Evaluation of the SRHR/HIV prevention program of the Young Africa Skills Center in Chitungwiza, Zimbabwe

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Abstract

Introduction: Zimbabwe is one of the countries where the HIV/AIDS prevalence is one of the highest in the world. A large part of the young adults is at risk of being infected or is already HIV/AIDS patient. Young Africa wants to create awareness and prevent the disease from spreading by giving their students Life Skills Training which teaches them not only about HIV/AIDS, but also addresses relating issues like SRHR and gender.

Evaluation objectives: The objectives of the evaluation are to see if the preferred changes took place in the knowledge, behavior, risk perception, attitude and future plans of the students and to see if the evaluation workbook Are you on the right track? of Stop Aids Now! and Rutgers WPF is a useful help in doing this.

Methods and results: For the evaluation 35 YA students and 19 former students were given a questionnaire as well as a comparison group of 36 people. The results show that the former students have a higher knowledge of HIV/AIDS related issues than the current students and the comparison group. They also have a higher risk perception, however the risk perception is high in all groups. The attitude of all groups is also generally positive. On the questions in the category ‘intentions’ however the former students chose the safe options, not having sex and using a condom, more often. In the category ‘skills’ the differences were small again and conclusions hard to draw, because of the way questions were stated. In the last category, ‘social influence’, it is clear that former students are more open to talk about sex related issues and would talk to peer educators and health workers about it more often than the comparison group.

Conclusion: The YA Life Skills Training has a positive effect on the knowledge, risk perception, intentions and ways in which people let themselves be influenced. The workbook Are you on the right track? provided useful tools for the evaluation and was a great help in the process.

Introduction

The Young Africa Skills Center in Chitungwiza focuses on the education of young adults in practical skills, with which they will be able to find a job or start up their own business with which they can provide for themselves and their families. But besides that Young Africa also wants to empower young adults so they can make their own choices in life and live a satisfying life. Therefore all students have to take part in the Life Skills Training, which focuses on sexual and reproductive health and rights (SRHR) in which HIV/AIDS prevention plays a large role.

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Zimbabwe, as a Sub-Saharan country, belongs to that part of the world where the HIV/AIDS epicenter of the HIV/AIDS epidemic can currently be located. (Adler 2005:62, National AIDS Council 2011:7) HIV prevalence is high and therefore not only the people suffering from an infection, but also their family and friends and the country as a whole are affected by the disease. According to Adler the life expectancy of people with AIDS in Zimbabwe is about half of that of the ones who are not infected. (2005:64) Which will because of the high prevalence rate eventually cause a loss of labor force of 23% by 2020 and besides that a severe loss of teachers, health workers and security forces, all of which are groups with a higher risk of infection. (Adler 2005:65,66)

For the young adults in Zimbabwe, who are the target group of the YA Life Skills Training, the numbers do not look very good. According to the Zimbabwe Demographic and Health Survey (ZDHS) of 2010-11 4.2% of the women who are 15 to 19 years old is HIV positive and 3.4% of the men in that age group. Of the 20 to 24 year-olds 10.6% of the women and 3.8% of the men are infected and of the 25 to 29 year-olds this is respectively 20.1% and 10.3%. (ZIMSTAT 2012:218) This means that the number of infected women almost doubles every five years and the number of infected men almost triples between the last two age groups.

The fact that people with HIV or AIDS are stigmatized does not make it any easier. Duffy, who studied the stigmatization of HIV patients in Zimbabwe, writes that the stigma does not only change the way people look at someone with HIV, but also the way someone looks at himself. (2005:15) People get isolated, because no one wants to associate or share anything with an AIDS patient and this is why many people rather keep quiet or do not even want to know their HIV status. (2005:16) This stigma seems to be worse for women, because they are more than men expected to be faithful and having HIV is strongly associated with promiscuity. (2005:16) But not only women are affected by the stigma of HIV and AIDS infected people, men also suffer under prejudice. In many African countries a masculinity is associated with being independent, physically strong, fearless and sexually unstoppable. (Skovdal et al 2011:2) Having HIV or AIDS does not fit in this picture and therefore it will hurt a mans manhood to admit that he is infected.

