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EVALUATION REPORT:

Assessing Sustainability of DAPP Targeted Gender Outcomes under the Total Control of the Epidemic (TCE) program in Mt Darwin

April 2015

Report compiled by the:
Development Aid from People to People (DAPP) in the –
Zimbabwe Gender Challenge Initiative (GCI)

This project has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) through Cooperative between the Centers for Disease Control and Prevention (CDC) and the Research Triangle Institute (RTI) under the terms of Cooperative Agreement Number: 1U2GPS003118-01

GENDER CHALLENGE INITIATIVE

DAPP
DEVELOPMENT AID FROM PEOPLE TO PEOPLE

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ACRONOMYS

AIDS	Acquired Immunodeficiency Syndrome
AGRITEX	Agricultural Technical and Extension Services
ART	Antiretroviral Therapy
CBO	Community Based Organisation
CDC	Center for Disease Control
DSW	Department of Social Welfare
DA	District Administrator
DAAC	District AIDS Action Committee
DAPP	Development Aid from People to People
FGD	Focus Group Discussion
GCI	Gender Challenge Initiative
HIV	Human Immunodeficiency Virus
HIV+	HIV positive
HPP	Humana People to People
HTC	HIV Testing and Counselling
IEC	Information Education and Communication
IDI	In-depth Interview
KII	Key Informant Interview
MRCZ	Medical Research Council of Zimbabwe
MoHCC	Ministry of Health and Child Care
M&E	Monitoring and Evaluation
NAC	National AIDS Council
NGO	Non-governmental Organisation
PI	Principal Investigator
PEPFAR	President's Emergency Plan for AIDS Relief
PDA	People Died with AIDS
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PITC	Provider Initiated Testing and Counselling
RTI	Research Triangle International
SADC	Southern Africa Development Community
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TCE	Total Control of the Epidemic
VCT	Voluntary Counselling and Testing
ZDHS	Zimbabwe Demographic Health Survey
ZIMSTAT	Zimbabwe National Statistical Agency

CONTENTS

1 EXECUTIVE SUMMARY

The study "*Assessing Sustainability of DAPP Targeted Gender Outcomes under the Total Control of the Epidemic (TCE) program in Mt Darwin"* was designed to evaluate the impact of TCE program on specific gender variables that was promoted by TCE during implementation period (from 2003-2007). This study is classified as an evaluation study that aims to assess the success factors of the program as well as the grey areas and gaps in order to improve future programming. The results of the project were used in conjunction with results from other similar studies and experiences to develop the proposed sustainability framework for the TCE program.

The first section presents the background of the study, explaining rationale, goal and objectives of the study area, the intended use of study findings and also discussing the methodology of the study, which includes data collection tools and conceptual framework. Chapter two presents and discusses the study findings of the project. The socio-demographic characteristics of the sample are discussed that show that the majority of participants are women. The major stakeholders that participated in TCE include government departments, local authority and NGOs. The study shows that HIV knowledge is generally high within the target communities though women often have less knowledge compared to men. The majority of people access health services from hospitals and clinics though there are some constraints in access and utilisation of these services with the major being financial, stigma, lack of information and transport. The findings indicate that main barriers to care for PLWHA are financial constraints and lack of food.

The study shows that the TCE gender target measures were generally effective in transforming harmful gender norms and practices resulting in improved outcomes for both men and women. Furthermore, the study indicates that the major missing link of the TCE was inadequate funding of income generation activities which is fundamental in enhancing nutrition security. Other major weaknesses include failure to support medical supplies, low involvement of men, absence of workplace activities and failure to nurture support groups to maturity/ sustainable levels.

Chapter three of the report presents the sustainability framework of the TCE program, utilizing the suggestions given by beneficiaries, stakeholders and lessons leant from other projects. The sustainability framework proposed is treated as recommendation of the study since it is informed by the study findings and good practices from similar projects. This sustainability framework calls for a concerted effort by the government, NGOs, community based groups and organisations to strengthen health delivery in the areas of HIV and AIDS.

The appendices provide the set of data collection tools used by the study.

2 INTRODUCTION AND BACKGROUND

2.1 Introduction

Development Aid from People to People (DAPP) is part of the Gender Challenge Initiative (GCI) consortium that was formed to improve evidence based programming in gender issues among the local non-governmental organizations (NGOs). The consortium has 9 NGOs partners that work directly with Research Triangle International (RTI). RTI is responsible for managing and mentoring these 9 NGOs to improve research and evidence based programming using funds from US President's Emergency Plan for AIDS Relief (PEPFAR) that is channelled through Center for Disease Control (CDC). In this project DAPP evaluated the gender outcomes for the Total Control of the Epidemic (TCE) project that was implemented in Mount Darwin from 2003 to 2007.

2.2 Background and Literature Review

The Total Control of the Epidemic (TCE) program was piloted in Zimbabwe's Bindura district in the year 2000 and in Mt Darwin district in the year 2007 by DAPP Zimbabwe to ensure effective HIV mitigation. TCE is a one-on-one HIV prevention program that aims to reduce the risk for transmission of HIV through a multi-component community based program that utilizes a combination of interventions and activities. The activities are mainly implemented through volunteers ("Passionates"). The main activities included risk reduction services, dissemination of health information related to HIV as well as referrals, linkages and follow-up to prevention, care and treatment services. The TCE program mainstreamed gender, meaning that it took into consideration the specific needs and concerns of males and females in order to achieve gender equality. Currently, the TCE program has reached out to 8 Districts in 4 Provinces of Zimbabwe and has generated local demand for scaling up by the National AIDS Council (NAC) and the Ministry of Health and Child Care (MoHCC). The programme has scaled up to the SADC region (i.e. South Africa, Botswana, Mozambique, Namibia, Zambia, Malawi, Angola, and Guinea Bissau) as well as China and India. Despite this remarkable scale up, DAPP has not systematically identified factors that lead to the success of the TCE program.

DAPP realized that gender inequalities and iniquities were a fundamental hindrance in HIV prevention and mitigation, thus it introduced a wide range of gender responsive measures in the TCE program. The key gender responses measures that were introduced by the TCE project are presented in Figure 1.1. These measures were meant to achieve targeted (practical and strategic) gender outcomes for women and men. The practical gender outcomes focus on the fulfilling the immediate needs of women and men. The practical gender outcomes targeted by the TCE project include access to sexual and reproductive health-care services; attendance by skilled health personnel; utilization of HIV testing facilities and treatments services by both men women; improved non-discriminatory and confidentiality in HIV/AIDS issues. The strategic gender outcomes focus on building the capacity, mechanisms and power to control one's life taking, into account unequal distribution of power and resources. The strategic gender outcomes targeted by the TCE project include skills to negotiate safe sex; awareness of men and women to their rights and risks associated with HIV; policy changes that address gender inequality; interventions that address disparity in income, risk-taking behaviour reduction; shouldering of responsibility with regards to sexual

reproductive health; changes in harmful gender roles, norms and stereotypes; improvement in assertive behaviour especially for women; improved open discussion about HIV in the community and amongst couples; decrease in gender based violence; cooperation by both males and females in HIV & AIDS mitigation.

Table 2.1: Gender related interventions introduced by TCE

Gender related interventions (Practical and Strategic)
• ***Door-to-do education sessions with couples and family members; reaching even marginalised groups;***
• ***Focus group discussions with communities and high risk groups on HIV and AIDS;***
• ***Establishment of support systems through PLWHA support groups and TRIOs;***
• ***Distribution of condoms in strategic places within the community including in public toilets;***
• ***Mobilisation of both women and men to get tested of HIV and to know their status;***
• ***Education on rights of children, individuals and women;***
• ***Education on safer sex, adherence and disclosure of HIV;***
• ***Safe parenthood education;***
• ***Gender based education and training;***
• ***Community dialogues on gender roles and access and control of resources;***
• ***Garden, poultry and bee projects mainly for women;***
• ***Establishment of herbal gardens with herbs like moringa tree and lemon grass.***

As the study focuses on the sustainability of DAPP Zimbabwe's TCE services and outcomes it is necessary that the concept of sustainability be explored and explained. The concept of sustainability arose from the debate on sustainable development, which gained popularity in the 1970s. This study adopts Organization for Economic Cooperation and Development (OECD/DAC, 1998 in CINARA/IRC/WSP, 1997) definition of sustainability, which describes a development programme as being sustainable, *when it is capable of supplying an appropriate level of benefits during an extensive time after the withdrawal of all forms of support from the external agency.* This study put into cognizance that the TCE program ended in Mt. Darwin district, thus attempts to assess whether there are long-term benefits accruing to beneficiaries and communities from the program in terms of the practical and strategic gender outcomes specified above, which in essence is sustainability in this context. What it entails is that if people are enjoying increased access and utilization of SRH services, including maternal health services (prenatal care, obstetric care and postpartum visits or follow-ups), the TCE program is sustainable in terms of delivering practical gender outcomes. The program is said to be sustainable in terms of delivering strategic gender outcomes, if people show that they have better knowledge about HIV and community members have been capacitated to reduce factors like adverse gender norms and income disparity among other strategic issues.

2.3 Rationale of the Study

The problem that the evaluation study seeks to address is the lack of an informed framework by DAPP Zimbabwe and its collaborating partners with regards to the sustainability of practical and strategic gender outcomes addressed by TCE program in Mt. Darwin district after the end of Humana

People to People (HPP) funding. This is important because at the beginning of TCE program there were a host of gender inequalities and iniquities which the program aimed to modify to achieve better practical and strategic gender outcomes. Some adverse factors included men and boys' gender expectations that encourage risk-taking behaviour and discouraging accessing to health services; low utilization of HIV testing and treatment facilities; intergenerational relationships, gender-based violence and power relations heavily in favour of men. However, up now it's not clear, whether and to what extent did the gender responsive measures introduced influenced practical and strategic gender outcomes. Lack of a clear sustainability framework can lead to the loss or reversal of specific impacts of the DAPP Zimbabwe TCE programme over the years in Mt. Darwin districts. In other words the lack of a robust framework may undermine efforts by DAPP and its partners to ensure sustainability of development efforts beyond donor funding phases.

With the wide scale up of DAPP's TCE Model worldwide it has become imperative for DAPP to systematically identify, document and share an informed sustainability framework for the DAPP Zimbabwe TCE Model with a view to make improvements to the sustainability of current and future DAPP TCE initiatives. This program evaluation study will enable DAPP to assess the contribution of the specific gender responsive actions/measures in improving targeted practical and strategic gender needs of women and men and to what extent women and men have gained from the gender targeted responses of the TCE program. The study will also identify the key gender related factors that promote or hinder the sustainability of DAPP Zimbabwe TCE information sharing model after the end of the funding phase in Mt. Darwin district. This will help DAPP Zimbabwe and its collaborating partners to ensure that appropriate and effective gender responsive measures are put in place in future programs.

2.4 Intended/potential use of study findings

The findings from this evaluation study will be used to develop an informed TCE sustainability gender model with a view to make improvements to the sustainability of current and future DAPP TCE initiatives. Furthermore, the findings of this evaluation study will be used by Mount District and national stakeholders and partners who are into HIV/AIDS prevention, mitigation and care. However, since the study is confined in one district of the country the findings may not be representative of the whole country (Zimbabwe), thus due care should be exercised when using them.

2.5 Goal and Objectives

The purpose of the program evaluation is to identify factors that promote and/or hinder sustainability of DAPP gender targeted outcomes of the Zimbabwe TCE program. This will help DAPP and its collaborating partners to develop an informed gender sustainability framework of the DAPP Zimbabwe TCE program after 11 years of concerted HIV and AIDS mitigation initiatives in the district.
The **specific objectives** of this evaluation are to:

1. To assess the impact of the DAPP Zimbabwe gender responsive measures on targeted gender outcomes.
2. To identify factors that promote sustainability of gender targeted outcomes of DAPP Zimbabwe TCE program after the end of the funding phase.

3. To identify factors that hinder sustainability of gender targeted outcomes of DAPP Zimbabwe TCE program after the end of the funding phase.
4. To identify gaps in the gender responsive measures introduced by DAPP Zimbabwe and its collaborating partners and how these can be addressed to achieve gender outcomes in future.

2.6 Evaluation Questions

The evaluation study questions that are capture the purpose and objectives of the study are:

1. What are the factors that promote and/or hinder the sustainability of targeted gender outcomes of women and men in Mt. Darwin?
2. What are the gaps in addressing the targeted gender needs of women and men within the TCE program?
3. How can the TCE programme be enhanced to achieve greater practical and strategic gender outcomes?

