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The Impact of Traditional Shona Beliefs on HIV/AIDS Intervention Work in Zimbabwe

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Abstract

Zimbabwe has one of the highest rates of HIV/AIDS infections of all countries worldwide. The prevailing attitudes, beliefs and practices that permeate traditional culture within Zimbabwe seem to be contributing to the severity of its pandemic. Some of these attitudes, beliefs and practices include the way in which Zimbabweans regard HIV/AIDS testing and condom use, the traditional belief that HIV/AIDS infection are caused by unappeased ancestors rather than unsafe sexual practices, and the practices of polygamy, gender discrimination and traditional medicine.

This study examined the relationship between secondary students in the rural and peri-urban areas of Mashonaland in Zimbabwe and their tendencies to agree or disagree with traditional Shona attitudes, beliefs and practices as they related to the HIV/AIDS pandemic. A convenience, cluster sample was used to identify the 482 students who participated in this study. A questionnaire composed of demographics, hypothetical and open-ended questions was administered to these students within the regular classrooms of their respective schools.

The main finding within the demographics of this study included the discovery that the majority of students from each school reported that school teachers were their first information source for HIV/AIDS. A higher percentage of rural students claimed that teachers were their first source of HIV/AIDS. Another key finding in this section is that gender disparity in terms of female enrollment seems to be occurring at Matsine Secondary School. A final finding in the demographics sections is that the vast majority of students from both schools responded that they knew someone in general who died of HIV/AIDS, but failed to acknowledge someone in their own families who died from this

died. Peri-urban students were more likely to acknowledge an AIDS-related death in their family.

The hypothetical questions revealed a relationship between how students responded to questions and their geographical location. Students from rural schools were more likely to provide traditional responses when answering a question involving HIV/AIDS as the context.

The open-ended questions revealed that most of these respondents were aware of the cause of HIV/AIDS and the consequences of unprotected sexual intercourse. However, there were slight responsorial differences regarding the students' views on the best preventative methods against HIV/AIDS. Rural students were more likely than urban students to regard condom use as the best preventative measure. Urban students were more likely to consider abstinence as their preventative method. Another key finding in this section is that the vast majority from both schools considered traditional healers to be ineffective in assisting HIV/AIDS sufferers. Peri-urban students were more likely to believe that these individuals could either treat the symptoms or cure patients with HIV/AIDS. A sizable amount of students from both schools believed that traditional healers actually worsened the conditions of their patients. Peri-urban students were also more likely to make such an assertion.

The study indicates that Zimbabwean schools are effectively teaching students about the cause of AIDS/AIDS and consequences of unprotected sex. Because more rural students seem to rely on teachers for information about HIV/AIDS and fewer females are enrolled in these schools, the implications are that youth in these areas may be more to HIV infection.

The vast majority of students from both schools may be unable or unwilling to acknowledge that AIDS-related deaths are occurring in their family. This indicates that these students may be in a state of denial about this disease. Students may be ashamed or possibly frightened to admit such deaths in their families, which may be attributable to stigmatization of HIV/AIDS sufferers within Shona society. The implication is that more advocacy needs to be occurring to provide support for HIV/AIDS sufferers and address stigmatization throughout the country.

Finally, the implication that most students do not believe traditional healers can effectively treat HIV/AIDS is that faith in this aspect of traditional culture is waning in the wake of this pandemic. The fact that many students fear that traditional healers worsen the conditions of their patients indicates that various forms of medical malpractice may be occurring in this sector of Shona society. The implication is that more government supervision is needed in this area.

HIV/AIDS in Zimbabwe: Statistical Evidence of a National Tragedy

The HIV/AIDS pandemic has become the leading cause of death in Zimbabwe for people between the ages of 15-49. According to the World Health Organization (WHO), the life expectancy for Zimbabweans has been reduced by more than 20 years as a result of this pandemic (WHO 2003: 8). Zimbabwean men and women now have estimated life expectancies of 40.9 and 37.89 years of age, respectively (CIA 2003).

The Joint United Nations Program on HIV/AIDS (UNAIDS) has estimated that 2,300,000 adults and children from a total population of 11,634,663 in Zimbabwe are living with HIV/AIDS. Zimbabweans between the ages of 15-49 account for 2,000,000 of these HIV/AIDS cases. From this population, 1,200,000 of these individuals are females, while males make up the remaining 800,000 cases (UNAIDS 2002: 190). Journalist Dennis Kapata with the Zimbabwe Mirror reported that approximately 1.1 million Zimbabweans are expected to die from this pandemic by 2005 (Kapata 1998). According to the Situational Assessment and Analysis conducted by UNICEF, one Zimbabwean dies of an AIDS-related illness every five minutes (UNICEF 2000).

Zimbabwe's epidemic skyrocketed from a 29% HIV infection rate in 1997 to a rate of 35% in the year 2000 (UNICEF 1999). According to Zimbabwe's Ministry of Education (MOE), this disease is systematically killing the country's youngest and most productive members. According to the MOE, the AIDS pandemic has increased markedly for Zimbabweans between the ages of 20-30 during the 1990's. "A look at the current statistics for AIDS in Zimbabwe indicates that the majority of people with HIV/AIDS are in the economically productive age group, 20-39 years" (MOE 1996: 21). Zimbabwe's enormous percentage of sexually-active HIV/AIDS sufferers poses a dire risk for those

young adults entering the age of sexual maturity. According to research published in *The Lancet*, increasing rates of HIV infection for sexually-active Zimbabweans poses a grave danger to young adults reaching sexual maturity. "One in four adults is currently infected, a level which, if maintained, means that a young person entering the sexually-active population today will have a two out of three chance of acquiring HIV infection before his or her fifty-fifth birthday" (Gregson et al 2002).

Zimbabwe's future in the wake of the HIV/AIDS pandemic seems quite uncertain. The country now has a population growth rate of .83%, which is far greater than the negative growth rate that UNAIDS and the Population Resource Center had predicted to occur in the country by 2003 (CIA 2003). However, this statistic is far less than the 3.1% growth rate that was recorded from 1982-1992. The National Economic Planning Commission of Zimbabwe warned of the devastating effects that the HIV/AIDS pandemic would have on the country's population and economic growth. "The current structure of the population decreases the nation's ability to save as the nation spends a large proportion of its resources on providing social services like education and health" (National Economic Planning Commission 1998: 4-5).

Journalist John Donnelly of the *Boston Globe* may have caused premature optimism for Zimbabwe with speculative reports that HIV infections in the country were possibly in decline (Donnelly 2003). However, UNAIDS and WHO have argued that this is not the case. They have concluded that the lower than expected infection rates were due to inaccurate estimates of the Zimbabwe's actual population size. "The corrective estimates therefore show no actual decline in HIV prevalence in the country, but do

confirm the leveling off of prevalence rates at very high levels since the late 1990's" (UNAIDS and WHO 2003: 9).

The Impact of HIV/AIDS on the National Economy

The HIV/AIDS pandemic is having a profound macroeconomic impact within many Sub-Saharan African countries, where infection rates are particularly high. Journalist Alexa Dalby of *African Business* underscored the negative impact of HIV/AIDS upon the entire continent of Africa. "It is estimated that AIDS reduces the GDP growth in Africa by .5% to 2.6% a year on average" (Dalby 2003).

Zimbabwe's national economy has suffered severely from losing many of its most productive population of 20 to 39-year old citizens, who have been among the worst affected by this pandemic. UNICEF suggested that the pervasiveness of HIV/AIDS throughout Zimbabwe could destabilize all professions within the country's workforce. "AIDS appears to be present among all socioeconomic groups. Its spread among the professional elite could result in severe disruption in administrative and economic activities" (UNICEF 1994: 84). With more of Zimbabwe's working population being affected by this pandemic, fewer international businesses seem willing to invest in the country's fledgling economy. Thus, fewer jobs will be available in a country that already suffers from an estimated 60% unemployment rate (CIA 2003). The Southern Africa HIV/AIDS Information Dissemination Service (SAFAIDS) states that the crippling effect of this pandemic on Zimbabwe's national workforce may result in a crisis of investor confidence. "The most recent economic studies indicate that HIV/AIDS can negatively affect a nation's overall economic growth, which in turn is likely to hinder the success of

trade and investment initiatives by limiting the number of businesses that are willing to invest in Africa" (SAFAIDS 2002: 6).

The HIV/AIDS pandemic is also having a severe microeconomic impact on Zimbabwe, affecting rural and urban families throughout the country. An estimated 62% of all Zimbabwean families are considered to be living in poverty. SAFAIDS points out that this pandemic can have a devastating effective upon families. "HIV/AIDS is known to be a disease that tends to impoverish families, particularly because infected individuals are often the main income earners in the household. As a result, families end up earning less but spending more on health care, leaving few resources available to purchase other goods" (6).

According to the Young Adult Survey (YAS), which was conducted by members of the Zimbabwe National Family Planning Council (ZNFPC), ten percent of the youth interviewed between the ages of 15-29 reported having at least at least one family member who was too ill to work for three or more months in the past year (ZNFPC 2002). The problems of HIV/AIDS and poverty within Zimbabwe seem to be intertwined. The Government of Zimbabwe warned that it may be impossible to reduce the rate of HIV infection without also addressing poverty conditions within Zimbabwe "Without a marked improvement in the economic performance of the country, there is little hope of improving the living conditions of the population. There is also little hope for increased resources being channeled to the provision of essential services (health, education, shelter) which are an essential part of fighting the problem of HIVAIDS" (Republic of Zimbabwe 1999: 9).

