiwara (Mrs)

Annexe E - FGD interview guide

FOCUS GROUP DISCUSSION GUIDE:

FOCUS GROUP CITY: HARARE/BULAWAYO

FOCUS GROUP LOCATION (RESIDENTIAL AREA):

FOCUS GROUP NUMBER:

NUMBER OF PARTICIPANTS IN THIS GROUP:

DATE:

START TIME:

END TIME:

NAME OF MODERATOR:

MODERATOR'S PHONE NUMBER

NAME OF RESEARCH ASSISTANT:

RESEARCH ASSISTANT'S PHONE NUMBER

INTRODUCTION (DO NOT read)

Welcome to the discussion. As explained in the sheet you have in front of you, my name is Mrs. Tsungai Chiwara. I'm doing this study in fulfilment of the requirements to complete my PhD in Health Studies. My area of interest is HIV and AIDS. I chose a topic that I believe will assist women as a whole in the area of HIV and AIDS. The results will shed more light and give new insights as to how you ladies view what has been done so far in the area of HIV and AIDS communication in relation to yourselves – the world needs to know your perspective and hear it from you directly. This information can then be studied and conclusions reached, guidelines and recommendations made and shared as part of my thesis or final report and this will go a long way in positively contributing the way HIV and AIDS communication is handled for women living in urban areas in Zimbabwe. You will be recorded because it is not possible to write everything you are saying, so it is to ensure accuracy when we compile the results. An experienced moderator (give name) will be leading the discussions, while the research assistant (give name) and I will be

taking down notes and assisting her. Please stop the moderator if you need them to repeat or clarify anything. I will be following various themes in an attempt to make the discussion orderly, productive and to cover key areas. To get our discussion going, please can each of you introduce yourselves? (AND TO SAY SOMETHING ABOUT WHO YOU ARE...30 seconds).

REMEMBER TO RECORD NOW – SAY LOCATION AND DATE

THEME 1: MODES OF INTERPERSONAL COMMUNICATION

1. As young women living in an urban area, describe from which PEOPLE you have heard information about HIV and AIDS (EMPHASIS IS ON INDIVIDUALS WHETHER CHURCH, CLINIC, HOME COMMUNITY etc)
2. As a follow up to number 1, share WHO you are most comfortable getting HIV and AIDS information from and why. (INDIVIDUALS)

THEME 2: MASS COMMUNICATION CHANNELS

1. Through which mass media have you, as young women, heard about HIV and AIDS?
2. In the case of radio, discuss what form the information came in.
3. In the case of television discuss what form the information came in.
4. In the case of newspapers and magazines, discuss the form the information came in.
5. For each of the channels stated below, where do young women access these?

Billboards, posters, pamphlets/brochures/leaflets

6. Discuss how you generally view the material/content or information on HIV and AIDS that is communicated through mass media. (REFER TO SHONA/NDEBELE VERSION)

THEME 3: HIV and AIDS KNOWLEDGE

1. Discuss your understanding of HIV and AIDS.
2. How is it possible for people to get infected by HIV?
3. What can promote the spread of HIV? (Epidemic drivers).

4. How can one minimise chances of getting HIV?
5. Is there any well-known personality on media (radio, television, newspapers, posters, pamphlets or other) that you associate with promoting HIV and AIDS issues? If yes, please name them and what their line of work is (musician, actor, actress, media personality, politician or other). (ISSUES for example CIRCUMCISION, TESTING, DISCRIMINATION etc.)

THEME 4: PERCEPTIONS AND BELIEFS

1. Of people in general, which person do you believe is likely to pass on the **most** accurate information about HIV to young women in urban areas? Why?
2. Of all the mass communication channels mentioned, which one do you believe is the **most** effective for young urban women? Why?
3. Describe which mass communication channel is most readily accessible to you as young women in an urban setting.
4. Comment on the language appropriateness used in mass media.
5. Comment on the sensitivity or lack of sensitivity of the information relayed through these channels, with regards to the needs of urban Zimbabwean women of your age group (20-29). (SHONA/NDEBELE VERSION TO EXPLAIN SENSITIVITY)
6. Discuss the type of communication for HIV and AIDS-related issues is preferable to you, interpersonal or mass communication? Why?
7. Do young women believe that it is important that they know their HIV status? Explain your answers.
8. What makes an urban woman vulnerable to getting HIV infection in Zimbabwe? (REFER TO SHONA/NDEBELE VERSION TO EXPLAIN VULNERABLE)
9. Discuss whose fault is it that HIV and AIDS has been spreading among young urban women in Zimbabwe?
10. Is there enough information available to women about HIV and AIDS?

THEME 5: CONTEXT

1. Discuss the role the community plays in HIV and AIDS communication?

2. Discuss what role, if any, religion or spirituality have in communicating HIV and AIDS matters?
3. How do you see the socioeconomic status of women in the urban areas being relevant in HIV and AIDS matters?
4. What aspects of culture in Zimbabwe promote the spread of HIV and AIDS among young urban women?
5. What aspects of culture in Zimbabwe help in reducing the spread of HIV and AIDS among young urban women?
6. Discuss the extent to which cultural aspects are adequately incorporated in HIV and AIDS communication?
7. What does the life of a Zimbabwean urban woman (20-29 years old) look like?

What role have you seen government, policy makers and the law playing in HIV and AIDS communication for the Zimbabwean urban woman?

Annexe F - Individual interview guide

INDIVIDUAL INTERVIEW GUIDE:

TO BE COMPLETED BY RESEARCH ASSISTANT

INTERVIEW CITY: HARARE/BULAWAYO

INTERVIEW LOCATION (RESIDENTIAL AREA):

INTERVIEW NUMBER:

DATE:

NAME OF RESEARCH ASSISTANT:

THEME 1: MODES OF INTERPERSONAL COMMUNICATION

3. From which people have you heard information about HIV and AIDS?
4. Which one are you most comfortable getting information from? Why?

THEME 2: MASS COMMUNICATION CHANNELS

7. Through which mass media have you heard information about HIV and AIDS?
8. In the case of radio specify what form the information came in.
9. In the case of television specify what form the information came in.
10. In the case of newspapers and magazines, specify the form the information came in.
11. For each of the channels stated below, where were these located physically:
 - (i) Billboards
 - (ii) Posters
 - (iii) Pamphlets/brochures/leaflets
12. How do you generally view the material/content or information on HIV and AIDS that is communicated through mass media?

THEME 3: HIV and AIDS KNOWLEDGE

6. Is there a difference between HIV and AIDS? Explain your answer.
7. How is it possible to get infected by HIV?
8. What can promote the spread of HIV? (Epidemic drivers).

9. How can one minimise chances of getting HIV?
10. Tell me what you know about the treatment of HIV infection.
11. Tell me what you know about Prevention of Mother to Child Transmission/PMTCT.
12. Tell me what you know about male circumcision and HIV.
13. Is there any well-known personality on media (radio, television, newspapers, posters, pamphlets or other) that you associate with promoting HIV and AIDS issues? If yes, please name them and what their line of work is (musician, actor, actress, media personality, politician or other).

THEME 4: PERCEPTIONS AND BELIEFS

11. Which people do you believe are the most likely to pass on the **most** accurate information about HIV? Why?
12. Which people do you believe are likely to pass on the **least** accurate information? Why?
13. Of all the mass communication channels mentioned, which one do you believe is the **most** effective? Why?
14. Of all the mass communication channels, which one do you believe is the **least** effective? Why?
15. Which mass communication channel is **most** readily accessible to you? Explain.
16. Is the language used in the mass communication appropriate? Elaborate.
17. Is the information relayed through these channels sensitive to young urban Zimbabwean women's needs of your age group (20-29)? Explain your view point.
18. Which type of communication for HIV and AIDS-related issues is preferable to you, interpersonal or mass communication? Why?
19. Do you believe that it is important that you know your HIV status? Explain your answers.
20. If you were to discover that you were HIV positive would you tell other people or would you hide it? Why?
21. Do you think you are or are not at risk of getting HIV infection? Elaborate.
22. What makes an urban woman vulnerable to getting HIV infection in Zimbabwe?
23. In your opinion, whose fault is it that HIV and AIDS has been spreading among young urban women in Zimbabwe?
24. Is there enough information available to young urban Zimbabwean women about HIV and AIDS?
25. Have **you** personally ever educated anyone about HIV and AIDS?