3 METHODOLOGY

3.1 Evaluation Design

The evaluation study adopted a cross-sectional descriptive design that use both qualitative inquiry and survey methodologies to evaluate the status on a set of indicators of sustainability tied directly to the targeted gender outcomes of the DAPP program in Mt. Darwin district. This was necessitated by the aim to collect reliable and valid data by capitalizing the benefits of each method to counterbalance weaknesses of each method. In this study, the quantitative component mainly provided breadth, by measuring levels and trends of occurrence of certain variables specifically using the semi-structured interview (survey) and enabled statistical computations to be done. The qualitative side mainly provided depth to the study through offering explanations and interpretations to certain situations, occurrences or trends, using focus group discussion (FGD), key informant interviews (KIIs) and other participatory approaches. The use of these two approaches enriched the study findings, by confirming and/or refuting certain occurrences and also enabled one situation to be observed from different perspectives.

3.2 Evaluation Study Population and Sample

The population consisted of direct DAPP TCE project beneficiaries, DAPP volunteers or 'Passionates' and representatives of collaborating service providers (NGOs and Government Departments) in Mt. Darwin district. Project beneficiaries are those that benefitted through various project inventions that include sexual reproductive health and gender information dissemination, support groups, income generation projects and VCT, ANC and referral services facilitated by DAPP. The volunteers are composed of religious leaders, village heads and village health workers who were trained and actively participated in the TCE project. DAPP conducted this evaluation study in 5 wards of Mount Darwin, namely, ward 16, 17, 23, 24 and 26. The first 4 wards are based in rural areas and 26 is a

based in the urban area. The 5 wards are expected to represent the situation in the entire district of Mount Darwin since TCE was implemented in all 40 wards in the district.

In-depth interview (IDI) participants were selected through systematic simple random sampling based on existing lists of households/contacts and with the assistance of volunteers. A total of 200 direct household beneficiaries were randomly selected from across the 5 wards. Since this is an evaluation study, a scientific sample size determination was not used. The main emphasis was to get a sample of more than 100 representative beneficiaries who can give information that can be used statistically. Beneficiary participants for the focus group discussions (FGDs) were selected by randomly sampling 8-11 household beneficiaries and volunteers from a gathering of beneficiaries and volunteers in each targeted ward. A total of 5 FGDs were conducted with 49 people that has an appropriate mix of beneficiary participants and volunteers that included young, middle and old adults. A total of 8 key informants drawn using expert or judgment sampling in order to get valuable information on the topic participated in the study. To complement data from IDIs, FGDs and KIIs, other participatory approaches were conducted namely Health Care Social Mapping, Health Care Service Provision Analysis and transect walks each targeted ward.

3.3 Data Collection Instruments

Four set of data collection instruments were used in this action study, namely IDIs, FGDs, KIIs and other participatory approaches.

3.3.1 Questionnaire

The questionnaire tool contained both open and closed ended questions and were administered to people affected by HIV/AIDS that were direct beneficiaries of the TCE program. Through face-to-face interviews specific variables of gender sustainability were obtained, like access to health services and changes in harmful gender norms.

3.3.2 Focus Group Discussion

Focus Group Discussions (FGDs) explored the various practical and strategic gender sustainability issues of the DAPP TCE project in detail through guided dialogue. The FGDs also explored the various gender responsive measures and how they contributed to attainment of targeted (practical and strategic) gender outcomes of TCE program. The FGDs were conducted by pairs of researchers drawn from government extension staff.

3.3.3 Key Informant Interview

Key informant interviews (KIIs) tapped the special knowledge of the experts on a particular issue(s) under study. The KIIs were conducted to TCE partners, namely government agencies, NGOs, TCE project volunteers and local leaders. The KIIs focused on issues of gender responsive measures introduced by the program. It looked on structures and systems established or enhanced by the TCE project, implementation and monitoring effectiveness and project design efficacy. The tool assessed how and to what extent has these gender responsive initiatives contributed to targeted gender outcomes at individual, household, and community level.

3.3.4 Other Participatory Approaches

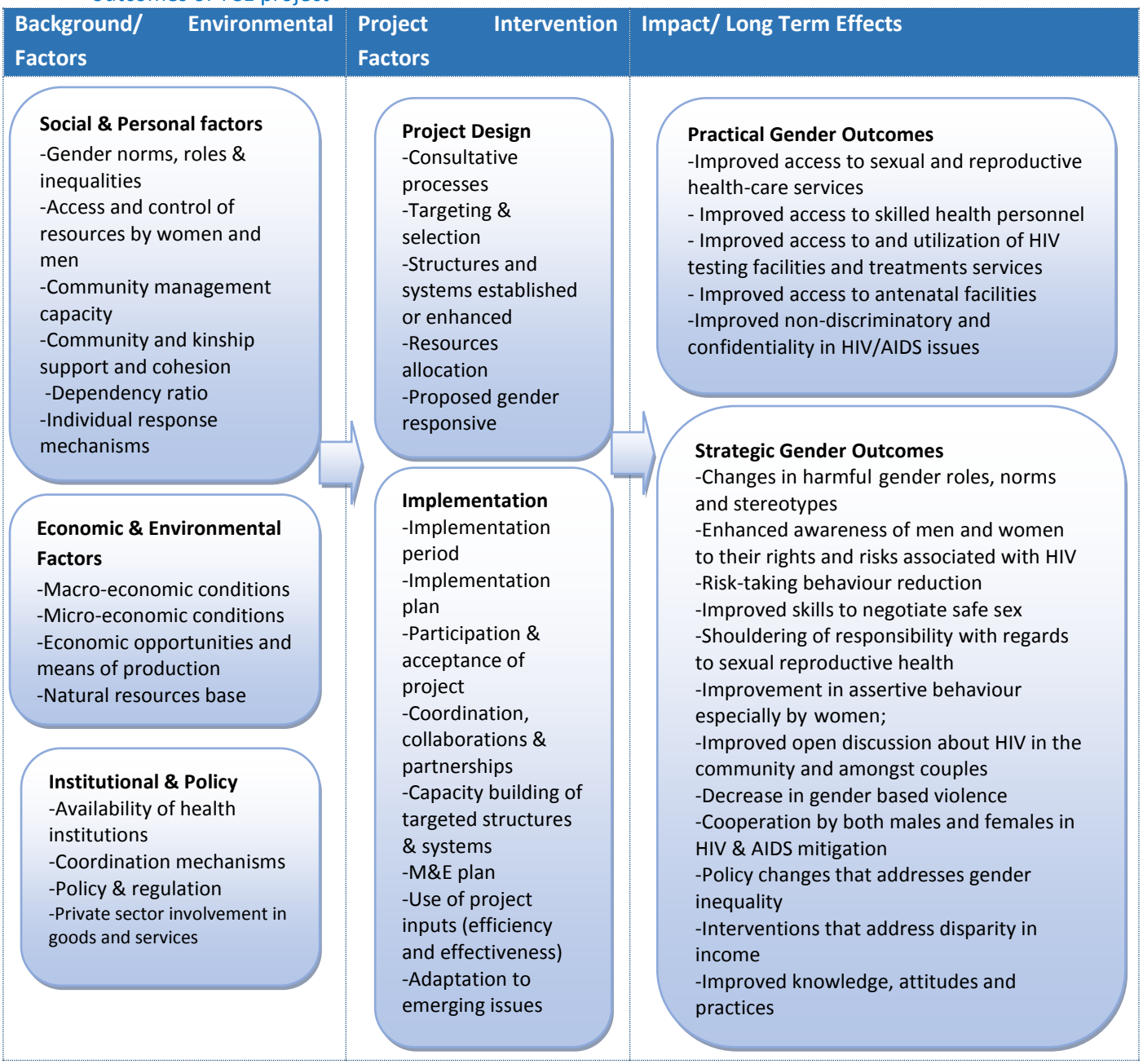
Three approaches were used to complement IDIs, FGDs and KIIs. Firstly, the Health Care Social Mapping tool involved participants drawing a map that shows major health facilities, service providers and also major connecting roads in their respective wards. The health care social maps helped to show the distribution of health facilities and showed areas that were marginalised in terms of health service provision. The Health Care Service Provision Analysis tool was used to identify the major health care service providers and to rate them in terms of availability, accessibility, acceptability and quality. Five transect walks were done at 2 clinics, 1 youth friendly centre and two schools. Generally the transect walks were done to verify the kind of health care services that were offered in the ward.

3.4 Conceptual Framework

The study adopted the Practical and Strategic Gender analysis approach as the analytical or conceptual framework. This framework was selected because one of the fundamental objectives of the TCE project was to improve practical and strategic gender outcomes of women and men in Mt Darwin. The framework posits that the benefits of women and men through the TCE project can be either in practical or strategic nature. As explained in section 1.2 the practical gender outcomes relates to the fulfilment of immediate needs of women and men, whilst strategic gender outcomes focus mainly on increasing control over one's life. According to this framework, the practical and strategic outcomes improve the welfare of both women and men and also transform existing distributions to create a more balanced relationship between women and men. The various interrelated factors or variables of this conceptual framework are captured in figure 1.2.

This framework assumes that delivery of the practical and strategic gender outcomes as presented in figure 1.2 occurred within a certain environment or within a certain background. This environment had challenges and constraints for both women and men that need to be addressed by the project interventions, and in this case the TCE project had a set of interventions. The attainment of practical and strategic gender outcomes depend mainly of the favourability of background factors and the effectiveness of project intervention factors to address adverse factors in the environment. The background factors that affected the TCE project include institutional, policy, social, economic, environmental and personal factors. The major institutional issues concern the availability, efficiency and effectiveness of health institutions within the catchment area to support health needs of both women and men. The institutional component also deals with coordination mechanisms of various partners working on HIV and SRH within the area and nationally to ensure that services are delivered efficiently and effectively. Effective coordination involves role clarity of developmental partners to ensure complementarity and to avoid wastage of resources through duplication. The national and local policies on HIV and SRH regulate what can be done or not and thus affect health services delivery and utilisation. Furthermore, policies affect fundraising opportunities from both local and international partners and also continued support of developmental initiatives. The private sector is very important in provision of health care goods and services thus their capacity and efficiency in delivery of these components are critical in access and utilisation of services.

Figure 3:1 - Framework that show the interrelated factors that affect practical and strategic gender outcomes of TCE project



The economic factors that affected the TCE project 'impact' included macro and micro economic conditions, as well as access to economic opportunities and means of production. Government and private players are affected by prevailing economic conditions in delivery of health care goods and services and consumers' capacity to afford health care services and goods is affected by the general macro and micro economic conditions.

The social issues that affected the TCE project included the nature of gender norms (expectations) and roles. Gender norms and roles determine what is appropriate and acceptable for women and men to do. However, the challenge is the unequal apportionment of roles that are less favourable to

women and to a lesser extent men, that result in unequal access to and control over resources and opportunities by women and men. Such inequalities and iniquities thus affect access and utilisation of health care services by women and men. Since HIV and SRH challenges affects the community, the extent of community and kinship support and cohesion determine to some extent the degree of support that people infected and affected will get and consequently their well-being. The nature of community management structures and systems affects the effectiveness of response mechanisms to critical challenges such as HIV/AIDS. For instance strong community management structures and systems will support developmental initiatives from both within and outside to ensure that affected people are assisted effectively. The framework also posits that apart from community level factors, there are personal factors that affect access and utilisation of practical and strategic gender outcomes. The individuals affected by a given stimuli, like HIV and AIDS are at different levels of socio-economic development and are likely to be affected differently by the same challenge. People also have different response mechanisms, which are shaped by so many factors that include educational level and wealth status. Some families have a high dependency ratio, meaning that they depend on one or few people to support the whole family economically thus if the financial provider is affected by HIV, a crisis immediately emerge and the family often struggle to survive or cope with the challenge.

This conceptual framework presumes that project intervention is made up of project design and implementation components which were a deliberate attempt through a set of gender responsive measures to improve the practical and strategic gender outcomes of women and men in Mt. Darwin district. These gender responsive measures targeted specific adverse issues in the environment (background factors) in order to improve project objectives. The project design components include (a) Consultative processes; (b) Effectiveness of the targeting and selection of beneficiaries; (c) Structures and systems established; (d) Resources allocated sufficiency to meet the project needs; and (e) Specific measures or actions to attain practical and strategic gender outcomes.

The implementation factors include (a) The feasibility of implementation period vis-à-vis the amount of work availability; (b) The robustness and effectiveness of the implementation plan; (c) The degree of participation by beneficiaries and community leaders and also acceptance of the project in the community; (d) The effectiveness of coordination mechanisms, collaborations and partnerships that are forged to solve available challenges and to enhance complementarity among the various partners; (e) The capacity of structures and systems established such as community home based care givers to deliver project outcomes; (f) The robustness and effectiveness of M&E plan and (g) Effectiveness and efficiency in use of project resources. During implementation, the implementers needed to be flexible and adapt to emerging issues. The framework posits that whether the context was favourable or adverse, it was the responsibility of the project designers to capitalize the favourable factors in the environment and to modify the adverse factors so that impact and sustainability is realized.