Other factors to take in to consideration when looking at the HIV/AIDS epidemic in Zimbabwe are local value systems, which make Zimbabweans and Zimbabwean women in particular, more vulnerable to get infected. Cultural practices like polygamy, widow inheritance, girl pledging and forced marriage, intra-vaginal practices, Chiramu (a husband having sex with his wife's sister), post menopausal abstinence for women, during which a husband may have sex with other women, and the practice of paying Lobola, which puts men often in a dominant position, all enlarge the change of getting infected. (National AIDS Council 2006:9)

To prevent the epidemic from getting worse, and to make young adults aware of the risks and the ways in which they can protect themselves, education is very important. (Duffy 2005:19, Adler 2005:67) This is also important to reduce the stigma about HIV/AIDS patients, because a lack of knowledge is one of the main factors to keep a stigma alive. (Genberg et al 2008:1) This is why YA teaches students what HIV/AIDS is, how to prevent it and how to act when you or a friend or family member gets infected, but besides that related issues like STI's, gender and SRHR are addressed.
Evaluation objectives
The objects of this evaluation are not only to see in how far the intervention program caused changes among the students in their knowledge, skills attitude and behavior concerning SRHR and HIV/AIDS, but also to see if the evaluation workbook of Stop Aids Now! and Rutgers WPF, ‘Are you on the right track?’, is an effective help to do this.

The preferred changes would be that students after following the YA Life Skills Training have more knowledge about HIV and AIDS, that their risk perception is improved, that they have a positive attitude towards gender related issues, that their plans for the future are responsible and safe, that they gained skills to act according to those plans and that they are not influenced by the wrong people, but choose responsible adults and peers to be their example.

Methods and results
Methodology
To get a good impression of the effectiveness of the SRHR/HIV prevention program of the Young Africa Skills Center I chose to use the questionnaire given in the evaluation workbook of Stop Aids Now! and Rutgers WPF, because it is the best tool if you want to reach a larger group of people and in my opinion it gives all the information needed to see if the program works well.

To get a good idea of the changes the program causes in the knowledge and behavior of people I chose to use a comparison group that consisted of students of the same age and background as the students of Young Africa, only who had not participated in the program. I used the students of the Academics Department at the Young Africa Skills Center, because the intervention program is not part of their curriculum, but if they want more information on the subject they can use the counseling services at the Young Africa Skills Center.

Besides the current students of Young Africa, who are participating in the intervention program now, I decided to include former students in the evaluation, not only because they have already finished the whole program and can therefore be considered to have mastered all the knowledge and skills presented in the program, while the current students are still learning and not all subjects might be covered, but also because including them would show if there are any changes in the results over the past three years that the program is running. It was however extremely difficult to find former students, because students did not answer the phone, had changed their number, did not have time to come or had moved out of Chitungwiza, so in the end I only got 19 former students to fill out a questionnaire, but I do not think this will be of a major influence on the reliability of the results.

In total I got back filled out questionnaires of 35 current students, 19 former students and 36 comparison group students. I tried to keep a gender balance in all groups, but as I did not want to throw any results out because of the already small size of the groups I did not get a fifty-fifty result. The average ages of all groups are close enough to make them comparable. The highest level of education of most of the respondents is secondary school or higher and I do not think that the difference between secondary education or college/university will be relevant for the purpose of this evaluation.
I also interviewed the SRHR/HIV counselor of the Young Africa Skills Center, because she is the one to whom students come for information and advise on sex related issues, so she knows which ideas, norms and values live among the students and could provide background information about the situation. She answers all the questions they ask her, to create openness on sex related issues. The peer educators were still following a training, so I could not incorporate them in the evaluation, as they were not teaching yet.

I did observe two of the lessons of the Life Skills Training. One was on what HIV/AIDS is and the difference between HIV and AIDS and the other was on stigmatization. Both times the teachers were confident and clear and the lessons interactive. The students, especially the girls, were encouraged to participate to by commenting on statements and answering questions. The YA Skills Center tries to get professionals from the field, like health workers, to facilitate the lessons. If the right person could not be found or is not willing to participate the lesson is given by the SRHR/HIV counselor or the Youth and Development Coordinator of the center.

I also got background information at the National AIDS Council of Zimbabwe, who recently opened a small library, which when finally found provided me with the statistics of HIV/AIDS prevalence in Zimbabwe and the intervention program of the government.