26. Is the knowledge on HIV and AIDS that you have gained so far likely to influence your behaviour? If so, how?
27. Do you believe that the level of HIV infection in Zimbabwe is low or high?

THEME 5: CONTEXT

8. What role do you see the community playing in HIV and AIDS communication?
9. What role, if any, does religion or spirituality have in communicating HIV and AIDS matters? Explain your answer.
10. How do you see the socioeconomic status of women in the urban areas being relevant in HIV and AIDS matters?
11. What aspects of culture in Zimbabwe promote the spread of HIV and AIDS among women?
12. What aspects of culture in Zimbabwe help in spreading the spread of HIV and AIDS among women?
13. To what extent are cultural aspects incorporated in HIV and AIDS communication? Explain.
14. What does the life of a Zimbabwean urban woman (20-29 years old) look like?
15. What role have you seen government, policy makers and the law playing in HIV and AIDS communication for the Zimbabwean urban woman?
16. What links, if any, do you see between HIV and AIDS, the urban Zimbabwean woman and any of the following:
- (i) Polygamy
 - (ii) Small houses
 - (iii) Sugar daddies
 - (iv) Sex work
 - (v) Gender roles
 - (vi) Gender and domestic violence towards women
 - (vii) Educational level attained

Annexe G - Key informant interview guide

KEY INFORMANT IN-DEPTH INTERVIEW GUIDE

NAME OF ORGANIZATION:

DESIGNATION OF INTERVIEWEE:

INTERVIEW NUMBER:

DATE:

As previously explained in the letter requesting to carry out this interview, my name is Tsungai Chiwara and I am a student at The University of South Africa, in The Department of Health Studies. I am studying towards a Doctor of Literature and Philosophy in Health Studies, my area of interest being HIV and AIDS. In fulfilment of the requirements for this, it is required that I undertake research and submit a thesis. My research title is '**Guidelines for improving HIV/AIDS communication for women in Zimbabwe**'.

I would like to interview you because you are a stakeholder who works in the area of HIV and AIDS communication and are a key informant for my study. Your organization interacts with women and in addition to communication aspects, is also able to have some insight into their knowledge on HIV and AIDS, their context, and other aspects. By interviewing you I will be able to gain useful insights. The interview will be for about 45 minutes to an hour and you may stop me at any time to seek clarity on a question. The questions I will be asking are all open-ended.

THEME 1: COMMUNICATION

1. How exactly is your organization involved in the area of HIV and AIDS communication in Zimbabwe?
2. What role do you play?
3. Which channels of mass communication does your organization utilize to spread the HIV and AIDS message?
4. How does your organization make use of personal communication, if at all, in HIV and AIDS matters?

5. From what you know or believe, which group of people have the highest HIV prevalence in Zimbabwe. What is the reason for it being highest in this group?
6. What is your organization doing to specifically target the urban Zimbabwean woman aged 20-29 in terms of HIV and AIDS communication?
7. Of all the mass communication channels, which one do you believe is the **most** effective? Why?
8. Of all the mass communication channels, which one do you believe is the **least** effective? Why?
9. Which mass communication channel is most readily accessible to young urban women? Explain.
10. Which languages are your communication materials in?
11. What has your organization done, in terms of surveys and other types of research, in order to get feedback from urban Zimbabwean women in relation to their perspective of HIV and AIDS communication?
12. What barriers to communication are there in the dissemination of HIV and AIDS information to urban Zimbabwean women aged 20-29?

THEME 2: HIV and AIDS KNOWLEDGE OF URBAN ZIMBABWEAN WOMEN

1. To what extent does the urban woman in Zimbabwe have high quality and adequate information about HIV and AIDS?
2. Which HIV and AIDS champions does your organization use for HIV and AIDS issues?
3. As far as urban woman in Zimbabwe are concerned, what are the HIV epidemic drivers?
4. What makes them vulnerable to HIV and AIDS?

THEME 3: CONTEXT

1. What is the context of the urban Zimbabwean woman?
2. What issues in her environment are relevant to HIV and AIDS?
3. How does her context influence how she perceives HIV and AIDS issues?

4. On a national level, what has been done by government policy makers to assist the urban woman in Zimbabwe with regards to HIV and AIDS communication? What can they still do?
5. How do you see the region being involved in HIV and AIDS communication for the benefit of HIV and AIDS communication for young urban Zimbabwean women?
6. How does spirituality come into play with young urban women and HIV and AIDS?
7. To what extent have gender inequalities and empowerment been addressed with regards to women and HIV and AIDS?
8. To what extent does the socioeconomic environment influence HIV and AIDS issues specifically for women?
9. To what extent does culture influence the HIV and AIDS content that you communicate, with regards to the urban woman?
10. What role has the community played and what additional role do you see community involvement playing in HIV and AIDS communication?
11. What efforts have your organization made in incorporating the Zimbabwean urban woman's context in HIV and AIDS communication efforts? Which themes have been covered?

Annexe H - FGD informed consent and confidentiality

MRCZ No. 2083

INFORMED CONSENT AND CONFIDENTIALITY FORM:

FOCUS GROUPS

Dear Participant,

- We give you this consent form so that you may read about the purpose, risks, and benefits of this research study.
- The main goal of research studies is to gain knowledge that may help future sectors of the population.
- We cannot promise that this research will benefit you.
- You have the right to refuse to take part, or agree to take part now and change your mind later.
- Whatever you decide, it will not have any consequences.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

My name is Mrs. Tsungai Chiwara. I am a student at The University of South Africa (UNISA), in The Department of Health Studies, studying towards a Doctor of Literature and Philosophy in Health Studies. In order to complete my degree, it is required that I undertake research and submit a thesis. My research title is '**Guidelines for improving HIV/AIDS communication for women in Zimbabwe**'.

The **aim** of the study is to explore HIV/AIDS communication from the perspective of Zimbabwean urban women and by so doing gain more and new insight and therefore

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MRCZ No. 2083



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contribute to the existing knowledge. At the end of the study, guidelines will be written for those involved in HIV/AIDS communication, with a view of improving the HIV/AIDS information targeted at Zimbabwean urban women.

Procedure: In order to achieve these objectives, while I will also be interviewing key people familiar with HIV/AIDS communication from several organizations, I would like to hold discussions with you in a group set-up so as to discuss several issues. The discussions will be recorded on an audio tape as well as using notes. This is in order to capture accurately what will have been discussed. I will be using an experienced moderator to guide the discussions, a research assistant to take notes, and I will also be taking down notes throughout. The research will be conducted in Zimbabwe only; in Harare and Bulawayo. The total number of participants in the focus group discussions will be about 85. The number of participants in each group will be 6-12.

Selection criteria: You qualify to participate in the study because you are a Zimbabwean woman aged 20-29 years who has been living in an urban area (Harare or Bulawayo) for at least the last 12 months.

Duration: The discussion will be no more than one and a half hours.

Approval: The study was approved by UNISA as well as the Medical Research Council of Zimbabwe and it has been deemed ethical.

Confidentiality: The results of the discussions will be safeguarded in that the findings of the study will be kept under lock and key and in a laptop with a password known only by myself, in the strictest of confidence – no names will be linked to the results at all. The study is purely for academic reasons and to improve on knowledge that is available on this topic, which will assist in developing guidelines for improving HIV/AIDS communication for women. If you indicate your willingness to participate in this study by signing this document, we plan to disclose the guidelines that will be developed, to the Ministry of Health and Child Care, which is the organization governing HIV/AIDS related issues.