3.5 Variables/ interventions for impact study

The critical variables/indicators of sustainability or impact that were collected, are in consistence with the conceptual framework above, and are presented below.

Practical Gender Outcomes:

- Improved access to sexual and reproductive health-care services
- Improved access to skilled health personnel
- Improved access to and utilization of HIV testing facilities and treatments services
- Improved access to and utilization of antenatal and PMTCT facilities and services
- Improved non-discriminatory and confidentiality in HIV/AIDS issues

Strategic Gender Outcomes:

- Changes in harmful gender roles, norms and stereotypes
- Enhanced awareness of men and women to their rights and risks associated with HIV
- Risk-taking behaviour reduction ; Improved skills to negotiate safe sex
- Shouldering of responsibility with regards to sexual reproductive health
- Improvement in assertive behaviour especially by women;
- Improved open discussion about HIV in the community and amongst couples
- Decrease in gender based violence
- Cooperation by both males and females in HIV & AIDS mitigation
- Policy changes that addresses gender inequality
- Interventions that address disparity in income
- Improve knowledge, attitudes and practices

3.6 Data Collection and Ethical Consent

Data collection of this study was done over 10 days, from 9th to 18th of June 2014. Permission to conduct the study was obtained through a request made to the Medical Research Council of Zimbabwe (MRCZ). The RTI and CDC internal ethical review boards also approved this evaluation study. The Mt Darwin district MoHCC head, District Administrator and Rural District Council Chief Executive Officer approved the study to be done in their district and introduced the research team to the district stakeholders during the stakeholder consultative meeting. Subsequently, district stakeholder (Department of Social Welfare) head who was the co-investigator introduced the entire research team to the community leaders, volunteers and village health workers. Therefore, the study was done following the internationally and nationally adopted ethical principles. Throughout its implementation, the research team worked in close collaboration with MoHCC, DSW, DA, with full support from technical partner (RTI).

The Principal Investigator (PI) and co-investigator trained 10 Research Assistants on 29-30 May 2014 to equip Research Assistants with relevant data collection skills and techniques. DAPP recruited 10 government staff to become Research Assistants of the GCI project. In each of the 5 targeted wards, 2 Extension staff members were selected from government departments that have a link towards the TCE project that was implemented by DAPP in Mount Darwin. A pilot study was conducted on the 30th of May 2014, in one ward of Mt Darwin as part of the training, in order to test the proposed study tools. The questionnaires for IDIs were modified slightly through feedback obtained from the pilot study.

4 PRESENTATION OF STUDY FINDINGS AND DISCUSSION

4.1 Introduction

This chapter presents the key findings of the evaluation study. The socio-demographic factors are presented to show the nature of participants of the study. Since the TCE project was a multi-stakeholder project, the key stakeholders that were involved in TCE are discussed. One of the objectives of TCE was to improve HIV and AIDS knowledge and transform adverse attitudes and practices that affect prevention, treatment and care thus a section is devoted to discuss this. This chapter discusses access to health services by target population, community support systems through care giving. Furthermore, the chapter presents the situation prior to the TCE project and the effects these has on people. The chapter presents the specific gender responsive measures introduced by the TCE project and the effects it had on individuals and the community.

4.2 Socio-Demographic Characteristics of the Sample

Overall, 70.7% of the participants were females and 29.3% were males when the survey and FGDs are combined. In the survey 70.5% females participated in the study compared to 29.5% males as shown in table 2.1 and in the FGDs, 71.4% were females and 28.6 were males as shown in figure 2.1. A significant percentage (21.5%) in the survey is in the 40-44 age group and almost two thirds (66%) of were between 30 to 49 years as shown in table 2.1. Twelve percent of were older people (60+ years). The majority (60%) of participants in the survey were married and a significant number (26%) were widowed, with the remaining 14% being divorced/ separated or never married before.

The majority of survey participants (50.5%) belonged to the Apostolic Faith/Zion church, with 31.5% affiliated to traditional church and 9.5% belonging to one of the following: Pentecostal, African traditional or being atheist as shown in table 2.1. In the survey 46.5% of older people had primary as their highest level of education, followed by 40% who attained some secondary education as shown in table 2.1. Six percent have no formal education and the remaining 7.5% have reached high school or tertiary level. Two hundred people participated in the survey or IDIs, thus exceeding the target number of 180 by 11% and 49 people participated in FGDs against a target of 50, thus falling behind target by 2%.

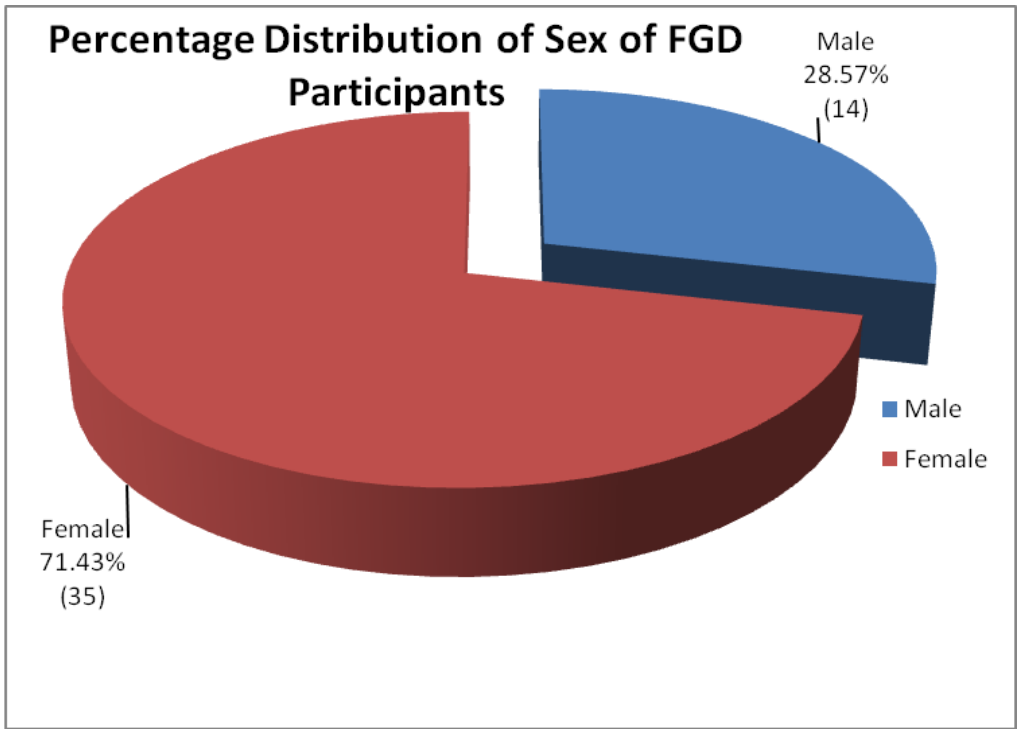
Table 4.1 ***Percentage distribution of socio-demographic variables in the survey***

Variable	Variable Description	Number/ Frequency	Percentage
Sex	Male	59	29.5
	Female	141	70.5
	Total	200	100
Age Group	15-19	2	1
	20-24	5	2.5
	25-29	6	3
	30-34	25	12.5
	35-39	30	15
	40-44	43	21.5
	45-49	34	17
	50-54	18	9

	55-59	13	6.5
	60-64	19	9.5
	65+	5	2.5
	Total	200	100
Marital Status	Never Married	8	4
	Married	120	60
	Divorced	17	8.5
	Separated	3	1.5
	Widowed	52	26
	Total		100
Religious Affiliation	Traditional Church	63	31.5
	Pentecostal	11	5.5
	Apostolic Faith/ Zion	101	50.5
	African Tradition	17	8.5
	Moslem	3	1.5
	Atheist	5	2.5
	Total	200	100
Highest Level of Education	Some Primary	93	46.5
	Some secondary	80	40
	High School	6	3
	Tertiary	7	3.5
	Completed University	2	1
	None	12	6
	Total	200	100

n= 200 (male= 59; female= 141)

Figure 4:1: ***Percentage Distribution of Sex of FGD Participants***



n= 49

A total of 8 key stakeholders who have a special interest and knowledge about the TCE study were interviewed against a target of 10. We could not find stakeholders with special knowledge in some critical ministries such as Ministry of Women Affairs, Gender and Community Development and Ministry of Agriculture, Mechanisation and Irrigation Development (MAMID) because the personnel in these ministries are relatively new and have little knowledge about TCE program in Mt Darwin. Half of the key informants interviewed are women and half are men. Furthermore, half of the participants are representing the district level situation and are drawn from the Ministry of Health and Child Care (PMTCT Coordinator); District AIDS Action Committee (DAAC Officer); ZIMSTAT (Team Leader) and Dotito Development Association (a local CBO). The other 4 key informants are from the targeted wards; 2 are Village Health Workers, one is former teacher and the other one is a Nurse at a local health centre.

4.3 TCE Stakeholders and Roles

In order to establish the partners that collaborated with DAPP in implementing the TCE project, key informants were asked to identify the key stakeholders and the roles that they played in the project. Table 2.2 show the key stakeholders identified by the key informants and their roles. The table also shows the classification of each stakeholder identified and also the number of key informants who identified the stakeholders.

Table 4.2: Key Stakeholders in TCE Project and their Roles

Stakeholder	Role(s)	Classification of the Stakeholder	# of Key Informants who identified Stakeholder
MoHCC	• Provision of SRH services • Supplying condoms to the TCE project • Supplying drugs to PLWHA • Supplying HIV and AIDS IEC materials • Coordination of HIV and AIDS activities • Mobilisation of communities through Village Health Workers and Community Based Health Workers	Government	7
Ministry of Primary and Secondary Education	• Training children on life skills • Dissemination of information to students and the community	Government	5
Pfura Rural District Council and District Administrator's Office	• Facilitation project community entry • Mobilisation of communities through councillors	Local Authority/ Government	4
National AIDS Council (NAC)	• Technical assistance provision to TCE Field Officers • Awareness campaigns on HIV and AIDS and PMTCT • Coordination of HIV and AIDS activities	Government	3
Local Leadership	• Mobilisation of people to participate in the project	Local Authority	3
DSW	• Registration of the project and monitoring	Government	2

Ministry of Agriculture, Mechanisation and Irrigation Development	• Training communities on agro-based income generation activities like gardening	Government	2
Ministry of Women Affairs, Gender and Community Development	• Advocacy for gender issues	Government	1
Population Services International (PSI)	• Provision of mobile testing facilities and/or services • Supplying IEC materials	International NGO	1
World Vision International	• Provision of supplementary funding for the Positive Living training	International NGO	1
ZAPSO	• Distribution of condoms	Local NGO	1
Churches	• Provision of psychosocial support		1

n= 8

The roles identified by the key informants are consistent with the officially ascribed roles of these organizations. However, some organizations (e.g., MAMID and PSI) that played had critical roles in the project were only identified by a few stakeholders implying that either their visibility or impact was low.

2.1 Situation Prior to TCE Project in Terms of Gender Targeted Components

The study explored the situation prior to the implementation of the TCE project in terms of access to practical and strategic components with regards to HIV/AIDS and SRH issues. Discussions with community members (FGDs) and stakeholders (KIIs) show that a host of challenges faced by women and men in accessing and utilization of health services. It also shows that before the TCE project men and women were unequal in many respects. In analyzing these challenges and differences between the women and men, and their effects, two categories in consistence with the analytical framework were identified (practical and strategic) as shown in figure 2.2. Figure 2.2 presents the qualitative descriptions as put forward by FGD participants and key informants, but some quantitative data as per the baseline survey will be explored in subsequent relevant sections.