HIV/AIDS is also believed to have an extremely negative affect on the national food supplies of several sub-Saharan African countries. Journalist Larry Elliott with *The Guardian* has suggested that HIV/AIDS and famine are also intertwined. "There are fewer people of working age and those affected by HIV/AIDS are less productive, yet demand for food has risen and the population is more vulnerable to shorter rations" (Elliott 2002). As the nation's supply of food declines, those affected by this disease will probably become even more ill as they struggle for daily nourishment. UNAIDS warns of the negative impact that malnutrition has upon HIV positive individuals. "HIV/AIDS and malnutrition often operate in tandem. Poor nutrition increases the risk and progression of disease. In turn, disease exacerbates malnutrition" (UNAIDS 2004).

UNICEF has reported that half of Zimbabwe's population is below the age of 18 (UNICEF 1999). Because such a high percentage of the overall population is comprised of such youths, it is important to the country's future growth and productivity that effective HIV/AIDS intervention programs are developed. Unless the attitudes and behaviors of Zimbabwe's youth towards HIV/AIDS undergo a rapid transformation, the country can expect continued economic and social hardships created by this disease.

Intervention Efforts for the Next Generation

Zimbabwe seems to be looking to the next generation of 12-19 year olds as the nation's hope for future economic and social productivity. According to Paulette Schatz and Kuzvinetsa Dzvimbo of the Canadian Society for International Health, the Zimbabwean school system have provided its youth with an AIDS action program, addressing the development of life skills, existing gender roles, the impact of peer pressure, and the dynamics of personal relationships and community involvement since

1993 (Schatz and Dvzimbo 2001: 135). According to Focusing Resources on Effective School Health (FRESH), an international program launched at the 2000 World Education Forum in Senegal, this school-based program is designed to dissuade youth from risky sexual behavior by offering them more information about the pandemic. "The program is aimed at students and teachers in grades 4-7 in all primary schools, and in grades 1-6 in all secondary schools. It aims to develop pupils' life skills such as problem solving, informed decision making and avoidance of risky behavior, using participatory and experiential teaching and learning processes" (Fresh 2000).

The Ministry of Education and Culture in collaboration with the Ministry of Health and Child Welfare, the National AIDS Council and other non-governmental organizations in Zimbabwe have led an aggressive public awareness campaign within secondary schools throughout the country, focusing mainly on messages of abstinence and prevention. The Ministry has disseminated educational posters, leaflets and newsletters within secondary schools to foster greater awareness of HIV/AIDS. It has mandated drama and debate programs, which focus on the AIDS pandemic, within the national education curriculum for secondary schools. The Ministry has also organized national HIV/AIDS quiz-team competitions for secondary schools.

Secondary school students may be ideal recipients for the government's HIV/AIDS campaign for several reasons. These individuals are at a stage in their lives where they are mature enough to begin thinking about their sexuality, but may not have yet engaged in sexual activities. Reports vary regarding the age in which Zimbabwean boys and girls experience their first sexual encounters. According to research published in *The Lancet,* focus groups conducted with Zimbabwean youth between the ages of 15-

24 indicated that the median age of first sexual encounter for boys and girls was between 16-17 years (Gregson et al. 2002). The Government of Zimbabwe has reported that the average age for first sexual encounter is 16.6 years for boys and 17.6 years for girls (Republic of Zimbabwe 1999: 13). Secondary school students generally commence their secondary school studies at the impressionable ages of 12-14 years, which may render them more receptive to HIV/AIDS information. Research published in the *International Family Planning Perspectives* suggests that HIV intervention is most effective when conducted with younger audiences. "Studies suggest that sexual responsibility interventions have the greatest impact on young people before they initiate sexual activity, perhaps even before they reach puberty" (Kim et al. 2001).

Secondary school teachers may also be the ideal people to address youth about HIV/AIDS. These instructors have an inordinate amount of power in helping or hindering students from continuing onto advanced and tertiary educational levels. They are revered and at times feared, because of their reliance on corporal punishment as a disciplinary technique. Secondary school teachers invariably command the respect and attention of their students. Their role in the government's school-based program is crucial, because they are responsible for bringing modern health-related information to students throughout the rural, peri-urban, and urban areas of the country. Quite often, these instructors are the first sources of information regarding HIV/AIDS for these children.

International Funding for HIV/AIDS Projects in Zimbabwe

Zimbabwe has received a substantial amount of past grant and loan funding from members of the international community for various health-related programs, which have been led by both state and non-governmental organizations. The government received a

$645 million loan in 1993 from the World Bank for efforts to control sexually transmitted diseases. Amir Attaran and Jeffrey Sachs noted in *The Lancet* that the US Agency for International Development (USAIDS) contributed $6.4 million in 2001 for Zimbabwe's HIV/AIDS prevention programs and care facilities (Attaran and Sachs 2001).

Unfortunately, international funds to combat this pandemic in Zimbabwe appear to be declining, even though the rates of HIV infections have remained relatively high. "The International aid effort is greatly incommensurate with the severity of the epidemic" (ibid). International donor fatigue for Zimbabwe may be heightening for several reasons. Until recently, Zimbabwe's national infection rate had shown no indication of leveling off. Such figures may have convinces donors that their funding was being wasted on ineffective HIV/AIDS intervention programs. Journalists Lara Weber and Luke Seeman of the *Chicago Tribune* have reported that international disenchantment for Zimbabwe's current social and economic policies may also be fueling such donor fatigue (Weber and Seeman 2002).

Many of the HIV/AIDS prevention programs throughout Africa simply do not seem to be reaching a very large portion of the counties' inhabitants. Within Zimbabwe, youth between the ages of 15-24 still remain one of the most vulnerable populations to this pandemic, despite all of the funds allocated and information disseminated to secondary schools nationwide for HIV/AIDS education. Paulette Schatz and Kuzvinetsa Dzvimbo of *Health Promotion International* questioned whether HIV/AIDS intervention programs were having any measurable effect in slowing down infection rates. "Despite a variety of AIDS prevention programmes, today's teenagers in this South African country continue to practice risky sexual behavior, thereby exposing them to infection. A US

$700 million education and condom programme has done little more than delay the inevitable" (Schatz and Dzvimbo 2001: 127). It is perhaps time to reexamine the manner in which these HIV/AIDS programs are being implemented and to explore why current programs are largely ineffective. This leads to two seminal research questions: What factors are contributing to the escalation of the HIV/AIDS pandemic in Zimbabwe? How can these factors be addressed by HIV/AIDS intervention workers in order to change the attitudes and behaviors of Zimbabweans towards HIV/AIDS?

The current research proposes that a significant factor contributing to the severity of this pandemic involves the role of traditional Shona culture within the lives of Zimbabweans. These cultural beliefs affect the manner in which Zimbabweans view such pivotal health-related issues such as condom use, sexual practices and the causes and treatments for HIV/AIDS.

Challenges for HIV/AIDS Intervention Workers

Traditional Shona beliefs influence the perceptions of many Zimbabweans towards social issues such as marital and sexual relations, gender roles, illnesses and deaths, and supernatural phenomenon. All of these social issues seem to affect HIV/AIDS interventions efforts to varying degrees. Traditional influences may be stronger within rural areas, where village chiefs and traditional healers seem to have greater authority. Such traditional beliefs may be weaker in urban areas, because Western ideas and influences have permeated these areas. Professor Michael Bourdillon, former Department of Sociology faculty member at the University of Zimbabwe, points out that some urban dwellers have experienced limited exposure to the rural communities, thereby weakening their ties to traditional culture. "Many people have settled permanently in a city, have

rejected the traditional way of life in favour of more westernized culture…" (Bourdillon 1998: 319).

Identifying the underlying sociological factors that contribute to the spread of this disease will be a positive step forward in leading an effective HIV/AIDS intervention campaign. Global health workers and researchers concede, however, that changing long-held attitudes and beliefs will be a gradual process. Indigenous and foreign HIV/AIDS intervention workers must still confront the unenviable task of convincing traditionalists to accept contemporary medical facts, which may contravene their cultural beliefs and practices. "Although it is unrealistic to expect to alter the underlying socioeconomic context quickly, understanding its nature and influence on local patterns of sexual behavior should aid development of more relevant and, therefore, more effective HIV prevention strategies" (Gregson et al. 2002).

Developing effective methods to address traditional attitudes and behaviors towards HIV/AIDS has proven to be particularly challenging to intervention workers. Researchers with *The Lancet* have voiced concern that HIV/AIDS awareness programs tend to focus exclusively on the scientific and medical aspects of the disease, while paying scant attention to cultural factors that may impact attitudes and behaviors. They question whether traditional adherents will be able to adapt contemporary medical explanations to their traditional lifestyles. "Studies show that most formal HIV/AIDS prevention messages are directed towards knowledge improvement and only superficially address cultural factors in the context of practice and not at all in the context of attitude and beliefs" (Ibid). Such prevention messages may seem so didactical to youths that they fail to assist them in developing the skills needed to make thoughtful decisions in their

own environs (Mackay 1998). “All too frequently, the culture (including school culture) has sought to issue commandments about sexuality to adolescents rather than assist them in developing the critical skills necessary to make considered decisions” (Schatz and Dzvimbo 2001: 128).

It is my hypothesis that secondary school students within the rural regions of Zimbabwe have been less responsive to HIV/AIDS prevention programs than those students from peri-urban regions, because of their tendency to embrace traditional culture and reject contemporary Western beliefs. There is a relationship between the geographical location in which Zimbabwean students reside and their tendency to incorporate traditional cultural attitudes, beliefs and practices into their lifestyles. If prevention programs become more sensitive to the traditional cultural influences of Shona students within rural areas, these individuals will be more responsive to HIV/AIDS intervention efforts. Collaborating with influential individuals such as traditional healers and village chiefs to develop an intervention approach that is more sensitive to cultural beliefs may improve the effectiveness of HIV/AIDS programs. They will, therefore, be more likely to alter their attitudes and behaviors towards matters of sexuality involved in the HIV/AIDS pandemic.