Answering questions: You do not have to answer questions that make you uncomfortable. You are free to continue with the interview even if you do not answer some of the questions.

Risks: There are no risks of any type anticipated. The discussions are purely for information sharing.

Benefits: The benefit to the participant, participants or others which may reasonably be expected from the research is that of improving the various aspects of HIV/AIDS information targeted at Zimbabwean urban women. We cannot and do not guarantee or promise that you will receive any benefits from this study.

Payment: There will be no payment given for this exercise – you are participating as a volunteer.

Voluntary participation: Participation in this study is voluntary. You may choose whether you would like to participate or not.

Withdrawal: You may ask to stop the interview and withdraw your consent at any time that you would like if you decide not to stay till the end. Discontinuing at any time carries no penalty whatsoever.

Offer to answer questions: Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over. You are welcome to contact me (0772 226155/0712 235 651) at any time should you have any questions or you need clarification.

Thesis/Final report: This can be made available for reading purposes, should you be interested, once it has been finalized and passed.

YOU WILL BE OFFERED A COPY OF THIS CONSENT FORM TO KEEP

MRCZ No. 2083

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Medical Research Council of Zimbabwe (MRCZ) on telephone (04)791792 or (04) 791193 and cell phone lines 0784 956 128. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

Statement of Consent to be audiotaped:

I understand that audio recordings will be taken during the study. *(Please choose YES or NO by inserting your initials in the relevant box)*

- I agree to being audio recorded

Yes

No

Name of Participant (please print)

Signature

Date

Phone Number:

The audio tapes will be kept under lock and key by the researcher, who is the only one who will have access to them. They will be listened to at least once, during the data analysis and discussion sections of the study, in order to confirm accuracy of what was said.

Authorization: You are making a decision whether or not to participate in this study. Your signature at the end of this form indicates that you have read and understood the

MRCZ No. 2083

information provided above, have had all your questions answered, and have decided to participate.

In addition, please also complete the attached demographic form 'FOCUS GROUP DISCUSSIONS: Demographic information for participant' whose purpose is to capture the details of the population participating in the study.

Thank you.

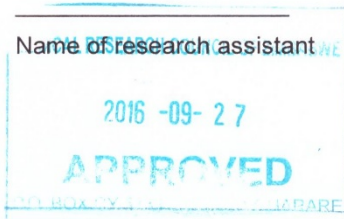
Name of participant (please print) Signature Date

Tsungai Chiwara

Name of researcher Signature Date

Name of moderator Signature Date

Name of research assistant Signature Date



Annexe I - Individual interview informed consent and confidentiality

MRCZ No. 2083

INFORMED CONSENT AND CONFIDENTIALITY FORM:

INDIVIDUAL INTERVIEW

PARTICIPANT NUMBER:

Guidelines for improving HIV/AIDS communication for women in Zimbabwe



Principal Investigator: **Tsungai Chiwara [MPhil; B.Pharm (Hons)]**

Phone number: **+263 772226155**

Dear Participant,

- We give you this consent form so that you may read about the purpose, risks, and benefits of this research study.
- The main goal of research studies is to gain knowledge that may help future sectors of the population.
- We cannot promise that this research will benefit you.
- You have the right to refuse to take part, or agree to take part now and change your mind later.
- Whatever you decide, it will not have any consequences.

- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

My name is Mrs. Tsungai Chiwara. I am a student at The University of South Africa (UNISA), in The Department of Health Studies, studying towards a Doctor of Literature and Philosophy in Health Studies. In order to complete my degree, it is required that I undertake research and submit a thesis. My research title is '**Guidelines for improving HIV/AIDS communication for women in Zimbabwe**'.

The **aim** of the study is to explore HIV/AIDS communication from the perspective of Zimbabwean urban women and by so doing gain more and new insight and therefore contribute to the existing knowledge. At the end of the study, guidelines will be written for those involved in HIV/AIDS communication, with a view of improving the HIV/AIDS information targeted at Zimbabwean urban women.

Procedure: In order to achieve these objectives, while I will also be interviewing key people from organizations that work in the field of HIV/AIDS communication from several organizations, I will be carrying out discussions in a group set-up and further, would like to interview you as one of several individual interviews of urban women aged 20-29. The interview will be recorded on an audio tape as well as using notes. This is in order to capture accurately what will have been discussed during the interview. I will be assisted by a research assistant during the interview who will be taking notes as well. The research will be conducted in Zimbabwe only; in Harare and Bulawayo. Different participants will be interviewed until such time that no new information is being collected.

Selection criteria: You qualify to participate in the study because you are a Zimbabwean woman aged 20-29 years who has been living in an urban area (Harare or Bulawayo) for at least the last 12 months.

Duration: The interview will be no more than one and a half hours.

Approval: The study was approved by UNISA as well as the Medical Research Council of Zimbabwe and it has been deemed ethical.

Confidentiality: The results of the discussions will be safeguarded in that the findings of the study will be kept under lock and key and in a laptop with a password known only by myself, in the strictest of confidence – no names will be linked to the results at all. The study is purely for academic reasons and to improve on knowledge that is available on this topic, which will assist in developing guidelines for improving HIV/AIDS communication for women. If you indicate your willingness to participate in this study by signing this document, we plan to disclose the guidelines that will be developed, to the Ministry of Health and Child Care, which is the organization governing HIV/AIDS related issues.

Answering questions: You do not have to answer questions that make you uncomfortable. You are free to continue with the interview even if you do not answer some of the questions.

Withdrawal: You may ask to stop the interview any time that you would like if you decide not to stay till the end. You may also withdraw your consent if you decide to.

Risks: There are no risks of any type anticipated. The discussions are purely for information sharing.

Benefits: The benefit to the participant, participants or others which may reasonably be expected from the research is that of improving the various aspects of HIV/AIDS information targeted at Zimbabwean urban women. We cannot and do not guarantee or promise that you will receive any benefits from this study.

Payment: There will be no payment given for this exercise – you are participating as a volunteer.

Voluntary participation: Participation in this study is voluntary. Discontinuing at any time carries no penalty.

MRCZ No. 2083

Offer to answer questions: Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over. You are welcome to contact me (0772 226155/0712 235 651) at any time should you have any questions or you need clarification.

Thesis/Final report: This can be made available for reading purposes, should you be interested, once it has been finalized and passed.

YOU WILL BE OFFERED A COPY OF THIS CONSENT FORM TO KEEP

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Medical Research Council of Zimbabwe (MRCZ) on telephone (04)791792 or (04) 791193 and cell phone lines 0784 956 128. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

Statement of Consent to be audiotaped:

I understand that audio recordings will be taken during the study. *(Please choose YES or NO by inserting your initials in the relevant box)*

- I agree to **being audio recorded**

Yes

No

Name of Participant (please print)

Signature

Date

Phone Number: _____

The audio tapes will be kept under lock and key by the researcher, who is the only one who will have access to them. They will be listened to at least once, during the data analysis and discussion sections of the study, in order to confirm accuracy of what was said.

Authorization: You are making a decision whether or not to participate in this study. Your signature at the end of this form indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.



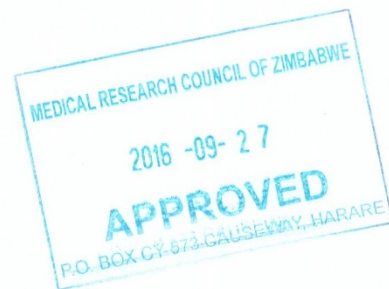
**Guidelines for improving HIV/AIDS communication for
women in Zimbabwe**

Version 1.0 13/06/16

In addition please also complete the attached demographic form 'INDIVIDUAL INTERVIEWS: Demographic information for participant' whose purpose is to capture the details of the population participating in the study.