Table 4.3: Gender difference situation and effects before TCE

Gender Components	Situation before the implementation of TCE	Effects
Practical Gender Components	• The majority of men were reluctant to access and utilize HIV testing and treatment facilities and services; • Few men were actively involved in HIV and AIDS programs; • The majority of men including those who were HIV+ were resistant to use condoms. Some would say, "*Hatidyire sweet mupepa*", metaphorically meaning we don't use condoms because they reduce the sexual enjoyment. Some men would say, "*Mombe dzangu dzakaenda kwababa vako dzakaenda dzisina macondom*", literally, "*My cattle (bride price) that I gave your father were not wearing condoms"*; • Males (boys and men) had far greater life opportunities since they were prioritized in terms of access to education and economic resources; • In general there was limited knowledge to SRH products and services by both men and women, therefore also limited utilisation	• High rate of HIV and STI transmission from men to their spouses; • High rate of HIV re-infection (spousal-spousal infection) resulting in high probability of acquiring different HIV strains; • High rate of parent to child transmission; • High number of AIDS related deaths; • A significant number of HIV+ men were not receiving treatment services; • Men had less knowledge on HIV compared to females; • High incidences of spousal conflict centred around the use of condoms; • Women usually get lower paying or inferior jobs within the district and elsewhere they went compared to men; • High level of prostitution among young women as means of survival; • High rates on intergenerational relationships between older men and young girls; • High mortality rate among young women due to AIDS compared to young men; • Late detection of STIs resulting in complications
Strategic Gender Components	• Men significantly dominated women in household and community decision making. • Men dominated allocation and use of household money, assets and other resources. • Men were the primary decision makers on the number, spacing and timing to have children with little consultation of their partners. • Men have greater control in determining the family planning methods that were being used by their partners • Women were restricted in participating in projects that have economic benefits • Adverse cultural practices such as pledging girls for the purpose of appeasing spirits and forced marriages. • Most believed that they should be allowed with multiple partners; "to graze around"	• Men were instituting abuse and gender based violence on women • High abuse of family financial and material resources leading to hunger and other forms of impoverishment of family members especially children and women • Most women were not able to negotiate for safer sex with their partners • High rate of unwanted babies and abortion • HIV disclosure was low amongst couples, with some secretly get tested and even if they realise they are HIV+ they would not tell their spouses

4.4 HIV and AIDS Knowledge, Attitudes and Practices

The survey results show that males have more knowledge about the modes of HIV and AIDS transmission compared to females as shown in table 2.3. All men in the sample know that HIV can be transmitted through sexual contact compared to 97.9% for females; whilst 79.7% of males identify blood contact as a transmission mode compared to 61.7% of females and 20.3% of males identify parent to child as a transmission mode compared to only 9.2% females. The results also show that sexual contact is the most known method of HIV transmission at 98.5%; followed by blood contact at 67% and then parent to child at 12.5%. Though the baseline data show that 98% of the people knew that HIV could be transmitted through sexual intercourse, the FGD participants and key informants explained that the depth in understanding of what actually happen for HIV to be transmitted from one person to another through sexual contact was enhanced through TCE, thus qualitatively the TCE significantly buttressed HIV transmission knowledge. One FGD participant remarked that, "*The TCE project taught us step by step what happens for one to finally get HIV from an infected person, thus helped people to prevent themselves and to acquire knowledge on what to do if they discover they are HIV positive*".

Table 4.4: Percentage distribution of respondents' knowledge of the modes of HIV and AIDS transmission disaggregated by gender

Variable	Variable Description	Percentage (%)	
		Within sex	***Of Total***
Sexual contact	Male	100	29.5
	Female	97.9	70.5
	Total	-	**98.5**
Blood contact	Male	79.7	23.5
	Female	61.7	43.5
	Total	-	**67**
Parent to child	Male	20.3	6
	Female	9.2	6.5
	Total	-	**12.5**
Don't know	Male	0	0
	Female	1.4	1
	Total	-	**1**

n= 200 (male= 59; female= 141)

The survey data show that those never married which are often have the least knowledge about HIV and AIDS transmission modes compared other marital statuses as shown in table 2.4.

Table 4.5: Percentage distribution of respondents' knowledge of the modes of HIV and AIDS transmission disaggregated by marital status

		Marital status					
Method of Transmission	**Percentage (%)**	**Never Married**	**Married**	**Divorced**	**Separated**	**Widowed**	**Total**
Sexual Contact	Within	75	99.2	100	100	100	**-**
	Total	3	59.5	8.5	1.5	26	**98.5**
Blood Contact	Within	62.5	65	76.5	66.7	69.2	**-**
	Total	2.5	39	6.5	1	18	**67**
Parent to Child	Within	12.5	13.3	29.4	0	5.8	**-**
	Total	0.5	8	2.5	0	1.5	**12.5**
Don't Know	Within	0	0.8	0	0	0.8	**-**
	Total	0	0.5	0	0	0.5	**1**

n= 200 (male= 59; female= 141)

The FGDs with beneficiaries and volunteers reveals that the community in general knows the three main HIV transmission modes, namely (a) sexual contact with an HIV infected person without protection; (b) blood contact with an infected person and (c) parent to child transmission in which the parent is infected. In consistent with the survey results the FGDs reveal that sexual contact is most known method of HIV transmission among the target communities. Both the survey and FGDs show that blood transmission is the second most known transmission mode despite the fact that in Zimbabwe it is the third in terms of rate of transmission at 1%. As the FDG participants were discussing, risks factors were identified that include unprotected sexual intercourse with multiple partners, sharing of needles and having sex with sex workers. The baseline survey shows that risk perception of contracting HIV was low at the beginning of the project with 20% of the people believing that they could not get HIV and 45% acknowledging that they had not made any changes in sexual behaviour in order to prevent contracting HIV.

The findings show that 70.5% of the survey participants know AIDS is caused by HIV virus, with men exhibit more knowledge at 78% compared to 67.4% for women as shown in table 2.5. Since AIDS is caused by HIV the results show that 29.5% have little knowledge or don't know what causes AIDS. Analysis for other socio-demographic variables along knowledge of what causes AIDS, show that there are certain groups that are less knowledgeable relative to other groups. For instance only 50% of the never married know that AIDS is caused by HIV and all the participants in the 15-19 age group do not know that AIDS is caused by HIV. The results in general show that the higher the education level the more knowledge about cause of AIDS; with 100% tertiary and university level participants compared to 67.7% of those with primary education knowing the cause of HIV. These findings are consistent with some earlier studies. A study in 8 high HIV prevalence countries (i.e., Zimbabwe, Kenya, Lesotho, Malawi, Swaziland, Tanzania, Uganda and Zambia) using demographic health

surveys reports shows a strong association between educational attainment and comprehensive knowledge about HIV among HIV positive people[1].

Table 4.6: Frequency and percentage distribution of respondents' knowledge cause of AIDS disaggregated by sex

			Cause of AIDS						
			HIV virus	Women / men	STDs	Up to God	Don't Know	Other	Total
Sex of Participant	Male	Frequency	46	6	1	0	6	0	59
		% within sex	78	10.2	1.6	0	10.2	0	100
	Female	Frequency	95	25	2	4	13	2	141
		% within sex	67.4	17.7	1.4	2.8	9.2	1.4	100
Total		Frequency	141	31	3	4	19	2	200
Total		**%**	**70.5**	**15.5**	**1.5**	**2**	**9.5**	**1**	**100**

n= 200 (male= 59; female= 141)

The three major strategies of HIV/AIDS protection from infection identified by respondents are condom use (89.5%), faithful monogamy (29%) and abstinence (24.5%). A small number of participants identified VCT (6.5%), alternative/ safe sex (6%) and avoidance of blood transfusion (5.5%) as methods to prevent HIV infection as shown in table 2.6. The knowledge level of prevention through condoms is higher for both men and women compared to the country level as recorded in the Zimbabwe Demographic Health Survey [ZDHS] (2010-11). Ninety-three percent of men and 87.9% of women in the survey identified condom use as a major strategy of HIV prevention compared to 82.4% of men and 80.9% of women in the ZDHS. The FGD participants and key informants highlighted that the widespread information dissemination reduced myths that was associated with condoms and the increase in community condom distribution centres introduced or strengthened by the TCE project was linked with an improved uptake or usage of condoms.

Table 4.7: Percentage distribution of HIV protection strategies from infection

		Sex of Participant				Total	
		Male		**Female**			
		Frequency	% within sex	Frequency	% within sex	Frequency	**%**
Protection from infection	Condom use	55	93.2	124	87.9	179	**89.5**
	Faithful monogamy	27	45.8	31	22	58	**29**
	Abstinence	15	25.4	34	24.1	49	**24.5**

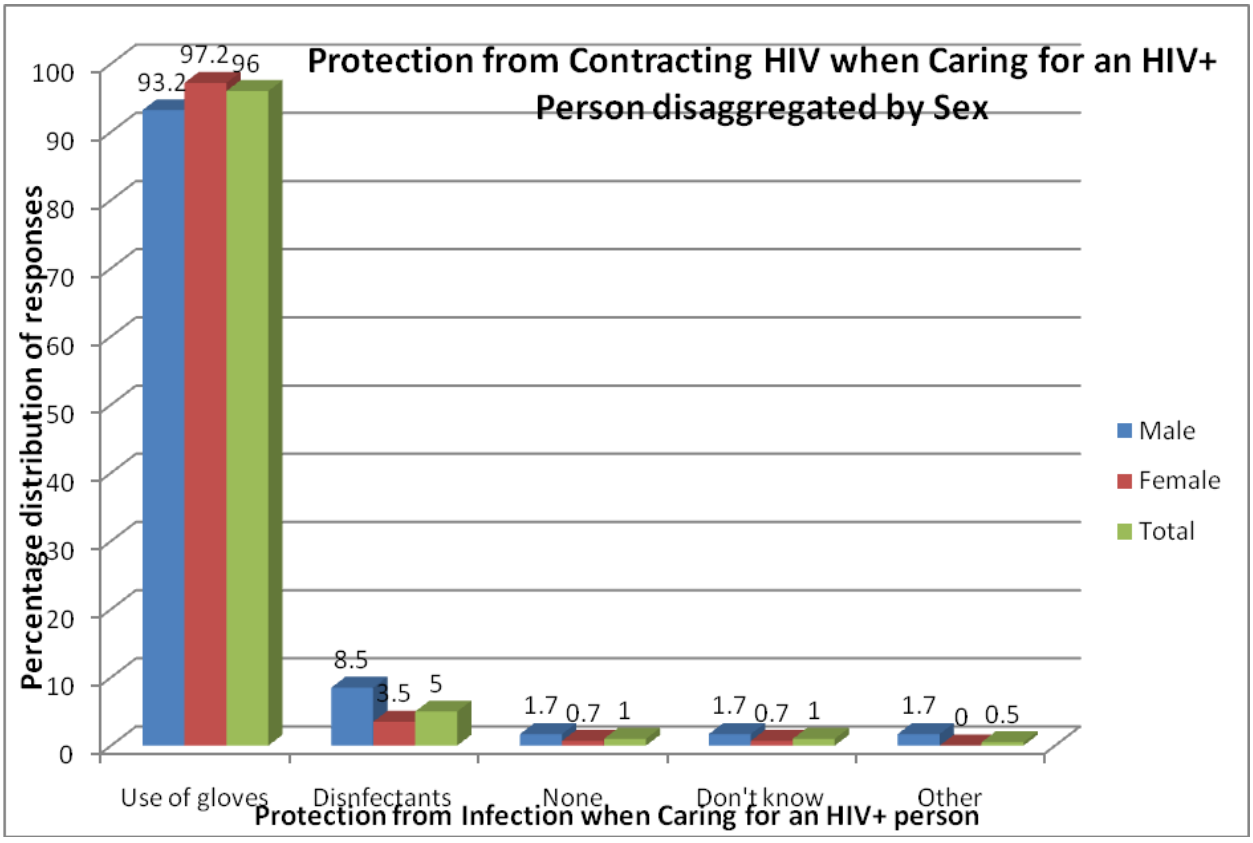
[1] Wang, Wenjuan, Soumya and Shanxiao Wang. 2012. *HIV-Related Knowledge and Behavior Among People Living with HIV in Eight HIV Prevalence Countries in Sub-Saharan Africa*: DHS Analytical Studies No. 29. Calverton, Maryland, USA, ICF International

	Reduction of sexual partners	6	10.2	13	9.2	19	**9.5**
	Alternative/safe sex	5	8.5	7	5	12	**6**
	Avoid blood transfusion	2	3.4	9	6.4	11	**5.5**
	VCT	5	8.5	8	5.7	13	**6.5**
	Spiritual/moral transformation	0	0	1	0.7	1	**0.5**
	Other	0	0	2	1.4	2	**1**

n= 200 (male= 59; female= 141)

The survey show that the use of gloves is the most known and used method to prevent contracting HIV as caregivers are caring for HIV+ people as shown in figure 2.3. The most common disinfectant that was identified through FGDs is Jik. The FGDs also bring out some methods that are used to protect caregivers that include the use of plastics especially in the absence of gloves and sterilisation of utensils.

Figure 4:2: Percentage distribution of methods used by caregivers to prevent contracting HIV when caring for HIV+ persons



More than three quarters of the survey participants pinpointed that rapid weight loss (76%) is a sign or symptom of AIDS. This is followed by diarrhoea lasting more than one week (53.5%) and dry

cough (53%). Table 4.5 shows more details on responses to the signs and symptoms of AIDS. The majority of the participants were able to identify at least 2 signs and symptoms of AIDS. All participants identified at least one of AIDS signs and symptoms.