Analysis
The data that was collected through the questionnaires was put in OpenOffice.org Calc, a data process program similar to Excel. All the students and the questions were put in a table. The answers were coded with the numbers 0 to as much options as there were for a particular question. So if a questions has the options 'yes', 'no' and 'I don't know' 0 stands for 'yes', 1 for 'no' and 2 for 'I don't know'. For the ones that had no answer I used 99. After this the given answers could be counted and percentages of students giving a certain answer could be calculated an put into graphs. For some questions all YA students are taken as one group, for other the current and former students are taken as two different groups, because of a considerable difference in the answers.

Results
The questions on the questionnaire are divided in six categories: knowledge, risk perception, attitude, intentions, self-efficacy and skills, and social influence. I will discuss the results per category.
The first five questions tested the knowledge of the students on SRHR and HIV related topics. Duffy noted in her article that the general level of knowledge of HIV/AIDS in Africa is high (Duffy 2005:18), which for Zimbabwe means that of the young adults of 15-24 years old in the urban areas 59.1% of the women and 62.8% of the men has a comprehensive knowledge of HIV, which means they know that condom use and faithfulness reduce the risk of getting infected, that a healthy looking person can have HIV and that they reject common local misconception. (ZIMSTAT 2012:206) These numbers are in accordance with the results of the questionnaire, as a high percentage of the comparison group compared to YA students still gives the right answers. For these questions the difference between current and former students is considerable and therefore they are taken as two different groups for these questions. The comparison group scored even better on this part than the YA students that are currently following the Life Skills Training. 54% of the current students answered that it is not true that a girl can not get pregnant the first time she has sexual intercourse compared to 66% of the comparison group. Of the former students however 84% chose this answer. (Graph 0.1) On the next question, if a person can tell by looking that another person has a sexually transmitted infection, about half of the current students (54%) and the comparison group (50%) answered ‘no’, compared to 89% of the former students. (Graph 0.2) Of the former students also a larger part (58%) knows that it is possible to contract HIV by having anal sex, compared to 40% and 39% of respectively the current students and the comparison group. (Graph 0.3)
0.3) And on the question if homosexuality is a disease 66% of the comparison group and 63% of the former students answered ‘no’ compared to 54% of the current students. On the question how one can protect oneself from HIV transmission more answers were possible. All groups scored high on condom use and abstinence. The differences were mainly in the percentages that chose the option ‘faithfulness’, 56% of the comparison group, 66% of the current students and 84% of the former students, and the option ‘both partners taking HIV test before sex’, 50% of the comparison group, 60% of the current students and 74% of the former students. (Graph 0.5) What we can conclude from these questions is that the knowledge is generally high as high percentages of the comparison group got the right answers. The knowledge of the former student is higher than of the current students, probably because they already finished the SRHR/HIV prevention program, while the current students had followed only 2 of the 6 months training at the time they were given the questionnaire.

The next questions in the questionnaire were about risk perception. The Zimbabwe National Behavioural Change Strategy 2006-2010 says that many Zimbabweans know that HIV/AIDS is a threat for the population, but that the personal risk perception is still low. (National AIDS Council 2006:7) But if the interventions taken since in the period 2006-2010 worked out well this should be better now and the results of the questionnaire imply a high personal risk perception under young adults. 75% of the comparison group and 74% of the current students acknowledge that HIV/AIDS is a threat to their personal health. (Graph 0.6) Only 63% of the former students gave the same answer, but that can be explained by the fact that because of their knowledge of HIV/AIDS and their lifestyle (74% is not planning to have sexual intercourse within the next six months as can be seen graph 1.8). If they think they know how to prevent getting infected the risk may seem and probably is less high. This is confirmed by the fact that the amount of former students that knows that they are likely to get HIV infected if they have unprotected sex is just as high as that of the current students and comparison group, 79% versus respectively 74% and 75%. (Graph 0.7) That having unprotected sex does not only enlarge the risk of getting infected with HIV, but can also cause women to become pregnant is known by 84% of the former students compared to 71% of the current students and 72% of the comparison group (Graph 0.8), however all
groups see becoming pregnant as a teenager as a problem in an equal amount of 80-90%. (Graph 0.9) The last question of this part was if having anal sex is a safe way to protect oneself from STI's. Here the former students had a better risk perception, 74% of them answered 'no' compared to respectively 66% and 58% of current students and the comparison group. (Graph 1.0) From the answers to these five questions can be concluded that the former students who have completed the SRHR/HIV program have a higher risk perception than the other groups, but also that the average risk perception among young adults is high in all groups.