A Review of Traditional Shona Culture and Practices

In order to effectively gauge the impact of traditional beliefs on HIV/AIDS intervention work conducted within Shona society, it is important to narrow the focus of those beliefs being studied. As Professor Bourdillon suggests, culture can encompass a wide variety of elements within a society. "Culture includes everything that we learn in our society: the language we speak, how to behave, music and dancing, knowledge and ways of thinking, values, beliefs, the technology we use at work and at leisure – everything" (Bourdillon 1998: 7). For the purpose of this thesis, traditional beliefs will be viewed in two different contexts. I will examine traditional culture rooted in the supernatural phenomenon. This will include analyzing specific aspects of traditional religion, ancestral spirits, witchcraft, omens, and ceremonies. I will also examine traditional culture as it relates to established mores and folkways in Shona Society. This will include the analysis of influential traditional leaders, laws, customs, and practices as they relate to gender roles, sexual practices and HIV/AIDS.

Polygamous Overtones in the Traditional Story of Creation

Traditional Shona religion is not dissimilar to many other established religions worldwide in that it is steeped in supernatural ideas and phenomenon. These supernatural beliefs have a myriad of shared characteristics. Like the Christian, Jewish and Islamic faiths, traditional Shona religion is essentially monotheistic. The Shona refer to God as *Mwari,* which means "He who is". The traditional Shona religion also has a story of creation, strikingly similar to that contained in the chapter of Genesis from the Old Testament.

> In the beginning Mwari (God) created the first man, Mwedzi, whom he placed in a pool. He asked to be released into the world for the pool life

> was boring. He was given the go-ahead after a bitter debate with Mwari. Mwari had insisted that Mwedzi would regret it since the earth was a lonely and desolate place (Banana 1991: 44).

Much like the story of Genesis, Traditional Shona religion cites that the first man created (*Mwedzi*) asked for and received a mate from God, whose name was *Massasi* (or "the evening star"). Unlike Genesis, *Mwedzi* petitioned for and received a second wife, *Murombo* (or "the morning star"), after *Mwari* took the first wife back to the pools.

The traditional story of creation may be perceived as validating the culture of polygamy. Some intervention workers may consider polygamy to be an extremely risky practice in the wake of the HIV/AIDS pandemic. The African Marriages Act of Zimbabwe enables men to have more than one wife. SAFAIDS contends that the attitudes that polygamy generates towards sexuality may be the most dangerous aspect about this traditional practice. "Today traditional polygamy has generally given way to informal polygamy. Men's right to more than one wife is interpreted as their right to have sex with as many women as they wish, without obligations of fidelity or family responsibility; almost all women are seen as sexually available, regardless of age or status" (SAFAIDS 2001: 10).

The Role of Ancestral Spirits in Traditional Shona Religion

Ancestral spirits are central to the traditional Shona religion. Essayist Ignatius Zvarevashe asserts that traditionalists believe that their lives are controlled by these spirits (Kileff 1997: 44). They also believe that they must petition these ancestral spirits in order to have their prayers and wishes brought before *Mwari*. When bad things happen to traditional adherents, they often assume that it is the result of unappeased ancestors (59). This mode of thought may be quite damaging to HIV/AIDS intervention efforts,

because it seems to negate personal responsibility for one's physical actions. There is the danger that intangible ancestral spirits may become the scapegoats for irresponsible behavior. Thus, such behavior that puts people at risk of contracting HIV/AIDS may be even slower to change. Those who believe sexually transmitted diseases result from unappeased ancestors rather than unsafe sexual practices also seem to be rejecting that this disease is blood born and primarily spread through sexual intercourse.

There are two main types of spirits that traditionalists believe to be responsible for sicknesses and deaths. These include wandering and angry spirits. Both types of spirits are believed to cause symptoms, which seem to mirror those that HIV/AIDS sufferers experience during different stages of their illnesses.

Wandering spirits, which are referred to as *mashave* in Shona society, are considered to be born of those who have died without having any living relations upon whom they can descend and possess. These spirits may belong to any race or species. They may even belong to inanimate objects. Those possessed by wandering spirits are believed to display mild symptoms such as coughing, diarrhea, and nausea. Such symptoms may actually represent the early to middle stages of HIV/AIDS. By attributing these symptoms to wandering spirits, traditionalists may actually be denying HIV/AIDS sufferers the opportunity to receive early treatment, which may increase their chances of living longer.

Angry spirits, which are referred to as *ngozi* in Shona society, are considered to be one of the most dangerous supernatural phenomena in traditional religion. The angry spirit returns to the physical world to gain vengeance on a family, because of an alleged injustice committed while he or she was living. This spirit is believed to be able to cause

grave illnesses, destroy property, cause family discord and bring all types of misfortune. They are also believed to be quite difficult to appease. The symptoms that these spirits allegedly cause may actually mirror those that HIV/AIDS sufferers experience in the later stages of their illnesses. Because these spirits are believed to be so difficult to appease, traditionalists may mistakenly attribute the incurable condition of a full-blown AIDS patient as being the embodiment of an unappeasable, angry spirit. Traditional healers may even resort to desperate measures to cure these individuals, such as encouraging these them to sleep with virgins. Such advise would expose young women to highly infectious individuals.

The Role of Witchcraft in Traditional Shona Society

The traditional belief in witchcraft is extremely damaging to HIV/AIDS intervention efforts because it also seems to negate personal responsibility for one's actions. It is not uncommon for people in traditional Shona society to blame their problems on either witchcraft or sorcery. Those afflicted with an illness such as HIV/AIDS may declare that they have been bewitched, which seems like a denial of the biological factors in which HIV infection is passed from one person to another. If this is the case, then efforts by HIV/AIDS intervention workers to advocate abstinence or safe sex to avoid contracting this disease may become futile.

Professor Gordon Chavunduka, president of the Zimbabwe Traditional Healers Associate (ZINATHA), argues that claims of bewitchment in cases of HIV/AIDS infection do not necessarily constitute a denial of the biological factors contributing to the spread of this disease. Professor Chuvunduka points out that when Africans make such a declaration, it is merely their way of saying that they were unlucky:

> The problem which the African answers with his belief in witchcraft is this: 'why misfortune to me?' He knows that there are diseases which make people ill, he knows that hippos upset dugouts and drown people. But he asks himself, 'why should I be ill and not other people?' The man whose son has drowned when a hippo upset his dugout in effect says, 'my son frequently traveled by the dugout on the river where there are always hippos, why on this one occasion should the hippo have attacked and drowned him?' This he answers: 'because we were bewitched.' (Chavunduka 1997: 87).

Professor Chavunduka's thoughtful explanation of this traditional response to misfortune still seems like a lightly veiled denial of personal responsibility in which luck rather than bewitchment becomes the scapegoat for personal responsibility. Declaring an HIV/AIDS infected individual as merely being unlucky after he or she has engaged in risky sexual activities in a population teeming with HIV/AIDS seems to be a gross understatement. Such rationalizations also seem to obfuscate more meaningful explanations such as the infected individual being uninformed, inebriated or fatalistic when they engaged in risky sexual behavior.

Intervention workers may have a difficult time confronting the matter of bewitchment for several reasons. Bewitchment is a widely believed phenomenon that is seldom discussed publicly. The country's Witchcraft Suppression Act, which was established during colonial rule, makes it illegal to accuse another person of being a witch (Tucker 1999). Professor Chavunduka opined that the so-called practice of witchcraft has gone underground, because people fear the steep sentences imposed for violating this law (Chavunduka 1997: 103). The alleged practice of witchcraft seems to be shrouded by mystery and fear, which obviously makes open discourse about this matter quite difficult.

The general belief of bewitchment by Zimbabweans may complicate efforts of HIV/AIDS intervention workers, because it reinforces traditional Shona perceptions that

there are no natural deaths. Thus, a premature death resulting from HIV/AIDS may be more easily explained and understood by traditionalists as bewitchment. "The Shona worldview is heavily spiritual, and the physical and spiritual aspects of life are viewed interchangeably. The germ theory of disease is often not accepted by the Shona culture, many believing that if a person is ill, it is because a hex has been placed by an enemy or witch" (Hall and Nokes 1999).

Traditional Shona Ceremonies and their Impact on the HIV/AIDS Pandemic

There are several types of ceremonies in traditional Shona society. Some of these traditional ceremonies may be having a negative impact on HIV/AIDS intervention efforts. One of the most important ceremonies relating to ancestral spirits is known as the *kurova guva*. This ceremony is conducted one year after the death of an adult in order to bring their spirit back to family members to protect them from evil forces. Those failing to recognize their relative with this ceremony are believed to be vulnerable to diseases and misfortunes. Some within the Shona culture may blame AIDS-related illnesses and other family misfortunes on their failure to appease ancestors. Individuals conducting such ceremonies may also obtain a false sense of security, believing that they will be protected from HIV/AIDS, even if they engage in risky sexual behavior.

The Shona also have an inheritance ceremony, which is referred to as the *kugadza nhaka*. This ceremony enables a widow to wed the brother of her deceased husband, provided that she is relatively young (Bourdillon 1998: 213-4). If the husband died of AIDS, it is quite likely that the widow will also have this disease. The inheritance ceremony can leads to the transmission of communicable diseases from one relative to another, perpetuating this pandemic.

The Role of Mores and Folkways in Traditional Shona Society

Folkways such as societal attitudes and behaviors towards condom use, HIV testing and sexual practices have negatively affected efforts by HIV/AIDS intervention workers to combat this pandemic. Mores such as marital customs and inheritance laws have also affected efforts by intervention workers to seek greater gender balance within the country.