Table 4.8: Percentage distribution of respondents' knowledge of the signs and symptoms of AIDS

		Sex of Participant				Total	
		Male		**Female**			
		Frequency	% within sex	Frequency	% within sex	Frequency	**%**
Signs and Symptoms of AIDS	Rapid weight loss	50	84.5	102	72.3	152	**76**
	Dry cough	27	45.8	79	56	106	**53**
	Recurring fever or profuse night sweats	14	23.7	24	17	38	**19**
	Profound & unexplained fatigue	5	8.5	15	10.6	20	**10**
	Swollen lymph glands in the armpits, groin or neck	9	15.3	18	12.8	27	**23.5**
	Diarrhoea lasting > a week	27	45.8	80	56.7	107	**53.5**
	Pneumonia	10	16.9	18	9.9	28	**14**
	White spots or unusual blemishes on tongue/ mouth/ throat	4	6.8	13	9.2	17	**8.5**
	Memory loss, depression & other neurological disorders	4	6.8	7	5	11	**5.5**
	Blotches on or under skin or inside mouth, nose/ eyelids	12	20.3	28	19.9	40	**20**
	Headache	8	13.6	36	25.5	44	**22**
	Other	3	5.1	3	2.1	6	**3**

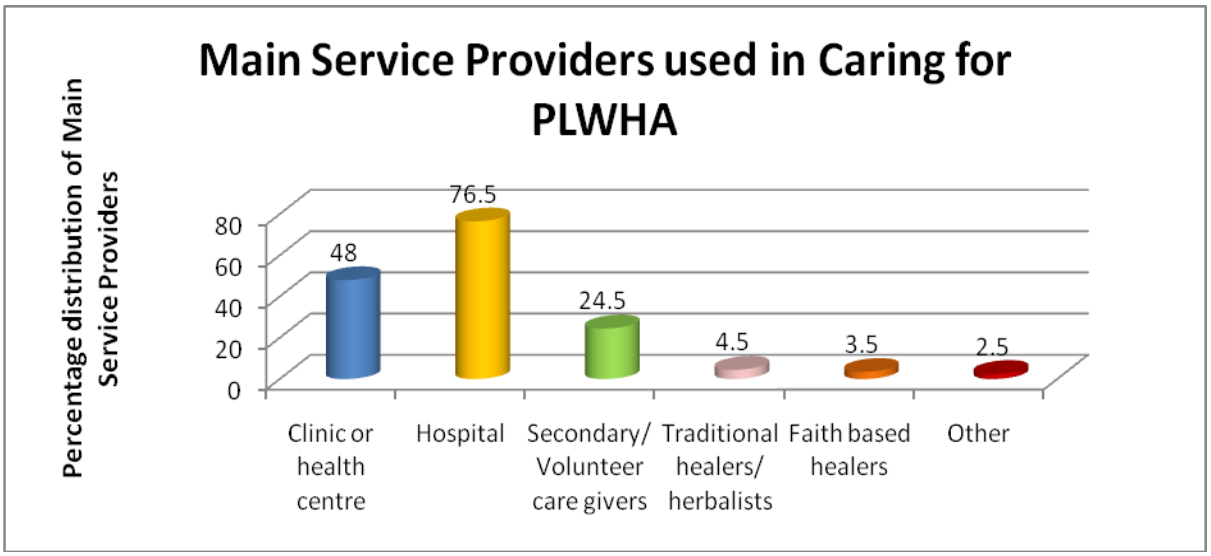
n= 200 (male= 59; female= 141)

Qualitative sources (FGDs and KIIs) show that the TCE project significantly increased access to information and education and communication (IEC) on SRH services and products by both men and men and in the process increasing awareness of SRH and family planning services, uptake of SRH, PMTCT and family planning services. Furthermore, the qualitative sources highlighted that the TCE assisted in reducing attribution of AIDS related deaths to withcraft, and to great extent reduced HIV related stigma.

4.5 Access to Health Services

The survey reveals that hospital (76.5) is the major service provider, followed by clinics (48%) for PLWHA as presented in figure 2.4. Health care mapping and transect walk exercises show that in 2 of the target rural wards near Mount Darwin urban, there are no health centres and thus most people access health services from Mount Hospital. In target urban there are no clinics so the people use the hospital. This state of affairs largely explains why hospital is the most used health care service provider.

Figure 4:3: Percentage distribution of main service providers used for caring PLWHA



The main services that are offered by hospitals and clinics include in relation to TCE project are: (a) Medication and treatment; (b) HIV testing and counselling; (c) Distribution of family planning tablets and condoms; (d) Health and nutrition education and advice; and (e) Distribution of supplementary food. The secondary care givers (Community based health workers and Village Health Workers) were identified as specialising in providing psychosocial support and referring people to health centres. The traditional and faith based healers concentrate on provision traditional medicines, holy water and prayers.

The survey show that the majority of people receive the necessary services as they care for PLWHA as shown in table 2.8; in which 88% have either said the services received meet their needs to a high or very high extent.

Table 4.9: Percentage distribution of extent services meeting needs in caring for PLWHA

		Sex of Participant				Total	
		Male		**Female**			
		Frequency	% within sex	Frequency	% within sex	Frequency	**%**
Extent services meet needs in caring for PLWHA	Very high extent	22	37.3	48	34	70	**35**
	High extent	31	52.5	75	53.2	106	**53**
	Moderate	5	8.5	18	12.8	23	**11.5**
	Marginal	1	1.7	0	0	1	**0.5**
	Total	59	100	141	100	200	**100**

n= 200 (male= 59; female= 141)

Table 4.10: Percentage distribution of health provision and services rating

		Sex of Participant				Total	
		Male		Female			
		Frequency	% within sex	Frequency	% within sex	Frequency	%
Health provision and services rating	Very high extent	17	28.8	36	25.5	53	**26.5**
	High extent	27	45.8	82	58.2	109	**54.5**
	Moderate	15	25.4	22	15.6	37	**18.5**
	Marginal	0	0	1	0.7	1	**0.5**
	Total	59	100	141	100	200	**100**

n= 200 (male= 59; female= 141)

The health care service provision analysis explored all the major health care service providers in the target areas and added the following qualitative measurement components; availability, accessibility, acceptability and quality. The results show that availability in terms of functionality of health facilities/ goods and/or services in sufficient quantity is the component that lacks most across the service providers. The detailed service provision analysis is shown in appendix 1.

The study explored the major HIV and SRH services that are offered in the area and the extent to which these services are accessible to target people. The survey findings show that ARVs drugs, PMTCT, antenatal and VCT services are generally accessible to target population as shown in figure 2.5. Complementary information from FGDs revealed that the TCE improved drug adherence. One FGD participant remarked, "*People now have knowledge to change their behavior, save their lives through use of ARVs and disclosing of their status*".

Figure 4:4: Percentage distribution of the extent of access to HIV and SRH services disaggregated by sex

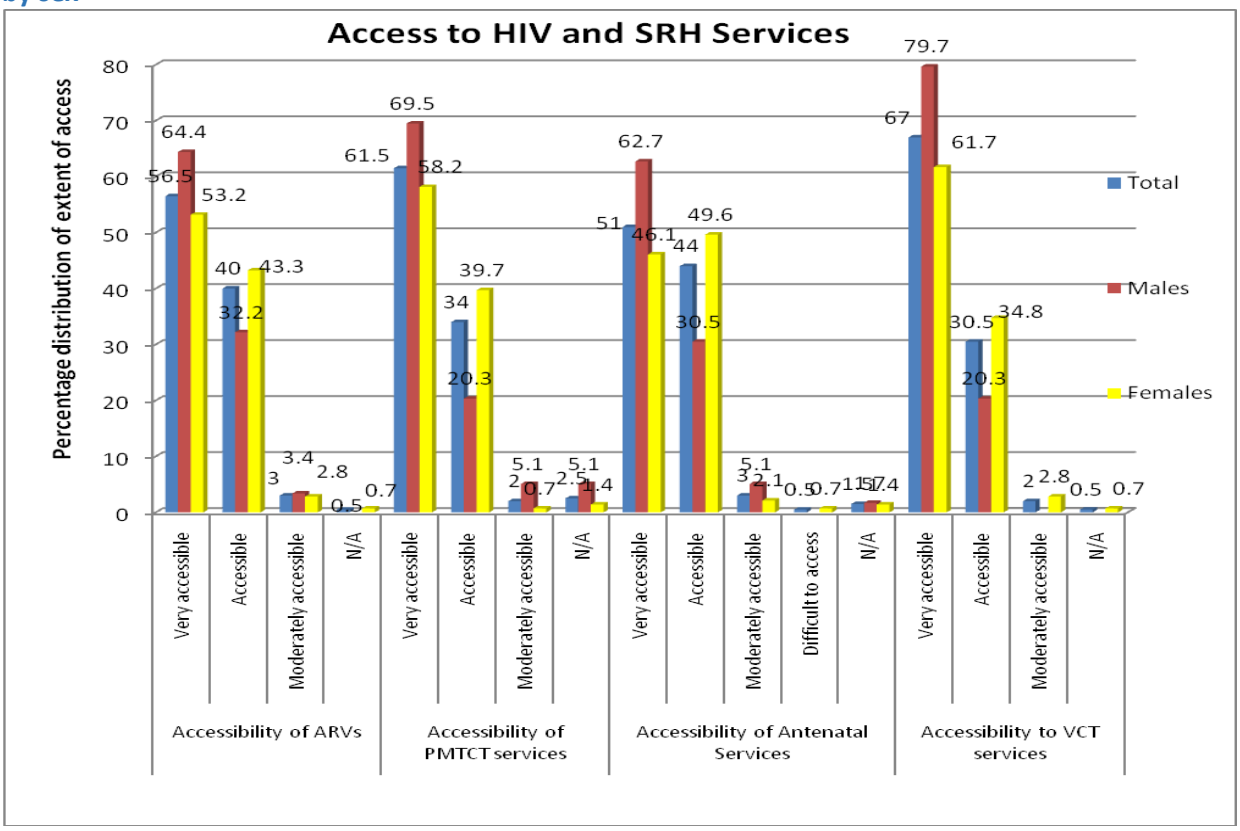
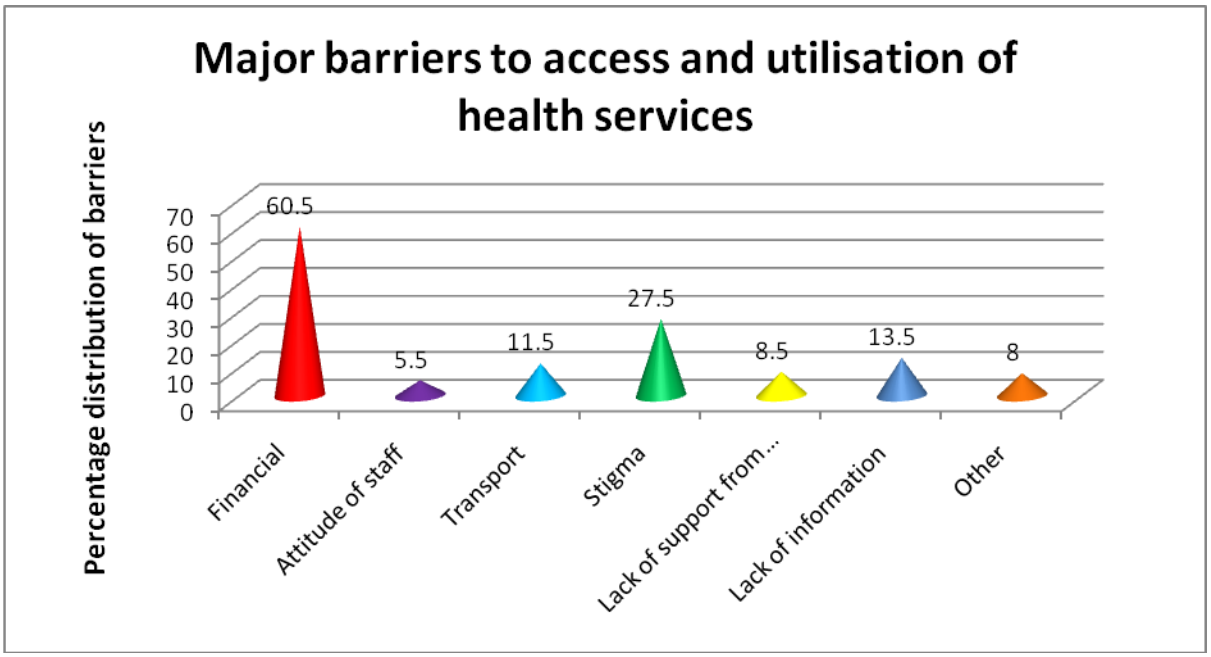


Figure 4:5: Percentage distribution of major barriers to access and utilization of health services



The survey results show that 43% of the people pay at least something when they visit health care centres. Complementary information from FGDs show that for non-HIV related services community