Thank you.

_____ Name of Participant (please print)	_____ Signature	_____ Date
TSUNGAI CHIWARA _____ Name of Researcher	_____ Signature	_____ Date
_____ Name of Research Assistant	_____ Signature	_____ Date



Annexe J - FGD demographic information for participant

FOCUS GROUP DISCUSSIONS: Demographic information for participant

FOCUS GROUP NUMBER:

LOCATION:

DATE:

1. WHICH PART OF ZIMBABWE ARE YOU ORIGINALLY FROM?

FOR EACH SECTION BELOW, PLEASE SELECT ONE OPTION AND TICK

2. AGE

20-24 YRS	<input type="checkbox"/>
25-29 YRS	<input type="checkbox"/>

3. MARITAL STATUS

SINGLE	<input type="checkbox"/>
MARRIED/CO-HABITING	<input type="checkbox"/>
WIDOWED	<input type="checkbox"/>
DIVORCED	<input type="checkbox"/>
SEPARATED	<input type="checkbox"/>

4. RELIGION

CATHOLIC	
ANGLICAN	
METHODIST	
DUTCH REFORMED	
SALVATION ARMY	
SEVENTH DAY ADVENTIST	
APOSTOLIC SECT	
PENTECOSTAL	
MUSLIM	
OTHER (SPECIFY)	
NONE	

5. LANGUAGES FLUENT IN (YOU MAY TICK MORE THAN ONE)

SHONA	
NDEBELE	
ENGLISH	
OTHER (SPECIFY)	

6. EDUCATIONAL LEVEL ATTAINED (TICK HIGHEST LEVEL)

PRIMARY SCHOOL (GRADE 7 OR BELOW)	
HIGH SCHOOL (UP TO FORM 2 OR BELOW)	
SECONDARY SCHOOL (UPTO FORM 4 OR BELOW)	
SECONDARY SCHOOL (UPTO FORM 6 OR BELOW)	
COLLEGE (CERTIFICATE OR DIPLOMA OBTAINED)	
UNIVERSITY (AT LEAST ONE DEGREE)	
PROFESSIONAL QUALIFICATION (FOR EXAMPLE IMM: SPECIFY)	

7. WORK

DON'T WORK	
SELF-EMPLOYED	
WORK FOR SOMEONE	
IF WORK FOR SOMEONE STATE DESIGNATION	

Annexe K - Individual interview demographic information for participant

INDIVIDUAL INTERVIEW: Demographic information for participant

INTERVIEW NUMBER:

LOCATION:

DATE:

1. WHICH PART OF ZIMBABWE ARE YOU ORIGINALLY FROM?

FOR EACH SECTION BELOW, PLEASE SELECT ONE OPTION AND TICK

2. AGE

20-24 YRS	<input type="checkbox"/>
25-29 YRS	<input type="checkbox"/>

3. MARITAL STATUS

SINGLE	<input type="checkbox"/>
MARRIED/CO-HABITING	<input type="checkbox"/>
WIDOWED	<input type="checkbox"/>
DIVORCED	<input type="checkbox"/>
SEPARATED	<input type="checkbox"/>

4. RELIGION

CATHOLIC	<input type="checkbox"/>
ANGLICAN	<input type="checkbox"/>
METHODIST	<input type="checkbox"/>
DUTCH REFORMED	<input type="checkbox"/>
SALVATION ARMY	<input type="checkbox"/>
SEVENTH DAY ADVENTIST	<input type="checkbox"/>
APOSTOLIC SECT	<input type="checkbox"/>
PENTECOSTAL	<input type="checkbox"/>
MUSLIM	<input type="checkbox"/>
OTHER (SPECIFY)	<input type="checkbox"/>
NONE	<input type="checkbox"/>

5. LANGUAGES FLUENT IN (YOU MAY TICK MORE THAN ONE)

SHONA	
NDEBELE	
ENGLISH	
OTHER (SPECIFY)	

6. EDUCATIONAL LEVEL ATTAINED (TICK HIGHEST LEVEL)

PRIMARY SCHOOL (GRADE 7 OR BELOW)	
HIGH SCHOOL (UP TO FORM 2 OR BELOW)	
SECONDARY SCHOOL (UPTO FORM 4 OR BELOW)	
SECONDARY SCHOOL (UPTO FORM 6 OR BELOW)	
COLLEGE (CERTIFICATE OR DIPLOMA OBTAINED)	
UNIVERSITY (AT LEAST ONE DEGREE)	

7. WORK

DON'T WORK	
SELF-EMPLOYED	
WORK FOR SOMEONE ELSE	
IF WORK FOR SOMEONE ELSE STATE DESIGNATION	

Annexe L - Individual interview transcript sample

INDIVIDUAL INTERVIEW TRANSCRIPT SAMPLE

RESPONDENT 8 – DZIVARASEKWA 2 (HIGH-DENSITY), HARARE

INTERVIEWER: From which people have you heard information about HIV and AIDS?

RESPONDENT 8: From the hospitals. When you go for treatment, you are given a lecture on HIV and AIDS, more so if you are expecting. The lectures are on how best you can look after yourself if you are found to be HIV positive.

INTERVIEWER: Is there anyone else who educated you on HIV and AIDS besides nurses at the clinic?

RESPONDENT 8: Ummh, no one.

INTERVIEWER: Which one are you most comfortable getting information from and why?

RESPONDENT 8: I am not sure, I have always assumed one can only get such information from health workers, for example doctors.

INTERVIEWER: So from whom are you comfortable getting information on HIV and AIDS?

RESPONDENT 8: Anyone who is able and qualified to teach me about the facts of life.

INTERVIEWER: Theme two is on Mass Communication Channels. Through which mass media have you heard about HIV and AIDS?

RESPONDENT 8: On TV and radio.

INTERVIEWER: In the case of radio, specify what form the information came in? Was it a lesson, an advertisement, a drama or it was on a news broadcast?

RESPONDENT 8: Once in a while I listen to radio but I may not know the title of the programme because I would have tuned in when the programme was mid-stream.

INTERVIEWER: In the case of television, specify what form the information came in?

RESPONDENT 8: I usually watch a programme called “Positive Talk” on television.

INTERVIEWER: In the case of newspapers and magazines, specify the form the information came in?

RESPONDENT 8: I have seen some articles in magazines, pictures may form part of the story.

INTERVIEWER: Have you seen any information on HIV and AIDS on billboards?

RESPONDENT 8: I have not come across them.

INTERVIEWER: Have you seen any HIV and AIDS information on posters?

RESPONDENT 8: I have seen posters at clinics.

INTERVIEWER: Have you seen HIV and AIDS information on pamphlets, brochures or leaflets. And where were these located?

RESPONDENT 8: Sorry, I don't recall seeing these.

INTERVIEWER: How do you generally view the material, content or information on HIV and AIDS that is communicated through mass media?

RESPONDENT 8: The content is okay as it is informative. Most of the time we are ignorant of HIV and AIDS issues and some of the content is educative.

INTERVIEWER: Is there any difference between HIV and AIDS?

RESPONDENT 8: Yes there is, from what I understand, if someone is HIV it does not mean they have the disease. They have a virus and they do not have the disease. When you have AIDS, you are said to be positive.

INTERVIEWER: How is it possible to get infected by HIV?

RESPONDENT 8: Through unprotected sex. Also, when an HIV positive person's blood mixes with an HIV negative person's blood.

INTERVIEWER: How does the blood mix?

RESPONDENT 8: Through open sores.

INTERVIEWER: What can promote the spread of HIV? What are the epidemic drivers?

RESPONDENT 8: HIV is spread through sex. The one who is HIV positive will infect the one who is negative. This is how it is spread.

INTERVIEWER: We agree the virus is spreading and yet the information on HIV is in abundance. So why is the virus still spreading?