Most of the questions in the category 'attitude' are answered in the same way by all the three groups. About three of every four people thinks the ideal age of having sex for the first time is 20 years or above (Graph 1.1) and almost everybody thinks a girl can not be forced to have sex (Graph 1.3) and that girls and boys can be friends without having sexual intercourse (Graph 1.4). On the question if a girls is asking to be raped if she wears figure hugging clothes the majority said 'no', 74% of the former students chose this answer, 67% of the comparison group and 57% of the current students (Graph 1.2). There is a noticeable difference between the current students and the comparison group which can not be explained by either gender balance of the group or any other factor, so it is probably caused by the small size of the groups which affects the reliability of the data. It is also interesting to see that 72% of the comparison group thinks all young people should use a condom when having sexual intercourse compared to just 54% of the current students and 58% of the former students (Graph 1.5). Maybe this can be
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explained by the fact that the YA students have a better knowledge of when you can have safe sex without using a condom (e.g. when both partners are tested and not infected), but there might be other explanations. On the question if it should be acceptable for people of the same sex to have a sexual relationship 89% of the former students answered 'no', which is more than current students and comparison group of which respectively 66% and 69% answered 'no' (Graph 1.6). This is because homosexuality is prohibited by law in Zimbabwe and therefore not encouraged in the SRHR/HIV lessons. In conclusion it can be said that the attitude of young adults towards sexual rights is tolerant, as they think that boys and girls should have the same rights and should not be forced into a sexual relationship.

The next category of questions is about 'intentions' and focuses on the future plans of the students. On the question if they think they will have sexual intercourse within the next six months about half of the comparison group (56%) and the current students (51%) answered 'no' compared to 74% of the former students (Graph 1.8). The former students are probably more aware of the risks of having sexual intercourse and are advised to abstain from sex in the Life Skills Training. Graph 2.0 shows that a large part of them does think they will use a condom when they will have sexual intercourse (84%). Of the current students almost a same amount says they will (80%) and a smaller part of the comparison group is planning to do so (56%). This tells us that the promotion of condom use in the prevention program is very effective. On the question if health services will be sought when needed in the future there is no big difference between the groups, about 80% of all of them say they will (Graph 1.9). The answers to these three questions suggest that students who followed the Life Skills Training altered their plans for the future, as a larger portion plans to abstain from sex and they plan use a condom if they will have sex in the future.
The questions in the category 'self-efficacy and skills' were all questions on which multiple answers were possible, which was not understood by all students, so some of them only gave one answer, which of course influences the results and makes it hard to draw hard conclusions. On the first question, what you should advice to a friend who is undecided to have sex with her boyfriend, most people said they would give advise about the risk of getting pregnant or HIV infected (about 65% in all groups), tell them to wait until the get married (64% of the comparison group and 71% and 74% of the current and former students) and tell them to use a condom (58% of the former students, 67% of the comparison group and 71% of the current students). Almost nobody would advice their friend to go ahead (Graph 2.1). When asked what to do when someone is forced to have sex a larger part of former students answered to report the incident to the police than of the current students and comparison group (89% versus 57% and 69%), while most of the comparison group more people would break the relationship (53% versus 34% of the current students and 26% of the former students). Almost half of all groups would shout for help and about one in four would inform a teacher. Only a small group would report the incident to the parents (42% of the former students, 36% of the comparison group and 26% of the current students). It is interesting to see that 36% of the comparison group would fight the person to free themselves, compared to only 11% of the former students. (Graph 2.2) The Life Skills Training did have a lesson on rape last year in which students were encourages to report incidents to the police, which in combination with the fact that some people only gave one answer explains the high percentage of former students choosing this answer. The next question was how one can negotiate for safe sex with ones boyfriend/girlfriend. Al small group would use contraception (8%-16%). Of the comparison group 58% chose the answer ‘a no should be a no’, which is a large part compared to the 34% and 32% of the current and former students making the same choice. Of the former students the majority (74%) would convince his girlfriend/her boyfriend to use a condom, which is what 61% of the comparison group and 57% of the current students will do. Still about one in five in all groups day they will not be able to convince their boyfriend/girlfriend (Graph 2.3). On the question how one can avoid situations which can lead to sexual intercourse a large part of the respondents answered ‘no touching and kissing each other’, with a considerable difference between the portion of the comparison group and that of the former students picking this answer (61% versus 47%). Also ‘not being alone in an isolated place with the opposite sex’ was chosen often. 47% of the former students chose this answer, 40% of the current students and 36% of the comparison group. Of the comparison group 47% thinks that not wearing revealing clothes would help, compared to 31% and 32% of the current and former students. Not being in a relationship was seen as the right solution by 11% of the former students, 17% of the comparison group and an odd 34% of the current students. (Graph 2.4)