The attitudes harbored primarily by Shona men towards condom use have hindered efforts by HIV/AIDS intervention workers to lead an effective prevention campaign. Although most seem to understand that condoms protect against sexually transmitted diseases, they fail to use them for various reasons. Researchers Danuta Kasprzyk and Daniel Montano have suggested that some are reluctant to use condoms, because they believe it interferes with the pleasures associated with sexual intercourse (Kasprzyk and Montano 2001). Dagobert Mureriwa, an intervention worker with the Harare HIV/AIDS prevention organization, Deseret International, noted that Zimbabwean men considered condom use during sexual intercourse to be the rough equivalent of "eating a sweet with the wrapper still on it" (Author's interview 2003). Professor Chavunduka concurred stating that men seem to understand the consequences of having unprotected sex, but still tended not to use them. "Having sex with a condom is no longer considered to be sex. It's masturbation. This may be traditional culture and it's been one of the biggest problems to overcome (Author's interview 2003).

According to SAFAIDS, traditional Shona men frequently associate condom use with promiscuous behavior. Many believe that condoms should be used solely with commercial sex workers and casual partners, and refuse to use them their wives

(SAFAIDS 2001: 19). Unfortunately, it is quite common for married Shona men to have multiple partners. “Many men and women think that it is natural for men to have more partners, or that a man’s sexual drive is so strong that it cannot be controlled. So boys grow up believing they have a right to have sex whenever they want it and girls grow up believing it is their duty to satisfy men” (10). Many of the men engage in extramarital affairs with high risk populations such as commercial sex workers. If these men either fail to use condoms or use them incorrectly in such situations, then they put their spouses at high risk of contracting a sexually transmitted disease.

Some Zimbabweans regard condoms as unreliable at best and agents of the pandemic at worst. The Modeling and Reinforcement to Combat HIV/AIDS (MARCH) Project, which was composed of members from the Centers for Disease Control (CDC), the National AIDS Council (NAC) and the Ministry of Health and Child Welfare (MOHCW), gathered qualitative data from rural and urban Zimbabweans to gauge general attitudes towards condom use. The study revealed a cultural belief that condoms were responsible for the rise in HIV/AIDS. They “were sometimes viewed as a source of infection, and were associated with the loss of traditional values and the adoption of Western values that encouraged sexuality” (The MARCH Project 2002).

A study conducted by members of the Department of Psychology with the University of Zimbabwe also found that over 90% of the males interviewed believed that most types of condoms, especially those supplied by hospitals, clinics and peer educators, were infected by sexually transmitted diseases. “None of the groups unanimously endorsed condom use as a safe method for preventing HIV infection. Thus, condoms are

not trusted by the majority of Zimbabwean men and male youths" (Chiroro et al: 2002: 25).

Zimbabwean attitudes towards HIV testing have been extremely detrimental to combating this pandemic. Studies indicate that Zimbabwean resistance to HIV testing may be due to fears of community stigmatization, rejection and abandonment by their spouses and partners and the stress of facing a seemingly certain death. Thus, many simply choose to forego testing. "It is estimated that 90% of those who are HIV positive in Zimbabwe do not know it" (Mann 2001). The study conducted by the University of Zimbabwe's Psychology Department found that none of the males interviewed would tell their wives or partners if they knew that they were HIV positive. These individuals worried that their loved ones would leave their children and them. They also believed that their women were "supposed" to stay with them (Chiroro et al 2002: 22).

The culture of male domination/gender inequality within Shona society may be one of the biggest problems confronting HIV/AIDS intervention workers. This culture renders women vulnerable to the HIV/AIDS pandemic, because it limits their lifestyle options. Females are much less likely than males to receive a formal education. Because of poverty conditions in Zimbabwe, families are often unable to send all of their children to primary and secondary school. Fewer still are able to pay for their children to attend advanced and tertiary levels of education. When forced to decide which of their progeny will receive a formal education, males are invariably given preference over females. Secondary and primary schools are important sources of HIV/AIDS information for children in their formative years. Those unable to receive this formal education are often deprived of the basic information needed to survive this pandemic. Failing to receive

primary, secondary and/or tertiary education also limits the employment opportunities of women. Often, females marry out of convenience in order to ease poverty conditions. Females are also pressured into early marriages by their parents.

> Our father denied us secondary education because he felt it useless since we were going to be married. He believed that when we got married, we would not go to work, but stay home looking after the children and doing some household chores. He would actually say that educating a girl was a waste of money (ZWRCN 1995: 30).

There are many aspects of traditional marital relations within Shona society that have also complicated HIV/AIDS intervention efforts. One such tradition involves the problem of bride price, which is referred to as *roora* or *lobola* in Shona society. Some believe that bride price has a dehumanizing effect upon the women, reducing her to a form of property. It is believed that the husband, therefore, may treat his wife as purchased property. "In marriage, the payment of lobola is said to give men sexual rights over their wives" (Armstrong 2000: 118). The study conducted by University of Zimbabwe's Department of Psychology found that 80% of the males surveyed believed they were entitled to complete control over their wives. Many of the nation's male dominated laws reinforce this assumption.

> The culture and legal system in Zimbabwe provide a fertile ground for the propagation and perpetuation of adversarial sexual beliefs, general-role stereotypes and high risk sexual behavior among men and male youths. This exposes them and their partners to the risk of contracting the HIV virus as well as compromising women's human and reproductive health rights (Chiroro et al. 2002: viii).

Women are unable to protect themselves from abusive or promiscuous husbands, because they are perceived as being property. It is culturally unacceptable women to refuse sexual intercourse or request that her husband wear a condom, even if she suspects

him of being unfaithful. She may be shunned and derided by family members and possibly beaten by her husband if she refuses intercourse to her spouse. "Cultural practices and assigned gender roles expect women to remain faithful, do what their partner wants and not question their partners' behavior resulting in the women to engage in protective sexual behavior" (ZWRCN 2000). Men may use condoms with prostitutes and mistresses, but they would consider using a prophylactic with their wife to be immoral.

There are a variety of traditional sexual practices and attitudes within Shona society that are also harmful to HIV/AIDS intervention efforts. A particular practice that is damaging to these efforts is known as dry sex. This occurs when the woman applies herbs to her vagina in order to tighten this part of her anatomy. This process dries the woman's vaginal mucus membranes, creating lesions and ultimately increasing likelihood of HIV/AIDS infection and transmission (Jackson 2002: 136).

Studies indicate that dry sex is incompatible with family planning and disease prevention practices, because condoms frequently break during intercourse. Women generally engage in dry sex at the request or demand of her male partner. Diane Civic and David Wilson reported in *Social Science Medicine* that men enjoy dry sex, because it seems to "magically" change an older, experienced woman into a virgin. The drying agents used in this act reportedly shrink the vagina, making this part of the woman's anatomy seem like that of a young girl. "Men are drawn partly by the enjoyable sexual experience but also as a result of the 'magical powers' of the agent" (Civic and Wilson 1996).

Another dangerous, cultural attitude that some men in Shona society share is the belief that sexual intercourse is necessary in order to maintain a healthy body and mind. The MARCH Project found that such attitudes are extremely dangerous, because they lead Shona men to very promiscuous behaviors in an environment rife with cases of HIV/AIDS.

> An unsatisfied sexual desire is believed to have negative health consequences (e.g., the individual would become sterile, would go mad, the penis would fall off, or they would end up raping someone). Men tended to describe sex as a 'natural' need that could not be denied, and that it was extremely difficult, if not impossible, to control; and that many men cannot be satisfied with one women (The MARCH Project 2002).

Important Figures in Traditional Shona Society

Two of the most important stewards of Shona culture are traditional healers and village chiefs. These individuals occupy influential positions within Shona society that have a clear impact on the HIV/AIDS pandemic. The traditional healer, who is referred to as a *n'anga*, serves a dual role in Shona society. They are the ministers of traditional religion, serving as mediums to the world of ancestral spirits. According to Professor Gelfand, family members of relative who died prematurely may visit traditional healers to ask them to petition ancestral spirits in order to gain insight into the true cause death of a loved one (Gelfand 1999: 114). Such individuals can change sociological perceptions regarding medical illnesses. What does this mean with respect to the HIV/AIDS pandemic? Traditional healers can essentially discount or even dismiss the role that an infectious disease such as HIV/AIDS had in causing the death of an individual. This can create pattern of a denial towards this disease, hindering efforts by intervention workers to raise awareness regarding the cause and nature of this pandemic.

Traditional healers also serve as medical practitioners within their respective villages, providing advice and herbal treatment to those seeking to remedy an illness. Their medical skills are believed to be inspired and developed through the assistance of ancestral spirits. "A true *n'anga* must be a man or woman who is possessed by divining or healing spirits or be a person who is able to solicit the aid of such spirits when the need arises." (Gombe 1995: 118). The so-called medical advice offered by these individuals may have a clear impact on the HIV/AIDS pandemic. For example, some healers advise their patients to have sexual intercourse with a virgin in order to cure their illnesses. Such advice renders young females vulnerable to contracting HIV/AIDS. Traditional healers may also put their patients at risk through the unhygienic operations they conduct. Some of these individuals use razor blades that are not sanitized to cut their patients and inject herbal remedies into their bloodstream.

The way in which traditional healers may diagnose illnesses seems also to pose a danger to HIV/AIDS intervention efforts. Professor Chavunduka defines illnesses in two categories. He states that mild illnesses such as such as colds and slight fevers may be regarded as natural, since they occur within people's lives intermittently. Chavunduka believes that natural illnesses may be treated either by modern or traditional medical practitioners. He opined that when such illnesses occur for a prolonged period of time, they are considered deviant and require an explanation. If the illnesses are attributed to social or cultural factors, then a traditional approach is required. "The main cause of cultural or social illnesses are believed to be ancestor spirits, angered spirits, alien or stranger spirits, witches and sorcerers" (Chavunduka 1997: 68). There is a great danger

that traditional healers may misdiagnose an illness such has HIV/AIDS, attributing it rather to social or cultural factors.