RESPONDENT 8: A lot of people are not going for testing so as to know their status. For some who go for testing, they then don't disclose their status to their spouse/partner. When they get to know that they are infected, they then deliberately go on to spread the virus to their partner and numerous other people.

I believe this is how it is spread.

INTERVIEWER: How can one minimise the chances of getting HIV?

RESPONDENT 8: One can use protective gloves. People need to change their behaviour and stick to one partner by so doing they minimise spreading the virus.

INTERVIEWER: Tell me what you know about the treatment of HIV infection?

RESPONDENT 8: Ummh I am not aware of how the virus is treated.

INTERVIEWER: Have you not heard from anyone what people who take HIV and AIDS treatment are given?

RESPONDENT 8: I have heard they are given pills called ARVs. Initially they are given pills depending at what stage they are and eventually they are put on ARVs.

INTERVIEWER: Would you recognize the ARVs if you saw them?

RESPONDENT 8: No I wouldn't. All I know is that ARVs are given to people with HIV.

INTERVIEWER: Tell me what you know about the prevention of mother to child transmission? In short, PMTCT.

RESPONDENT 8: When you get pregnant, you are advised to go for HIV testing. Should you be found to be positive, you are then put on medication. You are supposed to be on that medication throughout your pregnancy. This is done so as to prevent the transmission of the HIV virus to the unborn child.

I am however not aware what the medication is called.

INTERVIEWER: When you were attending antenatal clinic, were there any expecting mothers who were on PMTCT?

RESPONDENT 8: I am not sure.

INTERVIEWER: Tell me what you know about male circumcision how it is connected with HIV?

RESPONDENT 8: I only heard that men who are circumcised are not easily infected by HIV.

INTERVIEWER: Do you know of any popular personalities in the media (that is, radio, television, newspapers, etc) who promote issues related to HIV and AIDS?

RESPONDENT 8: I am not sure who hosts the “Positive Talk” show.

INTERVIEWER: Are there any musicians, actors, politicians etc, that you know or have seen advocating and talking about HIV and AIDS issues?

RESPONDENT 8: I don't have a Satellite Dish, I wouldn't know.

INTERVIEWER: What of TV or radio programmes?

RESPONDENT 8: I am not aware of any radio programmes.

INTERVIEWER: Which people do you believe are most likely to give out the most accurate information about HIV and AIDS and why?

RESPONDENT 8: Health workers that I see at clinics are most likely to give the most accurate information.

INTERVIEWER: Which people do you believe are likely to give out the least accurate information about HIV and AIDS and why?

RESPONDENT 8: Anyone in general can give the least accurate information. These are people who do not have knowledge on the subject matter.

INTERVIEWER: Of all the mass communication channels mentioned earlier, which do you believe is the most effective and why?

RESPONDENT 8: Television is the most effective because I find the information very educative and this is where I get most of my information. I have not met anyone out there who has imparted information on HIV and AIDS as much as I have seen on TV.

INTERVIEWER: Now let's talk about the least effective mass communication channel and why?

RESPONDENT 8: Posters are the least effective communication channel because while I am able to read the information on it, I might not be able to ask questions.

INTERVIEWER: Which mass communication channel is readily accessible to you? And you can explain why?

RESPONDENT 8: Television because I follow the "Positive Talk" show.

INTERVIEWER: Is the language used in the mass communication channels appropriate and elaborate?

RESPONDENT 8: It is appropriate because they use English and Shona and I understand both languages.

INTERVIEWER: Is the information relayed through these channels sensitive to young urban Zimbabwean women's needs of your age group, that is, 20 to 29?

RESPONDENT 8: Yes, it is.

INTERVIEWER: Explain your view point.

RESPONDENT 8: They have different programmes targeting different age groups and gender. At times HIV people are hosted on the shows. As a result, you get to know issues that you were not aware of. You also get to learn how to look after yourself if you are HIV positive.

INTERVIEWER: Which type of communication for HIV and AIDS related issues is preferably to you, that is, interpersonal or mass communication and explain why?

RESPONDENT 8: I prefer interpersonal communication because I am able to have an interactive discussion where I can ask questions and get answers. Whereas if it is on radio or television, I may have questions but am not able to phone in because I may not have airtime.

INTERVIEWER: If you discovered that you are HIV positive, would you tell other people or would you hide your status?

RESPONDENT 8: I can tell my husband.

INTERVIEWER: Why your husband?

RESPONDENT 8: I guess it's because of the fact that I wouldn't know how I got infected and there would now be need for me to seek treatment. So, if I hide my status, I will end up getting ill.

INTERVIEWER: Do you believe that it is important for you to know your HIV status?

RESPONDENT 8: Yes it.

INTERVIEWER: Why is it important?

RESPONDENT 8: It's a good thing just to know your status.

INTERVIEWER: So when you know your status, what will it change?

RESPONDENT 8: I would want to know if I am still safe and I will keep getting tested after every three months so I know I am safe.

INTERVIEWER: Do you think you are or are not at risk of getting HIV infection?

RESPONDENT 8: I am not.

INTERVIEWER: Why do you say you are not at risk?

RESPONDENT 8: The way you lead your life determines whether you are at risk or not.

INTERVIEWER: What makes an urban woman vulnerable to getting HIV infection in Zimbabwe? In other words, what increases the chances of women of your age group to HIV infection?

RESPONDENT 8: Its peoples' behaviour. Both men and women are promiscuous.

INTERVIEWER: In your opinion, whose fault is it that HIV and AIDS has been spreading among young urban women in Zimbabwe?

RESPONDENT 8: I cannot put blame on anyone. It is one's attitude, it seems people are not able to contain their feelings.

The problem is with each and every one of us. We cannot blame one person because that person cannot be the only one responsible for spreading the virus.

INTERVIEWER: Is there enough information to young urban Zimbabwean women about HIV and AIDS?

RESPONDENT 8: There is enough information because we now know the consequences of being promiscuous. People still carry on with their loose behaviour fully knowing that they may get infected. They have all the information on HIV and AIDS, but there is no behaviour change.

INTERVIEWER: Have you personally ever educated anyone about HIV and AIDS?

RESPONDENT 8: No I haven't.

INTERVIEWER: Is the knowledge of HIV and AIDS that you have gained so far likely to influence your behaviour?

RESPONDENT 8: Yes, the knowledge that I have gained has influenced me as I no longer put myself in risky behaviour.

INTERVIEWER: Do you believe that the level of HIV infection in Zimbabwe is low or high?

RESPONDENT 8: From what I understand, the prevalence of HIV and AIDS is high.

INTERVIEWER: What role do you see the community playing in HIV and AIDS communication?

RESPONDENT 8: I have only seen HIV and AIDS lectures at the clinic. It may be an idea to have road shows.

INTERVIEWER: What role, if any, does religion or spirituality have in communicating HIV and AIDS matters to their members? Can you explain your answer?

RESPONDENT 8: Churches should preach what the bible says, for example there is a verse in the bible that talks about "one man and one woman". By so doing people will know that it is against the bible to have more than one partner.

INTERVIEWER: What about those churches that allow more than one wife? Have you heard of such churches?

RESPONDENT 8: Yes, I have. The *Johanne Marange* Apostolic Sect.

INTERVIEWER: Is there a connection between the current socioeconomic status of women in the urban areas and HIV and AIDS matters?

RESPONDENT 8: Yes there is a connection. When a couple stays together, they should be aware how the virus is spread and take measures to change their behaviour so that they don't get infected.

INTERVIEWER: But the fact that there are no jobs and people are facing economic challenges, do you see any connection between these challenges that young women are facing and HIV and AIDS matters?

RESPONDENT 8: Ummh, I don't think so, I don't see any connection.

INTERVIEWER: What aspects of culture in Zimbabwe promotes the spread of HIV and AIDS?