The last category of questions was about 'social influence'. The former students answered considerably more often 'yes' on the questions if the have friends who have sexual intercourse, if they have friends who have used a condom during sexual intercourse and if they have friends who abstain from sexual intercourse. (Graph 2.5-2.7) It can be that they are more open with their friends about sex so they know more about their friends behavior, or that because they followed the HIV prevention program

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2 In the questionnaire the word 'not' was not part of the question, but I think it would be safe to say that the way in which the answer is generally understood is as a negative statement.
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Graph 2.1
Your friend is undecided whether to have sex with her boyfriend or not. What advice would you give her?

Graph 2.2
Describe what one can do when he/she is forced to have sex.

Graph 2.3
Describe how one can negotiate for safe sex with your boyfriend/girlfriend

Graph 2.4
How can one avoid situations which can lead to sexual intercourse?
together with friends where they were encouraged to abstain and use condoms they have more friends who actually do so than people form the other groups. Probably it is a combination of both. Former students also answered more often 'no' on the question if young people are encouraged to have sex with older adults compared to the current students and comparison group. (Graph 2.8) The differences between the percentages answering 'yes' are not very large, but those between the percentages who answered 'I don't know' or gave no answer are, which may imply that former students are more aware of what is going in around them than the others. The Life Skills Training definitely had a positive effect in the openness about sex related issues, as 89% of the former students answers that they have talked about sex, HIV and pregnancy with an adult, compared to 51% of the current students and 61% of the comparison group. On the question who they talk to most about sex all groups had a high percentage answering 'friends'. YA students tend to choose for a peer educator or health worker more often than the comparison group while the comparison group talks more with their parents than YA students. (Graph 3.0) These answers can result from the fact that the YA students know who the peer educators are at the YA Skills Center and are taught by them in the Life Skills Training. They are also encouraged to talk to a health worker if they have any questions on sex related issues. This is probably also why these two option are chosen even more often when the students were asked who they would go to for advice on sex related issues. A large part of the comparison group would in this case also
go to the health worker. It is interesting to see that only half of the people who said they talked about sex mostly to their friends would also go to them for advice. (Graph 3.1) The next question was if parents/guardians treated boys and girls in the same way. 79% of the former students said ‘yes’, compared to 43% of the current students and 50% of the comparison group. I think this can be explained by the fact that 0% of the former students answered ‘I don’t know’, while 17% of the current students and 20% of the comparison group did. (Graph 3.2) This might suggest again that the former students are more aware of the situation. The same thing might explain why a larger amount of former students does not think the health care providers in the community friendly/approachable than of the current students and comparison group, who again answered that they don’t know more often. (Graph 3.3) The former students have probably more experience with the health care providers than the others, since they were encouraged to go to them for testing and advice in the Life Skills Training.
The final questions on the questionnaire gave students the opportunity to give their feedback on the program and to tell what they liked or did not like about the lessons. About half of the students answered these questions and most of them were very positive. Some of the reactions were:

'I liked the way the educators expressed themselves. They were very open to us.'
'Every lesson is so powerful and teaching.'
'It helps me to prevent getting this disease.'
'It helps us to be faithful to one partner and to be tested before having sex.'
'I like the HIV program cause it helps us while we are growing up.'
'The information they give about HIV/AIDS is very relevant.'
'We could express our feelings without being judged or ridiculed.'

This shows that the lessons are appreciated by the students. They understand the importance of the Life Skills Training and are willing to learn. Some of them suggested to make the lessons more entertaining by adding more drama, poetry, films and outings, so more people would enjoy attending the lessons.