Chiefs are essentially the guardians and keepers of villages, presiding over the governance and judicial matters of their respective territories. They help to foster the folkways and mores of their rural villages by setting standards for acceptable behavior. Village chiefs can have an impact on the HIV/AIDS pandemic in several different ways. They have the authority to set aside village funds for impoverished children to attend school, thereby providing them access to valuable HIV/AIDS information and future job opportunities. Chiefs also preside over matters of sexual impropriety in which an unmarried girl has been seduced or another villager's wife has been abducted (Gombe 1995: 11). Thus, they have the ability to improve matters of gender equality, which intervention workers consider critical in combating this pandemic.

Methodology

The Impetus for this Study

Even though many aspects of the HIV/AIDS pandemic in Africa have been researched and documented, I was unable to locate an existing data set relating to my exact area of interest. I found the quantity of peer-reviewed literature on the role of traditional Shona beliefs in relation to HIV/AIDS in Zimbabwe to be extremely limited. I concluded that the best option was to design my own research material, locate willing participants for my study and create a new data set. I found this option to be quite appealing, because it enabled me to test a hypothesis of great interest within an area that has received relatively little research and then share these results with HIV/AIDS intervention organizations.

I was interested in studying several different groups within Zimbabwe regarding the role of traditional Shona culture and beliefs in relation to the HIV/AIDS pandemic. I eventually narrowed my list of prospective groups to two, which included traditional healers and secondary school students. I concluded that secondary level school students would the most appropriate group for this study for two main reasons. First, youths within the secondary school age range of 12-20 are considered to be one of the most vulnerable groups in the country. These students share the misfortune of coming of age sexually when an estimated 35% of all Zimbabweans between 14-49 years are believed to be infected by HIV/AIDS. Second, this population was unique in that it offered a large number of potentially willing participants within a finite amount of locations. I conduct my study in Zimbabwe over the course of three months with the assistance of the headmasters and faculty members of two secondary schools.

Background of Secondary Schools Participating in this Study

The two secondary schools selected to participate in this study were identified using a convenience, cluster sample method. The schools were located in rural and peri-urban eastern regions of Mashonaland. I hypothesized that the responses of students from the rural area would provide more traditional responses to this survey due to their relatively isolated geographical locations from westernized culture. Conversely, I expected responses from peri-urban students to be more contemporary due to their exposure to western culture.

Matsine Secondary School was the first school identified. I had previously taught at this school from 1999-2000. This site is a day school located in the rural region of Mashonaland East. Students from Matsine Secondary School were generally from poor families, whose occupations tended to be agricultural and service-industry oriented. Matsine Secondary School is not considered to be highly competitive academically in that it does not have demanding enrollment prerequisites.

Marondera High School is a boarding school located in the peri-urban area of Mashonaland East. Students from Marondera High School were generally from middle-class families, whose occupations tended to be in the areas of building and trade, education and civil service. Marondera High School is more competitive in that there are academic requisites for enrollment.

In order to illustrate the class differences between the two schools, I have listed the top three occupations for the students' paternal and maternal caregivers. Tables 6a and 6b (see Appendix B) provide greater detail with respect to the diverse occupations of the students' fathers and mothers, respectively.

Primary Occupation of Paternal Caregivers

Form 2 Matsine Secondary School

1. Unskilled labor: 46%
2. Service Industry: 17%
3. Skilled Labor: 13%

Form 3 Matsine Secondary School

1. Unskilled labor: 26%
2. Skilled labor: 21%
3. Technical/Professional: 11%

Form 4 Matsine Secondary School

1. Unskilled labor: 44%
2. Skilled labor: 23%
3. Technical/Professional: 11%

Form 3 Marondera High School

1. Technical/Professional: 42%
2. Business Owners/Managers: 21%
3. Governmental Services: 11%

Form 4 students Marondera High School

1. Technical/Professional: 32%
2. Business Owners/Managers: 23%
3. Governmental Services: 17%

Primary Occupation of Paternal Caregiver

Form 2 Matsine Secondary School

1. Unemployed: 77%
2. Unskilled laborers: 15%
3. Skilled laborers: 5%
4.

Form 3 Matsine Secondary School

1. Unemployed: 61%
2. Unskilled laborers: 19%
3. Skilled laborers:15%

Form 4 Matsine Secondary School

1 Unemployed: 44%
2. Unskilled laborers: 37%
3. Skilled laborers and services industry: 5%

Form 3 Marondera High School

1. Technical/Professional: 35%
2. Unemployed: 18%
3. Skilled laborer: 12%

Form 4 Marondera High School

1. Technical/professional: 35%

2. Unemployed: 18%
3. Clerical: 10%

Data Collection and Research Design

After identifying these prospective sites, I secured permission from the headmasters of both schools to conduct this study. I then determined that Form 3 and 4 students, which is the rough equivalent of 10th and 11th grade students in the United States, would be the primary participants in this survey. I concluded that these older students would be mature participants, providing thoughtful responses to very serious questions regarding sociological aspects of the HIV/AIDS pandemic in Zimbabwe. I also felt that older students would have the reading comprehension and composition skills needed to complete a relatively lengthy survey.

I drafted a questionnaire, composed of three main sections that served as the primary research tool for this study. These three sections included demographics, hypothetical, and open-ended questions. The demographics section of the survey enabled me to obtain such information as the students' family size, income source, religion, church attendance, and exposure to information regarding HIV/AIDS. The responses to these questions provided insight into the socio-economic foundations of the students participating in this study. This enabled me to consider whether such factors influenced the manner in which they responded to the hypothetical and open-ended questions.

The hypothetical questions enabled me to measure the attitudes of students towards various aspects of traditional Shona culture such as traditional healers, ominous symbols and bewitchment in relation to HIV/AIDS. These questions also allowed me to gauge their attitudes towards sociological factors as educational and income levels in

relation to this pandemic. Each of the hypothetical questions were measured on a plus two and minus two Likert scale of "I agree very much," "I agree somewhat," "I disagree somewhat," and "I disagree very much," to determine the degree to which students are influenced by traditional Shona belief. However, because each level of agreement or disagreement did not receive enough responses to ensure that statistical significance was established, I was advised to collapse the four potential responses into two responses of "I agree" and "I disagree."

The open-ended questions in the final section of this survey enabled students to expound on issues such as traditional medicine, culture and the HIV/AIDS pandemic, providing valuable insight into their village, nation and world views. Students were assured that their questionnaires would remain anonymous and confidential to encourage more frank and thoughtful responses.

Since the study involved youths below the ages of 18, I was required by the Institutional Review Board (IRB) of Duquesne University to obtain approval for my proposed study through the full board review. The IRB required students and their guardians to sign assent and consent forms respectively before this study could be conducted. The assent forms were in English, while the consent forms were in Shona. The teachers and headmasters from Matsine Secondary School and Marondera High School initially spoke to students within their Form 3 and 4 classes in order to gauge their willingness to participate in the proposed study. I was informed that all of the students from these classes agreed to participate in the study. Based on these results, the teachers then provided students with the assent and consent forms needed to participate in the

study. Selected faculty members also agreed to read the consent forms to parents of students unable to read in the languages in English or Shona.

A total of 482 students agreed to participate in this study. The sample was expected to contain a total of 12 different classes of students, which would include three separate groups of Form 3 and 4 students from each school participating in the study. However, Matsine Secondary School also inadvertently included students from two different Form 2 classes in this study. I was advised to keep this information and include it in the research findings section of the thesis. The main comparison of results would still be between Form 3 and 4 classes at each school. The Form 2 results were kept in order to gain insight into the responses of younger, rural students. Each of the Form 3 and 4 classes contained an average of 35 students.

In order to keep this study as naturalistic as possible for the students, I decided that each survey event would be conducted within the students' regular classrooms at each school. Students were given one hour to complete the survey. A faculty member at each school provided the students with instructions on completing the questionnaire forms. Students were explicitly informed of their right to refuse participation in the study. They were also asked to refrain from signing their names on these questionnaires in order to ensure the confidentiality of their responses. The faculty members also informed students that there was no right or wrong answers in completing these questionnaires, and that they were strictly a matter of opinion.

The IRB voiced concern that this study may arouse unpleasant memories or feelings for the participating students, because of the sensitive issues raised in the survey. Since many of these students have lost friends and relatives to the HIV/AIDS pandemic,

they were advised during the instructional portion of the study that they may raise their hands if they desired to leave the classroom. The schools agreed to place one faculty member with experience in HIV/AIDS counseling in their school libraries. Although this person would not trained in psychiatry, he or she would have at least three years of practical experience in working with students in the subject area of HIV/AIDS. The counselors agreed to make themselves available to students during regular school hours and up to two hours after the close of each school day; they would also be available during the weekends from 11:00 am to 1:00 pm for at least two months following the testing. The students were informed that they may speak to this counselor during or after the study if they experienced any emotional pain as a result of participating in this survey. The headmasters from Matsine Secondary School and Marondera High School reported that there were no students who requested to leave the room during the survey. Approximately one year after this survey was conducted, my research assistant, Mr. Chipa Kazingizi, has informed me that no child has sought counseling services as a result their participation in this study.

Following each of the twelve testing events, questionnaires were collected by a faculty member and placed in a prepared manila envelope; the date of the testing and a coded description of the class were printed on each of these envelopes. The quantitative data from each set of questionnaires has been recorded and statistical analysis employed to compare the results form both schools.

A major consideration in my project was to obtain a survey sample that is representative of the Mashonaland population. According to Zimbabwe's 2002 census report, the country has a total population of 11,634,663 (Central Statistical Report 2002:

9). According to the 2001 Education Statistics Report, there were a total of 231,735 students enrolled in secondary schools throughout all of Mashonaland. Within Mashonaland East, where the study was conducted, there were 101,412 students enrolled in secondary school (Central Statistical Office 2001: 33).

Clarifications in the Construction of Tables

Some of the data provided by students in this study were at times too vague, diverse or incomplete to analyze effectively. This occurred solely in the demographics section of the survey. To overcome this problem, I designed different coding systems to construct tables that I regarded as being more reflective of the responses provided.