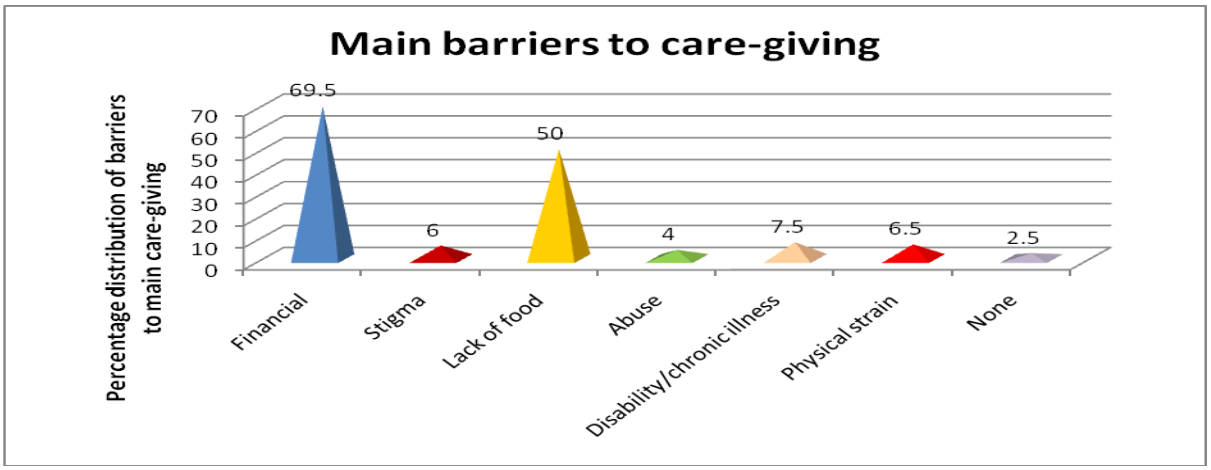
members usually pay consultation fees and purchase drugs unlike at local clinics. Futhermore, consultation fees at hospital is higher (at $3) compared to clinics (at $1). As result of these costs, 27.5% of the survey respondents said their households cannot afford the amount required at health centres when they access services and sometimes they are forced to sell their productive assets to meet these costs.

The study explored into the health referral points from where the the target population usually get their health services. The majority of people identified the provite hospital (59.5%) in Bindura as the referral point. This is largely to the fact that there is a church owned private hospital (Karanda) which offer good services at reasonable prices. The other major referral points are; district (31.5%) and provincial (27%) hospitals. The survey reveals that the the services at referral points are generally effective with 35% and 54.5 saying services are effective and very effecitive, respectively. However, a great number (61%) said the costs related to referral in terms of service fees and transport is high (45%) or very high (16%).

4.6 Care-giving and Support

The study explored the main care-givers within target households. The survey shows that the majority of primary care-givers are women at 75% and males at 25%, thus showing that women bear the most burden in caring for HIV+ people. One study in Uganda found that women were the primary caregivers in 86 out of 100 illness episodes[2]. FGD sources show that though women are still the major primary care givers, the TCE project has managed to increase sharing of duties in caring for sick people by women and men. The study shows that the TCE project improved caring practices for PLWHA. One FGD respondent said, "*Through improved caring practices HIV/AIDS persons can live a longer life just like other people suffering from chronic diseases like cancer*". The study went further to assess the main barriers to effective care giving. The major challenges are financial (69.5%) and lack of food (50%) as shown in figure 2.7.

Figure 4:6: Percentage distribution of major barriers to effective care giving



[2] Taylor, L., J. Seeley, and E. Kajura. 1996. Informal Care for Illness in Rural Southwest Uganda: The Central Role that Women Play. *Health Transit Rev* 6(1): 49-56.

Food as an important component of life was explored further to determine the major sources of food in caring for PLWHA. The main sources is own production (92.5%); followed by civic organizations (28%); and then government (18.5%). Other sources mentioned are remittances (6.5%) and community aid (4.5%). This study explored the extent to which food that are coming from sources are meeting the food requirements of the household. Over half (56%) said the food requirements were met to a moderate extent; with 25% saying their food requirements were to met to a marginal extent and 9.5% saying their food requirements at not bet met at all. Only 9.5% said the food their requirements were met to a high and very high extent.

The study established the kind of possible support households receive when caring for PLWHA or when they were caring for people who died of AIDS. Tables 2.10 to 2.15 detail the kind of support received by households from various people and organisations. In general, emotional, social/ cultural and spiritual support is moderate to effective from nuclear family, extended family and the community. Financial support is very limited at all levels; that is, at nuclear family, extended family, community, civic organisation, government and private organisation level. The results show that government support in terms of medical supply is mostly perceived to be effective or very effective the community members in Mt Darwin.

Table 4.11: Percentage distribution of the kind of support from extended family in caring for PLWHA or PDA

Variable	Support rating expressed in percentage					
	Not at all	*Slightly*	*Moderately*	*Effective*	*Very effective*	*N/A*
Psychosocial	*8*	*21.5*	*10*	*2.5*	*5*	*57*
Spiritual	*3*	*18*	*9*	*2*	*3*	*66.5*
Financial	*0*	*15.5*	*14*	*2*	*3.5*	*65*
Material	*0*	*12.5*	*13.5*	*1.5*	*4.5*	*68*
Medical	*0*	*3*	*1*	*0*	*7.5*	*88.5*

n= 200

Table 4.12: Percentage distribution of the kind of support from volunteers in caring for PLWHA or PDA

Variable	Support rating expressed in percentage					
	Not at all	*Slightly*	*Moderately*	*Effective*	*Very effective*	*N/A*
Psychosocial	*0*	*4*	*18.5*	*20*	*4*	*53.5*
Spiritual	*0*	*3.5*	*12.5*	*10*	*2.5*	*70.5*
Financial	*0*	*1*	*6*	*1*	*0.5*	*91.5*
Material	*0*	*6*	*9.5*	*7*	*1*	*76.5*
Medical	*0*	*3.5*	*7*	*7*	*3.5*	*79*

n= 200

Table 4.13: Percentage distribution of the kind of support from community in caring for PLWHA or PDA

Variable	Support rating expressed in percentage					
	Not at all	*Slightly*	*Moderately*	*Effective*	*Very effective*	*N/A*
Psychosocial	*0*	*5.5*	*22.5*	*3.5*	*1*	*67.5*
Spiritual	*0*	*2*	*18.5*	*10*	*1*	*68.5*
Financial	*0*	*2.5*	*5.5*	*0.5*	*0*	*91.5*
Material	*0*	*5*	*14*	*5*	*0*	*76*
Medical	*0*	*0*	*2.5*	*1*	*0*	*96.5*

n= 200

Table 4.14: *Percentage distribution of the kind of support from government in caring for PLWHA or PDA*

Variable	Support rating expressed in percentage					
	Not at all	*Slightly*	*Moderately*	*Effective*	*Very effective*	*N/A*
Psychosocial	*0*	*1*	*1.5*	*1*	*0.5*	*96*
Spiritual	*0*	*0.5*	*1.5*	*0.5*	*0.5*	*97*
Financial	*0*	*1*	*3.5*	*1.5*	*0*	*94*
Material	*0*	*4*	*20*	*10.5*	*5.5*	*60*
Medical	*0*	*0*	*3*	*18.5*	*44*	*34.5*

n= 200

Table 4.15: *Percentage distribution of the kind of support from civic organisations in caring for PLWHA or PDA*

Variable	Support rating expressed in percentage					
	Not at all	*Slightly*	*Moderately*	*Effective*	*Very effective*	*N/A*
Psychosocial	*0*	*1*	*3*	*4*	*2*	*90*
Spiritual	*0*	*1*	*2.5*	*5.5*	*3.5*	*87.5*
Financial	*0*	*0*	*4.5*	*1*	*0*	*94.5*
Material	*0*	*1.5*	*21.5*	*11.5*	*4*	*61.5*
Medical	*0*	*0.5*	*3.5*	*7.5*	*3*	*85.5*

n= 200

Table 4.16: Percentage distribution of the kind of support from private companies in caring for PLWHA or PDA

Variable	Support rating expressed in percentage					
	Not at all	*Slightly*	*Moderately*	*Effective*	*Very effective*	*N/A*
Psychosocial	*0*	*0.5*	*1*	*0.5*	*0.5*	*97.5*
Spiritual	*0*	*0*	*1*	*0*	*0*	*99*
Financial	*0*	*0*	*0.5*	*0*	*0*	*98.5*
Material	*0*	*0*	*3*	*1*	*0*	*96*
Medical	*0*	*0*	*0.5*	*0*	*0*	*99.5*

n= 200

4.7 Factors Promoting and Hindering Sustainability of Gender Outcomes

Since the TCE project aimed to introduce and strengthen structures, systems and interventions that bring long-term gains to both men and women, the study explored the factors that are still promoting the enjoyment of these long-term benefits. Furthermore, the study also explored factors that are currently hindering or threatening the sustainability of TCE outcomes. Figure 2.8 presents factors that were identified as promoting or hindering key gender outcomes.

Table 4.17: Factors that promote and hinder sustainability of targeted gender outcomes

• Factors Promoting Sustainability of Targeted Gender Outcomes	• Factors Hindering/Threatening Sustainability of Targeted Gender Outcomes
Practical Gender Outcomes	
Improved access to and utilisation of sexual and reproductive health-care services	
• **Improvement in HIV drugs availability at no cost at health centres enabling HIV+ to access them easily;** • **The increase in health seeking health behaviour by both men and women is helping people to know their HIV status and live a more positive life;** • **The greater use of HIV drugs and immune boosting herbs is prolonging life and health of HIV+ people.**	• Some wards have no health centres and thus must raise money for transport, which is a constraint to number of families; • Almost 60% of men refuse to accompany their wives to health centres for ANC services that also involve HIV counselling and testing;
Improved access to community support services	
• **The functional support groups provide psychosocial support, helping people who are HIV+ to accept their condition and live a positive life;** • **Some support groups have evolved to become village savings groups enabling members to access capital to start income generation projects and to fund the establishment of assets such as houses and also to meet emergency household needs such as food, medicines and school fees;**	• The non-functionality of the majority of support groups that were formed by TCE project is limiting the provision of psychosocial support. • Lack of management skills by community and beneficiaries leading to failure to sustain structures and systems that are introduced by TCE and other projects • Most support groups were not nurtured to reach maturity level thus the majority are no longer functional. One participant said, "*There were many disagreements in many support groups and the end result is that they dissolved*." The existence of many support groups was dependent on the TCE implementing partner thus they fail after the end of the project;
Strategic Gender Outcomes	
Changes in harmful gender roles, norms and stereotypes	
• **Some leaders and men have changed their negative perception of women and are active agents and partners in fighting the HIV pandemic in the community**	• Some adverse cultural practices. One key informant remarked that "*Some men still think that masculinity involves engaging in risk behaviour, including sleeping with many partners without protection*." • Some adverse religious beliefs. There are some churches in the district that discourage the use of condoms, arguing that it is not the plan of God; • Some men are still resisting to actively participate in HIV projects, saying that such projects are for women. These men are interested in projects that give monetary or material rewards, such as agricultural inputs projects. One stakeholder remarked, "*Some are reluctant to be actively involved because they think they have more knowledge and*

	are smarter than women."
Improved knowledge and open discussion about HIV in the community and amongst couples	
• **TCE project inculcated knowledge and skills of HIV prevention, care and treatment that are still being used by many people in the district;** • **People are still continuing to teach each other and share information about HIV on one-on-one basis and at times at community platforms such as village and ward meetings;** • **The TCE taught community leaders about HIV and the majority understood and accepted the importance of disseminating HIV information, thus they create time for volunteers to talk about HIV during community level meetings;** • **Major commemorations such as World AIDS Day are being used to disseminate HIV information to people;**	• Lack of current information or knowledge on HIV among the people. Information dissemination of the current information is weak in the district, thus people are unaware of new developments in the HIV sector. In particular people generally don't understand issues like Voluntary Medical Male Circumcision (VMMC);
Cooperation by both males and females in HIV & AIDS mitigation and SRH issues	
• **Shared couple decision making on family planning, SRH and economic issues. One FGD participant said, "*Woman can now decide on safer sex and community in general no longer perceive women who introduce condoms in their homes to be prostitutes*."**	• Lower involvement of men in HIV and SRH programs compared to women;
Interventions that address disparity in income	
• **No comment offered**	• Men are still more economically empowered than women, thus still have greater edge in terms of decision making within the family and in the community; • Lack of capital to start viable income generation projects especially among women; • Limited access to markets for the agro-produce hinder access to income;
Improvement in assertive behaviour especially by women	
• **Most women are aware of their basic right to life and some are able to talk to their partners to have safe sexual intercourse, which involves the use of condoms;** •	• Since men are still more powerful in terms of access to resources and decision making, the majority of women find it difficult to resist pressure from their partners who may want unprotected sexual intercourse, even in the face of risks;

4.8 Analysis of Project Intervention Factors

The conceptual framework of this study specify that project factors namely design and implementation are crucial in modifying the background factors (social, personal, economic and institutional) in order to achieve targeted gender outcomes. Since this study is evaluative in nature, the study explored the factors at design and implementation levels that contributed to the success or failure of the TCE project.