**Conclusion**

**Life Skills Training**  
The effects of the Life Skills Training seem to be positive. The former students of YA, who followed the whole program last year, have more knowledge than the current students and the comparison group. The current students have so far only followed a part of the Life Skills Training and therefore do not yet have the same level of knowledge as the former students. The comparison group did not follow the SRHR/HIV prevention program of YA so the difference is knowledge between the comparison group and the former students can be attributed to the impact of the intervention. Besides the difference in knowledge the risk perception of the students who have followed the Life Skills Training is also higher than that of those who did not and their intentions for the future are more often responsible and safe. The SRHR/HIV prevention program also has a positive effect on the openness about sex related issues. Former students have talked more often about sex related issues with an adults than the youngsters in the comparison group and they know more often of friends that they abstain from sex or use a condom, which can be a positive influence on their own behavior. Former students do not only talk more about sex related issues, but they also talk to different people than the comparison group. The former students tend to go to a peer educator or health worker more often, which will ensure them of dependable information as these people are trained to answer their questions. The effects of the Life Skills Training on the skills of the students were hard to measure with the used questionnaire, because of the way the questions were asked, so I do not want to draw any conclusion, but looking at the positive changes that the program caused in the other categories, it would surprise me if the skills of the students would not have improved.

The positive effects of the Life Skills Training were also confirmed by the
SRHR/HIV counselor of YA. According to her the program gives the students the knowledge they need to make the right decisions in life. She says that especially the use of condoms has increased and that the students are conscious that having sex with multiple partners enlarges the risk of getting infected, so they became more faithful. She does note however that there is still a cultural barrier for girls to be open about condom use.

From these results it can be concluded that the SRHR/HIV prevention program at YA teaches the students what they need to know to make safe and responsible choices on sex and HIV related issues. It must be noted however that the sample groups that were given the questionnaire, especially the group of former students, were small, which may have influenced the results. But in spite of this I believe it safe to say that the results are dependable enough to state that the effects of the program are satisfying and that a good effort is made to make young people in Zimbabwe aware of the risks and prevention methods of HIV/AIDS, so that they can make the right choices in life which will not only affect them, but also their families, friends and community.

workbook
The workbook Are you on the right track? is a useful tool for the evaluation of an SRHR/HIV prevention program. It provides different tools which help you to do a complete and thorough evaluation from the first step of thinking about why you actually want to do an evaluation to the last step of documenting the findings. As with all workbooks, it is important to keep a critical attitude and adapt the tools to the given situation. Some tools might need some adaptions to fit a particular program, but overall it is easy to use, very clear and the results are satisfying.

The tools I have used were the interview guide for educators, parents, health care providers, and community leaders on page 64. It helped me covering a whole range of topics and it complemented the information from the questionnaires. What I, as an inexperienced interviewer, though difficult were the closed questions. Many of the questions can be answered by only ‘yes’ or ‘no’, which makes it in some cases hard to get in dept information.

I also used the questionnaire for young people on page 70. This helped me very much, because it covered all the different aspects of a good SRHR/HIV prevention program. I did add some questions, but used most of the questionnaire in its original form. There were some questions that I would have altered in the end, like a statement in a negative form, which can be confusing, and some of the answers in the ‘skills’ category could be stated clearer, like ‘sticking to own ideas’ as a way to negotiate safe sex. But these were just minor troubles. I did experience that the questions on which only one answer was possible were answered better, and were easier to analyze, than those where more answers were possible. Very often only one answer was given, even though it was written above the questions that more answers could be right. This made it hard to guess if people had not read the question well or if they really though only one answer was right.

The observation form on page 66 seemed a very useful tool, but as most of the lessons were given in Shona, which I do not understand, it was hard to get the exact information and details, even if someone translated (and probably summarized) some parts of it. So I unfortunately could not use this tool as I wanted. I also wanted to use the questionnaire on page 75 for the peer educators, but as had not finished their
training yet I did not use this tool either.

In the end the tools I used helped me to reach the objectives of the evaluation, so besides some small troubles, which are probably met in almost every research, the workbook was a great help and recommendable to others who want to evaluate a SRHR/HIV prevention program.

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Stop Aids Now!, RutgersWPF et al, Are you on the right track? Six steps to measure the effects of your programme activities, www.stopaidsnow.org/downloads or www.rutgerswpf.org