The students provided a wide range of responses when reporting the occupations of their fathers and mothers. In order to narrow the scope of this data, I was advised to create the following eight general occupational categories to encompass these types of jobs:

> **1. Technical/Professional:** teachers, headmasters, lecturers, librarians, bank treasurers, financial advisors, accountants, medical doctors and physicians, pharmacists, radiographers, radiologists, soil technicians, laboratory technicians, pilots, engineers, auditors, underwriters, community brokers, clergy members, computer analysts, economists, and lawyers.
> **2. Business owners and managers:** Managers and Supervisors of state and local industry, commercial farmers and self-employed entrepreneurs.
> **3. Skilled laborers:** Welders, plumbers, carpenters, mechanics, bakers, electricians, crane operators, millers, tailors, nurses and beauty therapists.
> **4. Unskilled laborers:** Miners, general laborers, maids, peasant farmers and security guards.
> **5. Governmental services:** Military soldiers, postal workers, elected and appointed officials, police officers and all other state and municipal employees.
> **6. Service industry:** Transportation and hospitality industries.
> **7. Clerical:** Clerks, secretaries, bursars and registrars.
> **8**. **Unemployed:** Housewives, pensioners and those unemployed.

The students also provided a very wide range of responses when reporting the churches they attended. I created 12 categories, which included the Catholic Church,

Seventh Day Adventists, Jehovah's Witnesses, Indigenous Christian Churches, Other Christian Churches, Salvation Army, Anglican, Methodist, Church of Christ, Traditional, Moslem and No Church Attendance were listed. Those Christian churches receiving less than 10 responses were placed in the "Other Christian Church" category. Some of those churches listed in this category included Baptist, Reformed Church of Zimbabwe, Pentecostal, Mormon and Presbyterian. Some of those churches included in Other Indigenous Christian Churches include the African Apostolic Church, African Faith Mission, the Zimbabwe Assemblies of God in Africa (ZAOGA), Mughodi Christian Church.

When asked their religion, the vast majority of students reported that they were Christians. However, none of the students providing such a response made the distinction between being Christian or Indigenous Christian. I believe that there is quite a difference between these two faiths. Indigenous Christian adherents accept polygamous practices, resist western medical practices, focus on prayer as the sole source of healing and rely on prophetic visions as a cornerstone of this faith (*Center for Studies on New Religions* 1999). In order to report this distinction in religions, I examined the churches that every student attended. Those belonging to such churches as the African Apostolic Church, African Faith Mission, the Zimbabwe Assemblies of God in Africa (ZAOGA) and Mughodi Christian Church were identified as being Indigenous Christian.

The students provided extremely vague as well as a wide variety responses when asked to identify the amount of times they had received HIV/AIDS educational instruction. I created five categories to catalog these responses. Only the most literal

responses indicating daily or no exposure to HIV/AIDS instruction were placed in the categories of "daily" and "never", respectively.

Most of the students' responses were placed in the "weekly" category, which included such answers as "many times", "many, many times", "oftenly (sic) many times," "a billion, trillion times", "too many times I lost count", "more than often", "more than enough", "as many as possible", "every time I go for AIDS club meetings", "through the course of my life" and "too often that I've lost count".

The responses of students indicating that they've received between 12 and 52 teachings in HIV/AIDS education were placed in the "monthly" category. Since there are approximately 52 weeks in a year, it seems unlikely that one would receive such informational instruction on a weekly basis if they provided a response less than this number. However, since there are only 12 months in a year, it seems reasonable to assume that an individual claiming to have been instructed at least 12 or more times on HIV/AIDS has received "monthly" tutorials on this subject. If a student claimed to receive less than 12 lessons on HIV/AIDS, then it seems logical to place their response in the "yearly" category.

Research Findings

Information from the following three survey sections (demographics, hypothetical and open-ended questions) was entered into SPSS, creating the main data set for this study. The majority of these questions were analyzed using cross tabulations.

Findings and Analysis of Part I of the Survey: Demographics

Main Findings

There were numerous findings in the demographics section, which may have implications upon HIV/AIDS intervention efforts. According to Table 12 (see Appendix B), the majority of students (76%) participating in this study indicated that they knew of someone who had died of HIV/AIDS. By comparison, according to Table 13 (see Appendix B), only 12% of these students acknowledged that a family member had succumbed to this disease. This may indicate that students consider HIV/AIDS a disease that happens to other people, but are in denial when it occurs within their own families.

Another notable finding was that the majority of all classes participating in this survey indicated that they first learned about HIV/AIDS from their teachers. According to Table 16 (see Appendix B), 41% of these students regarded school teachers as their first source of HIV/AIDS information. In comparison, the students' mother received the second highest percentage (20%) of responses to this question. By a margin or more than 2 to 1, school teachers are credited by these students as being the first people to teach them about this pandemic. This finding poses another argument for total enrollment of all children in primary and secondary schools.

Another noteworthy finding, which can be observed in Table 7 (see Appendix B), was that students from every form at both schools reported that males (brothers or

fathers) received the highest amount of education in their families. This may lead one to believe that there is still a problem with gender equality in Zimbabwe. However, this gender differential appears to be narrowing considerably by each progressing generation. Fathers were considered to be much more educated than the mothers of students. Comparatively, the responsorial differences in naming the brother or sister as the most educated person was not as great. Marondera High School students were more likely to name a parent as the most highly educated family member, which may indicate that there is already an established tradition of education The comparatively lower percentage of responses from those at Matsine Secondary School naming their parents as the most highly educated family member may indicate that these respondents are among the first generation of students from this area.

According to data from Table 1 (see Appendix B), 51% of the entire survey population included males and 49% were females. The gender dispersion at these two schools differs moderately from that of national figures. According to Education Statistics Report from the Zimbabwe Central Statistical Office, males accounted for 53% of students nationally, while females made up 47% of all secondary school students within forms 1 through 4. From this data, it appears that Matsine Secondary School's gender dispersion is more representative of national figures than that of Marondera High School. In comparison to national figures, Marondera High School seems to have greater gender equity within its Form 3 and 4 student population.

There were also notable findings in this section that may have implications upon this study. The most significant finding involved the occupations of the students' fathers, which can be observed in Table 6a (see Appendix B). Students from Matsine Secondary

School indicated that their fathers were primarily unskilled and skilled workers. By contrast, students from Marondera High School indicated that their fathers worked mainly in technical/professional fields and as business owners and managers. These differences may pose a serious problem for this study, which seeks to determine whether geographical rather than socio-economic differences affects the way in which these individuals respond to questions involving HIVAIDS-related content.

Another important finding was that students from Marondera High School were a full year younger than their peers at Matsine Secondary School, which can be observed in Table 2a (see Appendix B). The median age for the Form 2, 3 and 4 students from Matsine Secondary School participating in this study was 14, 16 and 17 respectively. The median age for the Form 3 and 4 respondents from Marondera High School was 15 and 16, respectively. This age differential, albeit of only one year, may account for the divergent responses in this study.

The differences of ages may also reflect the inability of students from Matsine Secondary School, who appear to be from poorer families, to pay school fees continuously. These students may have postponed their education by one year in order to raise funds for these fees. The data from Table 3 (see Appendix B) also indicate that the median number of siblings (5) for students in Forms 2, 3 and 4 at Mastine Secondary School is greater than the median sum for students from Marondera High School (3). Because students at Matsine Secondary School seem to have more siblings per family, it is possible that these larger families have greater economic difficulty in sending all of their children to school.

The median year in which students from all forms claim to have been introduced to the subject of HIV/AIDS was 1997. This can be observed in Table 14a. According to Table 14a (see Appendix B), both forms at Marondera High School claimed to have heard about this pandemic at least one year earlier in their formal education. However, Matsine Secondary School students seem to be receiving HIV/AIDS education progressively earlier. This can be observed in the answers provided by forms 2 and 3 students, who have the highest percentage of respondents in their school claiming to be educated about this subject during primary school. This may indicate that AIDS education is being introduced to students a younger age in this rural area.

The data from this section also indicate that a higher percentage of the mothers and fathers of Marondera students were still alive as compared to those from Matsine Secondary School. This can be observed in Tables 4 and 5 (see Appendix B). Eighty-six percent and 91% of the Marondera High School students reported that their fathers and mothers were still alive, respectively. In comparison, 70% and 82% of Matsine Secondary School students indicated that their fathers and mothers were still alive, respectively. This data indicate that Marondera High School students may have an added economic advantage over those from Matsine Secondary School.

According to Tables 6a and 6b (see Appendix B), fathers reportedly have a full employment rate, while mothers have a 37% unemployment rate. Therefore, a fatherless child may experience greater difficulty in paying for school fees and buying other basic goods. Even though maternal caregivers reportedly had a much lower employment rate, these individuals are believed to wield considerable family influence to ensure higher educational standards for their children. Researchers Constances Nyamukapa and Simon

Gregson found that maternal orphans in the Manicaland region of the country tended to be less educated. “We found that children who had lost their mothers at an early age were less likely to have completed primary school than other children but that the reverse was true for paternal orphans” (Nyamukapa and Gregson 2003).

Table 6a (see Appendix B) also indicates that younger students from Matsine Secondary School are experiencing incrementally higher percentages of paternal caregivers being deceased. The opposite trend seems to be true for those at Marondera High School, where older students seem to be experiencing higher percentages of deceased paternal caregivers. This could indicate that the HIV/AIDS pandemic is becoming less severe for students in this peri-urban region. However, because we do not know the reason for these reported deaths, it is impossible to conclude with certainty that students from either school have been affected more severely by the HIV/AIDS pandemic.