4.8.1 Project Design Analysis

Consultative processes

Consulting the communities about their challenges, priorities and well as strengths is vital in enhancing the success of the project. The results show only sensitization meetings with leaders and stakeholders were done at the beginning of the project, but the actual consultations before the project to gather challenges, priorities and other things were not done. The stakeholders expressed that though there was an impression during sensitisation meetings that suggestions will be taken into account, in reality the TCE was not externally designed.

Identification of target beneficiaries and level of inclusiveness

Targeting involves the selection and registration of intended beneficiaries in the project. For a project to be successful, it has to target people who have targeted challenges or constraints. The study show that 80% of the key informants expressed that the TCE project was inclusive by virtue of targeting all households through the door-to-door approach. One stakeholder aptly said the TCE "*is a multi-component community based program and managed to reach all people one way or the other*." However, others thought that though the targeting was generally good some groups were not catered for fully, for example at schools TCE omitted pupils in grade 4 and below since they were omitted from educational sessions. Furthermore, other felt that little emphasis was placed on the people with disabilities who have special needs that require special attention.

Structures and Systems

The TCE project introduced PLWHA support groups for peer to peer support and TRIO for ARV adherence support. The key informants said that the PLWHA support played an important in providing comfort to HIV+ people as they met with their peers in the same condition, sharing experiences and challenges and also encouraging and giving each other advice. The TROs were deemed to have significantly increased the ARV adherence rate since PLWHA would be encouraged and reminded to take drugs at designated times.

Selected Gender Response Measures

The study explored the contribution of selected measures or activities that were implemented in the TCE project. The focus here is on the responses that are not or barely covered in other sections of this chapter.

- The door-to-door approach enabled the beneficiaries to access IEC materials and SHR services at their door steps. It therefore reduced costs on transport to visit SHR centres. Furthermore, this approach enabled those who normally are reluctant to go for health services to be reached with HIV and SRH information and services.
- SRH training empowered women to know and enjoy their SHR rights and assisted to break the barriers of accessing some of these services at health facilities without much depending on spouses.
- The facilitation of VCT including mobile services increased people's knowledge about their HIV status and also positive living.
- The use edutainment such as drama and songs in disseminating information on HIV/AIDs was effective especially among adolescents and youths.

- **Condom distribution centres** that were created at strategic places enhanced access and utilisation of condoms. The centres included clinics and selected shops.
- The support groups that were formed were effective in information sharing among PLWHA, and consequently contributed significantly to positive living.
- The herbal gardens were very useful in boosting the immune system of PLWHA especially when the HIV drugs were in short supply.
- Gender equality education reduced abuse of women by men.

Resources Allocation

The success of any project depends partly on the allocation of sufficient resources to accomplish project objectives. Therefore the study explored the adequacy of resources that were allocated for the project. The discussions with key informants show that the majority of the stakeholders were not aware the total resources that were allocated and used for the TCE project. What stakeholders could only do was to look at the needs versus what was deployed on the ground. There was consensus that a huge gap or deficit was there in terms of resources meeting the prevailing needs of the time. One key informant said the resources were, "*too limited and thinly spread*." This was also in reference to the TCE approach of reaching 100,000 people.

The study explored other resources that may have been required in order to improve the practical and strategic outcomes of the TCE project. Key informants suggested the following:

- Motor bikes and bicycles for field officers who had mobility challenges as they walked long journeys doing door-to-door education campaigns and in monitoring the project. Provision of quicker transport modes was likely to improve efficiency and effectiveness of field officers.
- Manuals and IEC materials that are tailor made for the various groups for example blind people, adolescents and older people. This would have enabled all groups to have materials to read and reference when needed.
- Income generation projects financial, material and technical support. The stakeholders suggested that more resources were required to support agro and non-agro related projects (e.g., sewing) that would have improved purchasing capacity of families. On the agro-related projects stakeholders thought that agro-processing machinery was also required to add value to agro-produce. One key informant said, "*The income generation projects were seriously under-funded and were very few; but I think that was an important missing link since money is important in improving the welfare of household members, including the ability to pay for health services.*"
- Medical products. Provision of drugs was important given there were still shortage of drugs at that time of which TCE project didn't do.
- Food supplement for people living with HIV to improve their nutritional status.
- Gloves and detergents. Some stakeholders think that the TCE should have provided such materials
- Incentives /tokens for volunteers were required to motivate them and to prevent volunteer fatigue.

- Visual aid gadgets such as videos were required for screening visuals that enhance understanding of crucial issues and adoption of improved practices. The visual aids such video screening was deemed to have the potential to increase interest of people including of those men who are reluctant to participate in other HIV programs.

The majority of key informants (80%) were not aware of mechanisms that were put in place to fund TCE activities beyond the lifespan of DAPP (implementing partner) funding. One key informant noted that the TCE activities were incorporated into MoHCC activities with no specific resources committed.

4.8.2 Implementation and Monitoring Mechanisms Analysis

Implementation period

There was no consensus with regards to how realistic the TCE implementation period was. The TCE was implemented for 3 years in the target district. Fifty percent of the key informants thought that the implementation period was short since behaviour change requires a long period. One stakeholder suggested that 5 to 7 years is required to make an effective and long lasting behaviour change. The other stakeholder remarked, "*For better impact the project needed more time than it was allocated because change is a process and people tend to revert to the old norms that may continue to negatively affect the woman*." Thirty seven and half percent of the stakeholders asserted that the implementation period of 3 years was appropriate and the remaining 12.5% were not sure whether the period was realistic or not.

Implementation plan with defined responsibilities

The KII data show that 87.5% of the stakeholders said the TCE project had an implementation plan that clearly defined responsibilities of its TCE members in communities. These stakeholders said during project launch an implementation plan was shared with the stakeholders. The TCE implementation plan specified the roles and responsibilities of various actors like the volunteers and field officers. The remaining 12.5% of stakeholders were not sure if the TCE had an implementation plan.

Participation and acceptance of the project

TCE project was accepted, endorsed and supported by the local leaders to a large extent. The KII data show that village heads and other community leaders were on forefront in mobilising people to seek health care services and participation TCE activities. Some local leaders were active volunteers or passionates of the project. The door-to-door approach and the use of community platforms such as village and ward meetings to disseminate HIV and AIDS information helped almost all people to participate in the project. However, participation was noted to be significantly lower amongst men compared to women due to adverse attitudes and stereotypes and in urban centres it was noted that the project didn't focus on HIV workplace activities thus missed some people especially men.

Coordination, Collaborations and Partnerships

The key informants remarked that the TCE project adequately collaborated with the MoHCC at district and community level in delivery of project activities. The MoHCC played a critical role in training Field Officers and development agents such as CHBC providers and other volunteers. Furthermore, DAPP worked well with the National AIDS Council (NAC), with NAC collecting information from DAPP and other partners for district level synthesis.

Capacity Building for Targeted Structures and Systems

The key informants noted that though the PLWHA support groups played an important in achieving the objectives of the project, the fact that most support groups were not nurtured to maturity and sustainable levels and to stand on their own reflects that capacity building of these structures was not adequate. The TRIOs were perceived to be more efficient than support groups and generally had greater longevity after than support groups since they involved 3 people only who had family or personal relationships and had in-depth concern for each other. The key informants and FGD participants emphasized that CHBC providers trained by the project linked the HIV patients with health service centres and were crucial in provision of counselling and also in encouraging patients to take their medication.

Monitoring and evaluation plan

The study results show that 62.5% of stakeholders expressed that the project had an M&E plan designed to guide the monitoring and evaluation functions and activities. One key informant asserted that the M&E plan was also being used by the provincial team that was based in Bindura town. However, one stakeholder had an important cautionary statement, "*Though the M&E plan was there the M&E process continued to be top-down instead of greater participation involvement of beneficiaries of the project*." The remaining 37.5% were not sure whether the M&E plan was there or not.

Institutional arrangement to monitor TCE objectives

The discussions with key informants show that institutional arrangements to monitor the TCE project objectives are weak though some said the project was handed over to District AIDS Council, MoHCC and local authorities. One key informant said, "*Currently here are no fixed and focused institutional arrangements in MoHCC for implementation and monitoring of TCE objectives*." Though some stakeholders identified churches, DAC, local authorities, Ministry of Women Affairs, Department of Social Welfare and MoHCC as responsible for monitoring the TCE objectives, it seems there are no concrete actions on the ground, thus implying that those institutional arrangements are weak.

5 TCE SUSTAINABILITY FRAMEWORK AND RECOMMENDATAIONS

One of the aims of this study is to use the study findings to develop a sustainability framework for the TCE program. Therefore, the TCE sustainability framework outlined here was developed using both the study itself and drawing lessons learnt from other similar projects. Since the sustainability model is using the research findings, suggestions from stakeholders and participants and also incorporating the findings and lessons from other similar projects, the framework itself can be viewed as a recommendation of the study. The study findings and literature show 4 major components that can be used to ensure the success and sustainability of the TCE project namely, (a) Community-led mobilisation and education; (b) HIV treatment and SRH services; (c) Response management and (d) HIV impact mitigation. These 4 components can also be viewed as the 4 strategies that can be used to ensure the TCE achieve its short and long term objectives. The diagrammatical TCE sustainability framework that was developed is shown in figure 3.1.

5.1 Community-led mobilisation and education

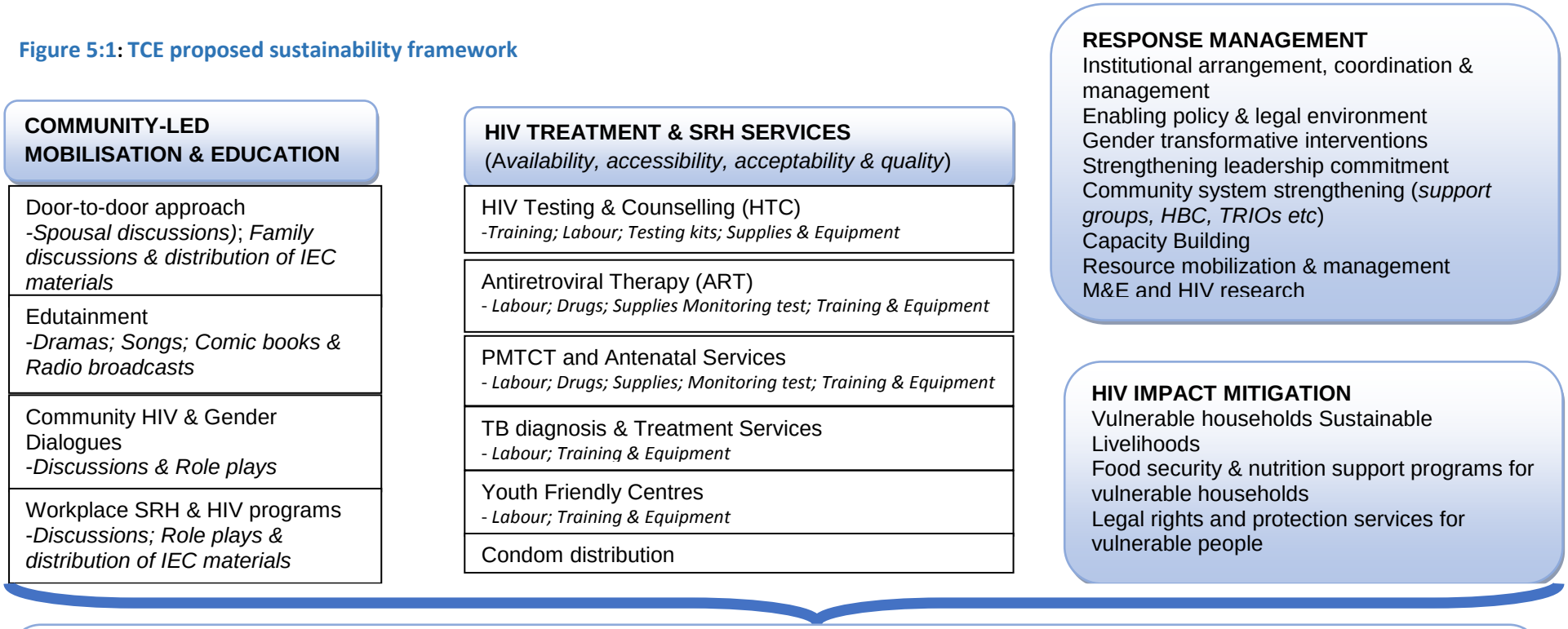
5.1.1 Door-to-door approach

The use of local people by the TCE model who are employed as field officers and some who are recruited as volunteers is effective in mobilising people to seek health services. The local people know the socio-cultural conditions and dynamics in the community and it's easier for them to encourage other community members as long as they have the necessary knowledge. Peer-to-peer discussions and influence occurs which help to disseminate information and also to tackle some critical barriers to health seeking behaviour. The TCE door-to-door approach is effective in reaching out to each household in a particular geographical area. This approach enables the project to reach out to the "hard to reach groups" like the people with disability, adolescents and youths and those who are usually reluctant to be active in HIV and SRH programs like men. The spousal discussions at household level with field officers enable a lot of HIV and SRH issues including myths to be clarified in a private friendly environment with the spouses being free to ask questions or express their feelings or concerns. Bearing the fact that each household is unique in terms of household composition and other demographic variables there is a need to develop a wide variety of IEC materials that are friendly to various groups so that they can be distributed during the doo-to-door visits, depending on need. There is a need to take special care on groups that normally have difficulties in accessing or using current IEC materials for example due to language or font sizes that are used. Both females and males must participate as field officers in TCE project.