RESPONDENT 8: Extra-marital affairs promote the spread of HIV and AIDS.

INTERVIEWER: Any other cultural customs that promote the spread of HIV and AIDS?

RESPONDENT 8: Polygamy also promotes the spread of HIV and AIDS. The fact that a man can have more than one wife makes it possible for him to expose his other wives to the virus because he can unknowingly marry a woman who is already compromised.

INTERVIEWER: Do you know of any aspects of our culture in Zimbabwe that help to reduce the spread of HIV and AIDS among women?

RESPONDENT 8: In the older days, the girl child abstained from sexual relationships until she got married.

INTERVIEWER: To what extent are our cultural customs incorporated in HIV and AIDS communication?

RESPONDENT 8: I am not aware of any aspects of our culture that have been incorporated in any HIV and AIDS communication.

INTERVIEWER: Earlier on you mentioned that you watch a lot of TV, have you not seen any dramas that incorporate some of our cultural customs in HIV and AIDS communication?

RESPONDENT 8: Yes, I think I have seen that on TV.

INTERVIEWER: What does the life of an urban women between the ages of 20 to 29 years looks like? Can you paint a picture of a young woman's life in Zimbabwe? How does her life look like?

RESPONDENT 8: Some are not yet married and are looking for partners while others have taken to prostitution.

INTERVIEWER: Have you seen any programme or policy that government is involved in in communicating issues of HIV and AIDS to its people?

RESPONDENT 8: I am not aware of any policy that the government has enacted as law. However, they do have educational programmes where they teach people on how to prevent being infected by HIV. By so doing I believe the government is active in issues pertaining to HIV and AIDS.

INTERVIEWER: Who owns the clinics and hospitals?

RESPONDENT 8: The government owns the clinics and hospitals. This is how the government is playing its role in HIV and AIDS issues.

INTERVIEWER: Have you seen any HIV and AIDS campaigns or road shows in this area?

RESPONDENT 8: No I haven't.

INTERVIEWER: What links, if any, do you see between HIV and AIDS, the urban Zimbabwean woman and polygamy?

RESPONDENT 8: Yes there is a link. For example, members of the *Johanne Marange* can marry up to 10 wives, so if one of the family members is HIV positive it means all of them will be infected.

INTERVIEWER: What about the link between HIV and AIDS, the urban woman and "small-houses"?

RESPONDENT 8: If a man goes to his small-house, does he know what the small-house gets up to when he leaves that small-house and goes back to his wife? This is what Mai Chisamba always asks men, "What happens when you leave your small-house?"

INTERVIEWER: What about sugar daddies?

RESPONDENT 8: Those involved with sugar daddies are not just waiting for one sugar daddy. Those girls can change from one sugar daddy to the other, it's like a business to them.

INTERVIEWER: How about commercial sex workers? Is there any link?

RESPONDENT 8: I believe the commercial sex workers are responsible for the high prevalence of HIV and AIDS. You can never know who many men they sleep with when they go to the pubs. HIV is spread that way.

INTERVIEWER: There are roles that women are expected to do and these include household chores, looking after the children, etc. And on the other hand, men go out to work and bring money home for the upkeep of the family. These are the roles that men and women do. Is there any connection between these roles and HIV and AIDS?

RESPONDENT 8: Yes there is a link. When I go to work, am I just going to work and go back home or there are other things that I get up to when I am at work, for example having a boyfriend. This is where the connection with HIV and AIDS is.

INTERVIEWER: What about gender and domestic violence against women. Is there a link between HIV and AIDS and domestic violence against women?

RESPONDENT 8: Yes there could be a link because when a man beats his wife, is it because there are problems within the marriage or could it be he is bringing his problems from outside the marriage. For example, he could be having problems with his small-house.

INTERVIEWER: What about the educational level attained. Does someone's level of education matter in terms of being infected or not being infected with HIV?

RESPONDENT 8: As far as I am concerned, I do not see any connection between HIV and AIDS and someone's level of education.

INTERVIEWER: Thank you for your time, do you have anything to add on what we have been discussing or any questions?

RESPONDENT 8: I may have had questions, but I have forgotten. I however wish to encourage my peers to uphold their morals and not be promiscuous. Those who are married should look after their families.

Annexe M - FGD interview transcript sample

FGD INTERVIEW TRANSCRIPT SAMPLE

FGD 3 GUNHILL (LOW-DENSITY), HARARE

INTERVIEWER: From which people have you heard information about HIV and AIDS?

RESPONDENT: I got to know about HIV and AIDS from school, through teachers.

RESPONDENT: I heard the information from doctors at the hospital.

INTERVIEWER: How did you end up being at the hospital?

RESPONDENT: I had just gone to hospital on a visit, this is when I saw people gathered and out of interest I also joined in just to hear what was going on.

RESPONDENT: I heard about HIV and AIDS information from a TV talk show called “Positive Talk” hosted by Tariro Chikumbirike.

INTERVIEWER: Which one are you most comfortable getting information from and why?

RESPONDENT: From a doctor.

INTERVIEWER: Anyone else, do you all agree on what the last speaker said?

RESPONDENT: Yes, we do.

INTERVIEWER: Theme two is on Mass Communication Channels. Through which mass media have you heard about HIV and AIDS?

RESPONDENT: I heard the information on television.

RESPONDENT: I hear it on the radio.

RESPONDENT: I heard it from the clinic through nurses.

INTERVIEWER: Ok, what other mass media channels have you heard the information on HIV and AIDS?

RESPONDENT: From billboards that are mounted along the roads.

INTERVIEWER: In the case of radio and television, specify what form the information came in? Was it a lesson, an advertisement, a drama or it was on a news broadcast?

RESPONDENT: It was a talk show called “Positive Talk” shown on TV. People who are already infected with the HIV virus are invited to the show and they encourage those who are also infected by the virus to take their medication on time.

RESPONDENT: The TV show has also hosted people who have been abused and were infected by the virus.

INTERVIEWER: What about the radio, in what form does the information come in?

RESPONDENT: Usually on radio they encourage people to go for testing. They also teach people on how to handle how to handle a situation where they are told they are HIV positive.

RESPONDENT: It would be a programme.

INTERVIEWER: Do you know the name of the programme?

RESPONDENT: At times you can just tune in and get to listen to the programme midstream, so I don’t usually get to know the name of the programme.

RESPONDENT: There is another programme that is usually hosted on Thursdays around 10am

INTERVIEWER: What time is the “Positive Talk” show aired on television?

RESPONDENT: It’s aired on Saturdays at 9pm.

INTERVIEWER: How long is the programme?

RESPONDENT: About 30 minutes.

INTERVIEWER: In the case of newspapers and magazines, specify the form the information came in?

RESPONDENT: I have seen adverts where people are encouraged to go and be tested.

INTERVIEWER: For each of the channels stated below. Where are they located physically? For an example, have you seen any information on HIV and AIDS on billboards? And where have you seen them?

RESPONDENT: You can see the billboards in the streets as you walk.

INTERVIEWER: Have you seen any HIV and AIDS information on posters?

RESPONDENT: At the clinics.

INTERVIEWER: Have you seen HIV and AIDS information on pamphlets, brochures or leaflets. And where were these located?

RESPONDENT: You can find them inside magazines.

RESPONDENT: They are also distributed in the streets by personnel from the clinic.

RESPONDENT: At the clinic they are distributed to each and every one.

INTERVIEWER: How do you generally view the material, content or information on HIV and AIDS that is communicated through mass media?

RESPONDENT: I think the content is okay because they also get to inform people on how to cope should they find out they are HIV positive.

INTERVIEWER: Is the information you are getting adequate, are you fully informed to the extent you are left without questions?

RESPONDENT: My view is that the information is adequate.

INTERVIEWER: So can we say the information is enough, there are no gaps?

RESPONDENT: The information is too much.

INTERVIEWER: Is the information easily understood?