Finally, results from this survey section indicate that the majority of students from both schools regard themselves as Christians. According to Table 9 (see Appendix B), 69% identified themselves with this religion. Twenty-nine percent of these students indicated that they attended Indigenous Christian churches. Many of these churches blend traditional influences with the Christian faith, including the acceptance of polygamous practices, resistance to western medical practices with a focus on prayer as the sole source of healing and an emphasis on prophetic visions as a cornerstone of the church (*Center for Studies on New Religions* 1999). Only 2% of all students regarded themselves as traditional religious adherents.

Findings and Analysis of Part II of the Survey: Hypothetical Questions

Main Findings

This section of the survey included 13 questions, posing hypothetical situations in which individuals were perceived as being at risk of contracting HIV/AIDS. The students were asked to assess the level of risk of these individuals when various aspects of traditional beliefs, intelligence levels and geographical locations were posed in hypothetical situations. Because Marondera High School students appear to be from different social classes, which may account for the diverse patterned responses to the hypothetical questions posed in Part II of this survey.

An important finding yielded from this section was that geographical location seemed to affect the way students responded to hypothetical questions in which traditional cultural beliefs were involved in situations where HIV/AIDS infection could be at risk. According to Tables 18, 24, 27 and 28 (see Appendix C), Matsine Secondary School students were more likely to respond that traditional healers and ancestral spirits could cure a person of HIV/AIDS-related symptoms in these hypothetical situations. According to Tables 19, 23, and 29 (see Appendix C), these individuals were also more likely to respond that traditional healers could bewitch others and that snakes, owls and black cats, which are all closely associated with witchcraft, were bad omens that could negatively affect their health. This finding seems to indicate that rural students still acknowledge and respond to many of the revered and feared ideas, icons, and people of traditional culture, even though they primarily identify themselves as being Christians.

Another noteworthy finding from this section is that Marondera High School students indicated that they would be more inclined to seek HIV/AIDS testing if they found that their partner living in either a rural or urban location had been unfaithful. This can be observed in Tables 17 and 20 (see Appendix C). However, slightly more of these students reported an interest in getting tested if the infidelity occurred in an urban setting. This may be due to the fact that urban areas tend to have higher a population of prostitution, which is often considered a catalyst in the spread of this disease.

Geographical location did not seem to affect the students' responses when a female's intelligence was a factor in determining whether she would be at risk of contracting HIV/AIDS when her partner had suffered multiple HIV/AIDS-related symptoms for a period of three months. In either case, students gave mixed responses when asked if the female should get tested for HIV. When the female was considered clever, while the male partner was regarded as less intelligent, 51% of the students agreed that the female should get tested. This can be observed in Table 22 (see Appendix C). When the female was considered foolish, while the male partner was regarded as clever, 57% of all students agreed that the female should get tested. This can be observed in Table 25 (see Appendix C). It is difficult to interpret the implications of these results. It is quite possible that a large portion of students from both schools did not relate the prolonged ailments of the male partner (headaches and sore throat) that were noted as being HIV/AIDS-related symptoms.

The initial question of Part II of the survey asks whether a person should get HIV tested after discovering that their partner has been unfaithful with someone in the urban area of Zimbabwe. This question enables us to compare the geographical residential

location of Zimbabwean students and their attitudes towards HIV testing when their partner has been unfaithful with someone living in an urban part of the country.

Question #1: Rudo lives in a rural area. She has been dating a boy named Peter for three years. Rudo wants to have a faithful relationship with Peter. However, Rudo just learned that Peter has another girlfriend who lives in the city. Rudo should be concerned about her health. She should get tested for AIDS.

The data from Table 17 (see Appendix C) indicate that the vast majority of students from both schools agreed that an individual should get HIV tested if he/she found that their partner had been unfaithful with someone living in an urban area. However, the relationship between school location and viewpoint on this issue is statistically significant (.05). This is due, in major part, to the very high percentage of students in Marondera Form 3, who agreed with the notion of getting tested in such a situation. This may be seen as a positive development in that these students are potentially responding to information of HIV/AIDS that they've received in school and perhaps at home.

The second question in this survey asks students whether they believe a traditional healer has the ability to bewitch a person. This question enables us to compare the geographical residential location of Zimbabwean students and their belief in a traditional healer's ability to cure chronic illness.

Question #2 Lovemore has been feeling very ill for three months. He has been having diarrhea constantly. Lovemore decided to visit a traditional healer in his village. The traditional healer told Lovemore that he would feel better once he appeased his ancestors. Lovemore will begin to feel better when he follows the instructions of the traditional healer:

The data from Table 18 (see Appendix C) indicate that the vast majority of students from Marondera High school do not believe that a traditional healer has the ability to cure a person by communicating with his/her ancestors. Matsine Secondary School students gave mixed responses to this question. The relationship between school

location and viewpoint on this issue is statistically significant (.000). This is due, in major part, to the comparatively high percentage of students in Matsine Form 4, who agreed with the notion of getting tested in such a situation. The data indicate that younger rural students were increasingly less likely to believe in the ability of traditional healers to cure a person by communicating with his/her ancestors.

The third question in this section of the survey asks students whether they believe that that a snake represents an ominous symbol of misfortune. Snakes are also considered to be used by witches to curse their enemies. "Witches are supposed secretly to keep familiar beasts of the night or of stealth, such as hyenas, owls, antbears and snakes, which they can ride or send on their evil errands: these beasts can be used to bewitch a victim (their presence in a homestead is considered evidence of an attack by witches)" (Bourdillon 1998: 175).

This question enables us to compare the geographical residential location of Zimbabwean students and their belief in snakes as a traditionally ominous symbols of misfortune.

Question #3 Tendai wants to marry a girl named Loveness. Tendai and Loveness have both tested negative for HIV/AIDS. Tendai and Loveness both feel strong. However, Tendai is concerned because he recently saw a green mamba in a tree located near the home of Loveness' family. Tendai should not marry Loveness:

The data from Table 19 (see Appendix C) indicate that the vast majority of students from both schools do not believe that snakes represent bad omens. However, the relationship between school location and viewpoint on this issue is statistically significant (.000). This is due to the extremely high percentage of students in Marondera Form 3 and 4, who did not agree that snakes were ominous creatures. The data indicate that older students from both schools were increasingly less likely to regard snakes as bad omens.

The fourth question in this section asks students whether they believe that a person should get HIV tested after discovering their partner has been unfaithful in a rural area of Zimbabwe. This question enables us to compare the geographical residential location of Zimbabwean students and their attitudes towards HIV testing when their partner has been unfaithful with someone living in the rural areas of Zimbabwe.

Question #4 Tatenda lives in the city. She has been dating a boy named William for three years. Tatenda wants to have a faithful relationship with William. However, Tatenda has just learned that William has another girlfriend in the rural areas. Tatenda should be concerned about her health. She should get tested for AIDS:

The data from Table 20 (see Appendix C) indicate that the vast majority of students from both schools agreed that an individual should get HIV tested if he/she found that their partner had been unfaithful with someone living in a rural area. However, the relationship between school location and viewpoint on this issue is statistically significant (.000). This is due, in major part, to the very high percentage of students in Marondera Form 3, who agreed with the notion of getting tested in such a situation. This may be seen as a positive development in that these students are potentially responding to information of HIV/AIDS that they've received in school and perhaps at home. Younger students from Matsine Secondary School appear to be increasingly less likely to seek testing, which may indicate that they are more sensitive to stigmatization in their village.

The fifth question of this section asks students whether they believe that a person's Christian faith will protect them from contracting HIV/AIDS. This question enables us to compare the geographical residential location of Zimbabwean students and their belief that having a strong Christian faith and frequent church attendance will protect them from the HIV/AIDS pandemic.

Question #5 Farai is a Christian. He goes to church every week. Farai has a very beautiful wife named Spiwe. Before Spiwe was married, she had several boyfriends. She has been very sick for the past six months. Farai should be concerned about his health. He should get tested for AIDS:

The data from Table 21 (see Appendix C) indicate that the vast majority of students from both schools do not believe that a strong belief in Christianity will protect a person from the HIV/AIDS pandemic. However, the relationship between school location and viewpoint on this issue is statistically significant (.003). This is due to the extremely high percentage of students in Marondera Form 3 and 4, who disagreed that strong faith in Christianity will protect one from this pandemic.

The sixth question of this section asks students whether they believe that a person's intelligence level will affect their chances of contracting HIV/AIDS. This question enables us to compare the geographical residential location of Zimbabwean students and their belief that those with greater levels of intelligence will intrinsically be less vulnerable to the HIV/AIDS pandemic.

Question #6 Rutendo is the most clever girl in her school. She always gets very good grades. Her boyfriend is not very clever. Her boyfriend has been complaining about having a headache and a sore throat for the past three months. Rutendo should be concerned about her health. She should get tested for AIDS:.

The data from Table 22 (see Appendix C) indicate that students from both schools are divided as to whether they believed that a female of greater intelligence will vulnerable in contracting HIV/AIDS when her partner is less intelligent and exhibits AIDS-related symptoms. The relationship between school location and viewpoint on this issue was not statistically significant (.643).

The seventh question of this section asks students whether they believe that a black cat represents an ominous symbol of misfortune. This question enables us to

compare the geographical residential location of Zimbabwean students and their belief that black cats represent a traditionally ominous symbol.

Question #7 Obert wants to marry a girl named Nyasha. Both Obert and Nyasha have tested negative for HIV/AIDS. However, when Obert went to visit the family of Nyasha, he saw a black cat sitting by the door of their house. Obert should not marry Nyasha.

The data from Table 23 (see Appendix C) indicate that the vast majority of students from both schools do not believe that black cats represent bad omens. However, the relationship between school location and viewpoint on this issue is statistically significant (.000). This is due, in major part, to the extremely high percentage of students in Marondera Form 3, who did not agree that black cats were ominous creatures.

The eighth question of this section asks students whether they believe that a traditional healer can bewitch another individual. This question enables us to compare the geographical residential location of Zimbabweans and the belief that traditional healers have the power to curse an individual.