5.1.2 Edutainment

Edutainment combines education and entertainment with the aim to disseminate particular information and to ultimately transform behaviour. The study show that TCE use two tools of edutainment namely dramas and songs in order to reach to community members. However, there are other tools such as comic books, sports tournaments, radio broadcasts and video screening that were not used by the TCE but are effective in reaching out to people. The recommendation is that TCE should incorporate these edutainment tools so as to improve interest of the community and in the process strengthening information dissemination and mobilisation and the tools must reach out to both women and men.

Figure 5:1: TCE proposed sustainability framework



5.1.3 Community HIV and Gender Dialogues

The community HIV and gender dialogues are village level structures that are created to facilitate discussion of HIV, SRH and gender issues. These dialogues are sanctioned by the village heads that are often trained in HIV, SRH and gender advocacy to increase their level of support to these forums. The volunteers and at times field officers facilitate focus group discussions and role plays on critical areas that the community identity as problematic in their village or area.

5.1.4 Workplace SRH and HIV programs

The study shows that workplace education was a critical missing link in the TCE project resulting in some people especially men not reached with HIV and SRH information. Workplace programs that are properly designed have a potential to complement door-to-approach in HIV prevention, treatment, care and support. It recommended that *NAC Workplace HIV and AIDS Policy and Programme Development Guide 2010* be used to capture all the critical elements of a workplace programme. Successful workplace interventions will help to reduce absenteeism, early retirement, and skills loss and concurrently increasing productivity and profits of organisations and this has a domino effect on the national economy.

5.2 HIV Treatment and SRH Services

The education and mobilisation efforts of the TCE model can only become effective when the people can access and use HIV treatment and SRH services at health facilities and other structures that can provide these services. There are four critical issues here, namely availability, accessibility, acceptability and quality of services.

For services to be called they are available, the health facilities must be functional and provide services in sufficient quantity. This means that the TCE program must work with other partners to ensure the proper functionality of health facilities. The TCE program also has to ensure that it address or at least work to improve physical, economic and information access of the target people. The study show that in some wards there are no health centres and people have to look for transport money to go and access health services. Such a situation decrease access propensity of people given the general financial challenges people are facing in Zimbabwe. The economic accessibility denotes to level of affordability of services by target population. The consultation and drug fees are a barrier in accessing health services and these must be addressed in various ways including by reducing the user fees and increasing the capacity of people to afford these services.

For health services that are offered by providers to be acceptable, the services must be culturally appropriate. If they are socio-cultural barriers, they must be addressed in order to enable the communities to accept the services. Acceptance of services and health products is enhanced when service providers are sensitive to group differentials in terms of ability, literacy levels, physical conditions and so forth. For instance, pregnant women need special prioritisation at health services due to the condition. Age, gender and disability are some of the factors that must be considered in provision of services in order to improve access and utilisation of services.

The quality of services provided by service providers is vital in motivating people to seek health care services and in determining health outcomes of clients. Service that are scientifically and medically appropriate increase access and utilisation of health services, thus the TCE program must collaborate with other partners to ensure these issues are addressed if the quality of services are poor.

5.2.1 HIV testing and counselling (HTC)

The HTC uses both voluntary counselling and testing (VCT) and provider-initiated testing and counselling (PITC). The VCT allows individuals to learn their HIV status through pre- and post-test counseling and an HIV test. VCT is client-initiated, as opposed to provider-initiated testing and counseling (PITC) when health care providers initiate discussion of HIV testing with clients who are seeking health care for other reasons. VCT can be provided through stand-alone clinics or offered through community-based approaches, such as mobile or home-based HIV testing. In addition, counseling for VCT may take place at the individual, couple, or group level. The key inputs to the HTC is training of service providers, testing kits, supplies and equipment.

5.2.2 Antiretroviral therapy (ART)

The antiretroviral drugs are essential in HIV treatment and the TCE programs must work with the MoHCC and other partners to ensure availability and usage of these drugs. This includes incorporating advocacy for medical products or supplies within the TCE project.

5.2.3 PMTCT and Antenatal services

PMTCT services are important in averting new paediatric HIV infections and improving HIV-free child survival, thus the TCE program must take this component seriously. Since the majority of men are reluctant to accompany their partners in accessing ANC services, the TCE project must foster discussions on this issue in the community and mobilise men to go for ANC services with their partners.

5.2.4 TB diagnosis and treatment services

The HIV/TB co-infection is very high in Zimbabwe at 75%[3] , and the Global TB Report 2013 shows that HIV-positive TB patients are at 70% and TB patients with known HIV status are at 88%. This high co-existence of HIV with TB require that the TCE project to screening, diagnosing and treating TB in order to improve the welfare of target communities. Currently the community led mobilisation of TB is low, and many clinics have no microscopes and GeneXpert machines to diagnose TB.

5.2.5 Youth Friendly Services

Adolescents and youth are a vulnerable group in terms of HIV transmission because there are a host of hormonal changes that are occurring as the children are in transition to adulthood. At this stage adolescents like to experiment with a lot of things including engaging in sexual activities. However, adolescents have disadvantages because of the fact that they are economically and emotionally weaker than other people in the sexual reproductive age groups. This vulnerability of adolescents

[3] *Zimbabwe TB Program Country Team Portfolio Analysis Summary2012*

necessitates special programs and activities for this age group. These include youth friendly centres and Joint-In-Circuit that were proven effective in providing SRH services to both out of school and in-school adolescents and youths.

5.2.6 Condom distribution

Condom promotion and distribution is vital in increasing access and use of condoms to prevent HIV and STI transmission. The use of many condom distribution centres by TCE is commendable and recommended to continue since it significantly increase uptake and usage of condoms. However, this study shows that the female condom is not as used as the male condom because some women think that the condom is too big whilst others are afraid that their male partners may think that they like sex too much or they are perceived as prostitutes. Therefore, the TCE program must address societal barriers towards the use of female condoms.

5.3 Response Management

For the TCE program to be successful it must strengthen several HIV and SRH response mechanisms.

5.3.1 Institutional arrangement, coordination and management

This study reveals that the TCE did not put enough institutional arrangements to sustain the benefits of the program. Therefore, from the outset the TCE program must work hand in glove with key government departments and institutions such as MoHCC, NAC and ZNFPC in order to strengthen coordination and management of HIV and SRH service provision. Effective utilisation of resources can only occur when there is coordination and collaboration with key government departments and other partners in the area.

5.3.2 Enabling policy and legal environment

Local, national and international policies and acts affect access and utilisation of HIV and SRH services. Policies affects allocation of resources, thus the TCE must play a critical role in advocating for policies that support increase in access and utilisation of health services. The policies include local by-laws by the councils and community laws by traditional chiefs.

5.3.3 Gender transformative interventions

Men and women have distinct needs and priorities with regards to access and utilisation of health services. However, in all the communities in Zimbabwe there are some adverse or harmful gender norms, roles and stereotypes that prevent women and men to access and utilise health services. When implementing a TCE program it is important to take stock of all harmful norms, roles and stereotypes in the target area and develop interventions that transform these. Some of the interventions were discussed like gender dialogues and spousal discussions. Many stakeholders suggested gender training with local leaders and community members, but there are a number of gender transformative interventions that can be explored at the design stage of the TCE project.

5.3.4 Strengthening leadership commitment

Local, district and national leaders are important change agents with the communities and must be targeted to support the TCE program and to take the lead in influencing people positively.

5.3.5 Community systems strengthening

The TCE project uses positive living support groups, TRIOs and community home based care-givers to provide psychosocial support to PLWHA. This study has shown that the majority of the support groups dissolved soon after the completion of the project because most of them were not mentored to reach maturity or sustainable stage. Community groups normally go through four stages namely, (a) Infancy/Formation Stage; (b) Growth Stage; (c) Maturity Stage and (d) Sustainable Stage. The groups that are left in infancy or growth stage after the completion of the project usually dissolve quickly because they are not yet ready to operate on their own without external support. The TCE must ensure that support groups are mentored to sustainable stage before the completion of the project. Major issues that must be tracked include governance (leadership structure, constitution and adherence to constitutional requirements, participation of members and voice in decision making); resources (ability to mobilize own resources to fund group activities); objectives (clarity of vision, goals and aspirations); systems (financial, implementation, risk management and M&E) and impact (group's achievement of its objectives and understanding of the resultant impact and benefits.

Community home based care system is critical in providing care for PLWHA through primary and secondary care givers who must be equipped with relevant knowledge in skills in care-giving. Community led monitoring and reflection systems are necessary and the community members must be trained to monitor and review their activities. Other community networks, linkages and partnerships must be established to enhance service delivery and advocacy, to maximise use of resources and increase impact.

5.3.6 Resource mobilization and management

This study reveals that the TCE project in Mt Darwin did not put funding mechanism beyond the life span for the project. When implementing TCE it is imperative to scan for sources that will continue to fund critical TCE activities after the completion of the funding window. This calls for coordinated and collaborative approach in resource mobilization.

5.3.7 M&E and HIV research

The TCE program must incorporate strong M&E system in order to collect information and data that will be internalized and become knowledge that promotes learning. Learning from M&E will be used to improve the overall performance and quality of results of the current and future projects, programmes and strategies. M&E information will be used to track progress against the implementation schedule and to track changes that might call for adjustments of objectives, work plans or procedures. In essence M&E activities will give early warning signs for both positive and negative progress which enable project staff to modify particular elements in order to achieve the project goals. Apart from regular M&E activities the TCE project is recommended to incorporate operational research in specific areas that need special attention. Such research may require the involvement of consultants that design tools, collect, analyse and interpret data. The research component promotes evidence based programming.

5.4 HIV Impact Mitigation

5.4.1 Vulnerable households and sustainable livelihoods

It is important for the TCE project designers to assess possible sustainable livelihoods options for vulnerable households for the target area, and in women in particular must be prioritised since they have less access to resources compared to men. This must be done at the design stage so as to include the costs involved in the budget. Furthermore, there must be a link with organisations that primarily deal with livelihoods to achieve greater results.

5.4.2 Food security and nutrition support programmes

Food is important for both HIV+ people thus the TCE must include interventions that increase food and nutrition security. Food aid can work in the short term as relief but a more permanent solution is to empower vulnerable households to produce their food or alternatively to have income to purchase food. Food availability does not necessarily translate to a healthy family because some people have little knowledge on how to cook healthy meals, thus there is a need for nutrition education in TCE projects.

5.4.3 Legal rights and protection services for vulnerable people

Disenfranchisement of legal rights for vulnerable people such as people living with disability, children, PLWHA and women reduce access and utilisation of health services thus the TCE program must carry out assessments to determine these in a particular target area and develop interventions that enable the enjoyment of rights by rights holders. The TCE must advocate for protection systems that enable vulnerable people to be capacitated. In Zimbabwe social protection systems are generally weak due to funding constraints and the TCE must be active in generating ideas that strengthens these systems.

6 CONCLUSION

The TCE program has a potential to avail greater long term benefits to target communities if it deals suggestions raised stakeholders and beneficiaries from previous projects, and incorporate good practices from similar projects. Since gender affect access and utilisation of health services it is imperative at the outset of the TCE project to take stock of the practical and strategic gender needs of women and men within the target area and develop strategies that ensure that both men and women will benefit and also to generate strategies that increase equality among women and men. The TCE sustainability framework proposed here can be modified to suit local context and to suit available resources which may be limited and thus in such cases the designers must work closely with local people and stakeholders in finding priority issues. The proposed sustainability framework is dynamic and will need to be adapted taking into account emerging issues that are related to HIV/AIDS and SRH issues.

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