RESPONDENT: For those who have ears to hear and eyes to see, the information is adequate.

INTERVIEWER: Can we get views from all of you?

RESPONDENT: I would have been comfortable with a situation where they visit people's homes and get to hear people's views. By so doing they will get people to ask questions which they can answer fully.

INTERVIEWER: Ok, so you are saying besides the posters and billboards, there is need to have outreach programmes where they can mingle with the community and talk to people?

RESPONDENT: Yes, there are still people who seem not to understand HIV and AIDS issues. The outreach programme could be tailor made for these people so that they get to understand HIV and AIDS.

INTERVIEWER: Who are these people that you think are not yet familiar with HIV and AIDS issues?

RESPONDENT: People in the rural areas don't seem to comprehend what HIV and AIDS is. Some areas are remote and have inadequate information. They have no access to TV, newspapers, etc.

Others don't even own mobile phones, so information does not filter to them.

INTERVIEWER: Now we are going to talk about HIV and AIDS knowledge. Is there any difference between HIV and AIDS? What do you understand about the term HIV and the term AIDS. And if you understand these terms, is there any difference between them?

RESPONDENT: There is a difference. They are two different conditions.

RESPONDENT: AIDS is a different disease from HIV.

INTERVIEWER: So they are two different diseases. Are you able to give us more details on that?

RESPONDENT: HIV is a virus.

INTERVIEWER: So if HIV is a virus, what is AIDS?

RESPONDENT: (conversation amongst RESPONDENT 3- not audible)

INTERVIEWER: How is it possible to get infected by HIV?

RESPONDENT: You can get infected if you don't protect yourself.

INTERVIEWER: What do you mean by protecting yourself?

RESPONDENT: This is when you have unprotected sex without the use of condoms.

INTERVIEWER: Ok, are there any other ways that one can get infected by HIV?

RESPONDENT: When you use razors and needles.

INTERVIEWER: These are sharp objects that would have been used by someone who is HIV positive?

RESPONDENT: Yes.

INTERVIEWER: Any other ways that can get someone infected by HIV?

RESPONDENT: HIV can be transmitted through open wounds.

RESPONDENT: HIV can also be transmitted during child birth from mother to child.

RESPONDENT: I understand if one is pregnant and they are HIV, they should immediately be on medication so that they do not transmit the virus to the unborn child.

INTERVIEWER: What can promote the spread of HIV? What are the epidemic drivers?

RESPONDENT: Unprotected sex promotes the spread of HIV.

RESPONDENT: Having multiple partners without using protection.

INTERVIEWER: You alluded to the fact that HIV and AIDS information is in abundance, so why is the virus still spreading?

RESPONDENT: I believe the reason the virus is spreading is because a lot of women are living in poverty. As a result, they decide to go to pubs and engage in prostitution so as to generate income for their survival. They get infected in the process.

INTERVIEWER: Ok so poverty is a major contributor in terms of the virus spreading.

RESPONDENT: Some men get so drunk and end up looking for prostitutes in the avenues. In their drunken stupor, they may not even be able to use condoms.

RESPONDENT: Rape is also another contributing factor in the spread of HIV.

INTERVIEWER: Any other reasons that contribute to the spread of the virus?

RESPONDENT: Prostitution promotes the spread of HIV

INTERVIEWER: How can one minimise the chances of getting HIV?

RESPONDENT: By protecting one's self.

INTERVIEWER: How does one protect themselves?

RESPONDENT: By using condoms.

INTERVIEWER: That is what we want you to explain, does protecting one's self involve locking yourself indoors?

RESPONDENT: Before we did not have female condoms, but nowadays they are available so a woman can use them.

RESPONDENT: People should stick to one partner.

INTERVIEWER: Ok staying faithful to one partner, what else can one do to minimise the spread of HIV and AIDS?

RESPONDENT: One should go and be tested after every three months so that you know your status all the time.

INTERVIEWER: Do you know of any popular personalities in the media (that is, radio, television, newspapers, pamphlets, etc), musicians, actors, politicians who promote issues related to HIV and AIDS?

RESPONDENT: I know of Tariro, she hosts a TV show called "Positive Talk".

RESPONDENT: Ruvheneko Parirenyatwa also has a TV programme that she hosts.

RESPONDENT: Mai Chisamba also host a TV talk show.

INTERVIEWER: What of musicians?

RESPONDENT: Oliver Mtukudzi.

RESPONDENT: Winky Dee.

RESPONDENT: Suluman Chimbetu.

RESPONDENT: They are so many.

INTERVIEWER: Give us all their names.

RESPONDENT: Jah Prayzah,

RESPONDENT: Sniper.

INTERVIEWER: What is the name of the programme that Ruvheneko's hosts?

RESPONDENT: I don't remember the name of her show, but she discusses various topics including positive living and how to take ARVs.

RESPONDENT: Ruvheneko is the one who talked about free HIV and AIDS medication on one of her talk shows.

INTERVIEWER: What of drama programmes?

RESPONDENT: I have seen street theatre although I don't the name of group.

RESPONDENT: HIV and AIDS is talked about at different forums including road shows.

RESPONDENT: Where ever people are gathered, there is bound to be a discussion on HIV and AIDS.

INTERVIEWER: We are now going to talk about perceptions and beliefs. Which people do you believe are most likely to give out the most accurate information about HIV and AIDS and why?

RESPONDENT: In my view, doctors are the only people I feel can give me accurate information about HIV and AIDS.

RESPONDENT 3-2: The good thing about doctors is that they have this doctor/patient confidentiality clause. They would never disclose your status to anyone, in fact they can even go on to counsel you.

INTERVIEWER: Do we all agree that doctors are the only people likely to give you the most accurate information on HIV and AIDS?

RESPONDENT: Yes, we do.

INTERVIEWER: Of all the mass communication channels mentioned earlier, which do you believe is the most effective and why?

RESPONDENT: I think all channels of communication are effective. It depends on where you are. Others might have access to newspapers while others don't. Some people may only have access to the radio and not the television.

INTERVIEWER: Which is the most effective to you the young urban women?

RESPONDENT: The social media is the most effective, for example WhatsApp.

RESPONDENT: Radio is effective in the rural areas.

INTERVIEWER: We want to concentrate on the young urban women.

RESPONDENT: Radio is the most effective because you can also listen to your mobile phone radio.

INTERVIEWER: Now let's talk about the least effective mass communication channel?

RESPONDENT: The newspaper is the least effective because not everyone is able to buy it.

RESPONDENT: Besides, some of the news articles on newspapers are aired on radio so I see no need of buying a newspaper.

INTERVIEWER: Which mass communication channel is readily accessible to you? And you can explain why?

RESPONDENT: Television is the most accessible as one can spend most of the day watching it.

RESPONDENT: While watching a programme or drama on television, adverts usually appear during interludes and some of these adverts are about HIV and AIDS.

INTERVIEWER: Is the language used in the mass communication channels appropriate and elaborate?

RESPONDENT: Shona is the language that is understood by the majority of people.

RESPONDENT: English is used for the majority of the programmes on the mass media communication channels.

RESPONDENT: Ndebele is also used.

INTERVIEWER: Is the use of the English language appropriate in putting across the concept of HIV and AIDS?

RESPONDENT: English is okay, we understand it.

RESPONDENT: But people in the rural areas may not understand English, they would prefer Shona.

INTERVIEWER: Is the information relayed through these channels sensitive to young urban Zimbabwean women's needs of your age group, that is, 20 to 29?

RESPONDENT: I think the information is sensitive because it is easily understood.

INTERVIEWER: So the information is sensitive enough to cater for your needs?

RESPONDENT: Yes.

INTERVIEWER: Which type of communication for HIV and AIDS related issues is preferably to you, that is, interpersonal (one-on-one) or mass communication and explain why?

RESPONDENT: Would prefer one-on-one.

RESPONDENT: One-on-one

RESPONDENT: One-on-one.

RESPONDENT: One-on-one.

RESPONDENT: I would want to get the information on radio and then one-on-one.

INTERVIEWER: I know we would want to access information on all communication channels, but I would want you to tell us the one that you would prefer.

RESPONDENT: I would prefer radio.

RESPONDENT: I would prefer one-on-one because I am able to ask all the question that I have. I may not be able to do the same on radio, that is, ask questions. I believe information on radio is meant for one to just listen.

RESPONDENT: I prefer one-on-one because you are able to ask questions privately because you may be shy to ask the same questions in public.

INTERVIEWER: I also prefer one-on-one because I may have a number of questions to ask. I cannot ask the same number of questions in public or on radio.

Radio talk shows have a phone in facility but I may not be able to call because I might not have air time to call.

INTERVIEWER: So can we conclude that the majority would prefer one-on-one.

RESPONDENT: Yes.

INTERVIEWER: Do you believe that it is important for you to know your HIV status?

RESPONDENT 3: Yes, it is important to know your status.

INTERVIEWER: Why is it important?

RESPONDENT: So that you know when to start taking medication.

RESPONDENT: To avoid taking the ARVs when you are too weak.

RESPONDENT: The early you know the better so that you start taking medication.

INTERVIEWER: What makes an urban woman vulnerable to getting HIV infection in Zimbabwe? In other words, what increases the chances of women of your age group to HIV infection?

RESPONDENT: Young urban women always want to have a nice time as a result they are vulnerable to HIV infection.

RESPONDENT: They want to own all sorts of things when they really can't afford to buy them.

RESPONDENT: Being unfaithful to your partner.

RESPONDENT: They are not satisfied with what they have and as a result they are envious of other people who are well off.

RESPONDENT: Extra-marital affairs by men puts women at risk.

RESPONDENT: Women too can have extra-marital affairs when their husbands are not able satisfy their needs.

RESPONDENT: In my opinion, I believe generally it's the men who can't stick to one partner. There may be isolated case of women who cheat but the majority are men.

RESPONDENT: There are cases where the husband can convince her wife to prostitute herself in order to generate income for the sustenance of the family.

INTERVIEWER: In your opinion, whose fault is it that HIV and AIDS has been spreading among young urban women in Zimbabwe?

RESPONDENT: I think it's our fault. We don't seem to care about our welfare. We all know HIV and AIDS is a reality and yet we still put ourselves at risk.

INTERVIEWER: Is there enough information to young urban Zimbabwean women about HIV and AIDS?

RESPONDENT: There is enough information because when a woman gets pregnant, she has to visit the clinic and this is where she is told about the virus. They are tested for the virus after every three months until they give birth. So, for women, the information is enough because of the clinic visits.

RESPONDENT: Yes there is adequate information on HIV and AIDS.

INTERVIEWER: What role do you see the community playing in HIV and AIDS communication?

RESPONDENT: I think people could be invited to a public gathering where they can be taught on issues concerning HIV and AIDS. This will help sensitize people so that they get to know that HIV and AIDS is a reality.

INTERVIEWER: Have there been such gatherings here in Gunhill?

RESPONDENT: I have not seen such gatherings ever since I moved to Gunhill.

INTERVIEWER: What role, if any, does religion or spirituality have in communicating HIV and AIDS matters to their members?

RESPONDENT: There is a lot of information on HIV and AIDS at the churches. A lot of people attend church and the sermons always address the issue of HIV and AIDS.

RESPONDENT: At our church, we usually have the main service then later the youth are invited for a group meeting and HIV and AIDS is one of the topics discussed.

INTERVIEWER: Which church is that?

RESPONDENT: AFM, Devine and *Masowe*

INTERVIEWER: How do you see the current socioeconomic status of women in the urban areas being relevant in HIV and AIDS matters?

RESPONDENT: Women are facing financial challenges and this forces them to get into risky situations so as to get money for their survival. They are now found standing at corners of the road.

INTERVIEWER: What will they be doing in the roads?

RESPONDENT: They will be looking for sugar daddies. The women can even accept small amounts of money because money is hard to come by these days.

INTERVIEWER: Are there any more contributions? Do you agree with what has been said or you disagree?

RESPONDENT: We agree.

RESPONDENT: In my opinion I don't think it's about whether someone is able to sustain themselves or not, it's about upholding your morals as an individual.

INTERVIEWER: What aspects of culture in Zimbabwe promote the spread of HIV and AIDS among women?

RESPONDENT: There are some churches in Zimbabwe that promote polygamy. The *Johanne Marange* apostolic church encourages polygamy. By marrying many women, some of them may be infected and the virus will spread to the other wives.

INTERVIEWER: Besides the *Johanne Marange* apostolic church, polygamy is a Zimbabwean cultural custom.

RESPONDENT: The other one is where a family female member dies and it is arranged that her young sister takes her place and moves in with her brother-in-law. The young sister will also get infected by the virus that her sister died of.

RESPONDENT: It can also be the other way round, where a woman's husband dies and she is re-married to a brother of her late husband.

INTERVIEWER: Do you know of any aspects of our culture in Zimbabwe that help to reduce the spread of HIV and AIDS among women?

RESPONDENT: In our culture, women are encouraged to abstain from having sex until they are married. And before you get married, you are supposed to go for HIV testing. Marriage will take place only after the test.

INTERVIEWER: To what extent are these cultural aspects incorporated in HIV and AIDS communication?

RESPONDENT: Yes, we have seen our cultural customs incorporated in HIV and AIDS communication.

RESPONDENT: But cultural customs that are incorporated in these dramas/programmes are shown for a short time.

INTERVIEWER: So you would have preferred a situation where the programmes were longer.

RESPONDENT: If they could be shown for an hour instead of just 30 minutes it would be better.

INTERVIEWER: What does the life of an urban women between the ages of 20 to 29 years look like? Can you paint a picture of a young woman's life in Zimbabwe? How does her life look like?

RESPONDENT: We seem to want to copy the way women dress on television. This may lead to someone being raped.

INTERVIEWER: How do women dress?

RESPONDENT: We put on very short minis and bum shorts.

RESPONDENT: People in the rural areas observe some of our cultural customs compared to urban women.

There are a lot of pubs in the city frequented by young women.

RESPONDENT: Yes, there is a pub called “Big Apple” in the CBD and it is frequented by school children. This is where they meet sugar daddies.

INTERVIEWER: So besides the dressing how is life like for the young urban woman?

RESPONDENT: I think it’s better to live in the urban areas because the chances of going to school are high compared to young women who live in the rural areas where girls get married soon after primary or secondary school.

RESPONDENT: There is a lot of competition amongst young women in the urban areas.

INTERVIEWER: Looking at the socioeconomic situation, what is it that is affecting the young urban woman?

RESPONDENT: Life is tough for us, we are facing a lot of challenges.

RESPONDENT: Seeing other women prosper makes us envy their lifestyles and this puts us in risky situations as we try to emulate their fancy lifestyles.

INTERVIEWER: Have you seen any programme that government is involved in in communicating issues of HIV and AIDS to its people?

RESPONDENT: The government could do HIV testing for free, this could encourage people to go for testing.

RESPONDENT: There is a road show group called *Chipawo*, they go around educating people on HIV and AIDS.

RESPONDENT: I have seen village health workers in the rural areas. They go around educating people on health issues.

INTERVIEWER: From what we have discussed, do you have anything that you want to add or ask?

RESPONDENT: I would want to encourage people to constantly go for testing so that they know their status.

People are still getting involved in risky behaviour even when they know there is HIV and AIDS. So, if there are more HIV and AIDS road shows it might influence people to change their behaviour.

Some people seem to be now relaxed because it is now known that there is HIV and AIDS and the attitude is “so what?”

INTERVIEWER: Thank you all for your time.