Question #8 Fungai feels very strong. He is very faithful to his wife. The traditional healer in Fungai's village said that he would bewitch Fungai because he will not appease his ancestors. Fungai should be concerned about his health. He should appease his ancestors:

The data from Table 24 (see Appendix C) indicate that the majority of students from both schools do not believe that a traditional healer have the ability to bewitch a person. However, the relationship between school location and viewpoint on this issue is statistically significant (.000). This is due, in major part, to the extremely high percentage of students in Marondera Form 3, who agreed with the notion of getting tested in such a situation.

The ninth question of this section asks students whether they believe that a person of lesser intelligence is more vulnerable to contracting HIV/AIDS. This question enables us to compare the geographical residential location of Zimbabwean students and their

belief that those with lower levels of intelligence will intrinsically be more vulnerable to the HIV/AIDS pandemic.

Question #9 Tatenda is the most foolish girl in school. She always gets very poor grades. Her boyfriend is very clever. However, he has been complaining about headaches and a sore throat for the past three months. Tatenda does not know why her boyfriend is feeling so poorly. Tatenda should be concerned about her health She should get tested for AIDS:

The data from Table 25 (see Appendix C) indicate that a slim majority of students from both schools agree that a female of lesser intelligence is vulnerable of contracting HIV/AIDS when her partner is highly intelligent and exhibits AIDS-related symptoms. The relationship between school location and viewpoint on this issue was not statistically significant (.069).

The tenth question of this section asks students whether they believe that a person's lack of religion will make him more vulnerable to contracting HIV/AIDS. This question enables us to compare the geographical residential location of Zimbabwean students and their belief that those with less religious faith and church attendance will be intrinsically more vulnerable to the HIV/AIDS pandemic.

Question #10 Trymore is not religious. He never goes to church. Trymore has a very beautiful wife named Tsitse. Before Tsitse was married, she had many boyfriends. She has been very sick for the past six months. Trymore should be concerned about his health. He should get tested for AIDS:

The data from Table 26 (see Appendix C) indicate that the vast majority of students from both schools believe that a man with no religious faith is vulnerable to contracting HIV/AIDS when his partner previously had many boyfriends. However, the relationship between school location and viewpoint on this issue is statistically significant (.000). This is due to the extremely high percentage of students in Marondera Form 3 and 4, who agreed such an individual would be susceptible to this pandemic.

The eleventh question of this section asks students whether they believe that a traditional healer is able to cure himself of an illness by appeasing ancestors. This question enables us to compare the geographical residential location of Zimbabwean students and their belief that traditional healers can cure themselves of AIDS-related symptoms.

Question #11 Chipo is the traditional healer of his village. His wife died two years ago after a long illness. Chipo has diarrhea sometimes. He believes that his ancestors will cure his diarrhea and make him strong again. Chipo will soon be cured. He should not be concerned about his health:

The data from Table 27 (see Appendix C) indicate that the vast majority of students from Marondera High School do not believe that traditional healer have the ability to cure themselves of AIDS-related symptoms by communicating with his/her ancestors. However, the relationship between school location and viewpoint on this issue is statistically significant (.000). This is due to the extremely high percentage of students in Marondera Form 3 and 4, who did not believe that a traditional healer could cure himself of AIDS-related symptoms. Younger students from both schools were increasingly more likely to believe that traditional healers can cure themselves by communicating with their ancestors. This indicates that traditional beliefs regarding the curative aspects of ancestors have not waned in these areas.

The eleventh question of this section asks students whether they believe that ancestors have the power to bewitch a person. This question enables us to compare the geographical residential location of Zimbabwean students and their belief that seeking medical (non-traditional) treatment for an illness will anger their ancestors, putting them in grave physical danger.

Question #12 Farasai went to visit his medical doctor in the city when he began to feel ill. Now he feels well. However, the people in his village believe that he should have gone to the traditional healer first. Farasai should be concerned that his ancestors will hurt him:

The data from Table 28 (see Appendix C) indicate that the vast majority of students from both schools do not believe that a person's ancestors have the ability to make him/her ill. However, the relationship between school location and viewpoint on this issue is statistically significant (.000). This is due to the comparatively higher percentage of students in Marondera Form 3 and 4, who did not believe that ancestors can harm a person. Younger students from both schools were less likely to believe that ancestors will hurt an individual for seeking Western medical attention. This indicates that younger students may becoming more accepting of Western medical pratices.

The thirteenth question of this section asks students whether they believe that owls represent an ominous symbol of misfortune. This question enables us to compare the geographical residential location of Zimbabwean students and their belief that owls represent traditionally ominous symbols of misfortune. There are a variety of animals within Shona society that symbolize bad omens and are considered harbingers of evil. "The Shona believe an owl is an omen of ill fortune and a harbinger of illness or death" (Kileff 1997: 50).

Question #13 An owl is sitting on the top of Trymore's house every night. His neighbors believe that something very bad is going to happen to him. Trymore should go to the traditional healer for protection.

The data from Table 29 (see Appendix C) indicate that the vast majority of students from Marondera High school do not believe that an owl is an ominous symbol. Matsine Secondary School students gave mixed responses to this question. The relationship between school location and viewpoint on this issue is statistically significant (.000). This is due to the comparatively high percentage of students in Marondera Form 3 and 4, who agreed with the notion of getting tested in such a situation.

Results and Analysis of Part III of the Survey: Open-Ended Questions

Main Findings

I created the open-ended questions for two reasons. First, I wanted to afford the students an opportunity express themselves as fully as possible about issues relating to traditional beliefs and the HIV/AIDS pandemic. I felt that such qualitative data would provide me with more insight into the thoughts of these youth. My other reason for adding this section to the survey was that I wanted to gauge how students would respond to these direct questions. I concluded that the indirect hypothetical questions would more likely yield greater insight into the sub-conscious thinking of the students, while the open-ended questions would more likely reflect the conscious thoughts of these individuals. The following five open-ended questions were posed to the students:

1. What is the real cause of HIV/AIDS?
2. How can traditional healers help a person with AIDS?
3. What is the best way to avoid getting HIV/AIDS?
4. What happens to a person who does not protect himself or herself during intercourse?
5. What happens to a person after he or she dies?

There were several notable findings in the open-ended questions section, which may have implications upon HIV/AIDS intervention efforts. According to Tables 30 and 33 (see Appendix D), geographical location does not affect the students' understanding of either the cause of HIV/AIDS infections or the consequences of having unprotected sex. Students from both schools demonstrated a comprehensive knowledge of accepted medical explanations for the various causes of HIV/AIDS infections. They seemed to also have a thorough understanding of the consequences of unprotected sexual intercourse.

The data from Table 32 (see Appendix D) indicated that geographical location did seem to affect the way students regarded the best way to avoid contracting HIV/AIDS.

The majority of students from both schools considered abstinence to best the means of preventing HIV/AIDS infection. However, a considerably higher percentage of Marondera High School students regarded abstinence the best way of avoiding HIV infection. This may indicate that Marondera High School students are perhaps less experienced sexually, and have more idealistic thoughts on HIV/AIDS preventions. Matsine Secondary School students had a higher percentage of respondents, who considered condom use to be the best means of prevention. This may indicate that these students have already seriously considered condom use as a practical means of prevention sexually transmitted diseases. Students from each class selected "fidelity" as their second most popular means of prevention overall against the HIV/AIDS pandemic. Many of the students seemed to quote a slogan ("being faithful to a faithful partner") to show their support for this method of prevention.

The greatest responsorial differences between the two schools occurred in those questions in which traditional Shona cultural issues were raised. When asked whether traditional healers could assist HIVAIDS sufferers, Matsine Secondary School students were far more likely to respond that traditional healers were of no help to people with such an illness. This can be observed in Table 31 (see Appendix D). This contravenes my hypothesis that rural students are more likely to embrace traditional cultural values. It is quite possible that these students have personally witnessed the uselessness of traditional medicine in combating HIV/AIDS-related illnesses.

Marondera High School students were more likely to respond that traditional healers made matters worse. This may be due to the increased publicity that traditional healers seem to receive in the peri-urban areas. Traditional healers are more likely to

engage in self-promotional strategies in urban areas. If these individuals are suspected of malpractice, stories about these individuals may be more highly publicized. It may also be due to differing styles of practice by Traditional healers in the two areas. "Urban healers receive fees for herbs that they recommend to their patients instead of waiting to collect the fees after a cure has been effected and the client's family is satisfied. In the rural areas most traditional healers continue to follow the normal practice of not receiving fees until the patient is fully cured (Chavunduka 1997: 44-5). Marondera High School students were more likely to use harsh language in describing traditional healers. Several students referred to these individuals as liars, who were only interested in separating chronically ill patients from their money and blaming the source of the illness on one of their family members. Matsine Secondary School students were much less likely to make such inflammatory accusations, which may be due to cultural values of showing respect to their elders. It could also be attributed to their fear of reprisals from traditional healers. As illustrated in the hypothetical question section, students from Matsine Secondary School were more likely to believe in a traditional healer's ability to bewitch a person.

Marondera High School students were much more likely to believe that traditional healers could treat the symptoms of a HIV/AIDS suffer, though not cure these individuals. There are a couple of potential explanations for this result. Traditional healers in the peri-urban area of Marondera may be more knowledgeable in the art of holistic medicine. Matsine Secondary School students may also have more personal experience in witnessing the failure of these individuals to treat HIVAIDS sufferers.

Very few students believed that traditional healers could cure individuals suffering from HIV/AIDS. Only 2.4% of all students believed that traditional healers

could cure this illness. Marondera High School students responded slightly higher that these individuals could cure HIV/AIDS.

Finally, geographical location seemed to affect the way in which students regarded what happened to a person after death. Matsine Secondary School students were far more likely to give a biological example, such as the body decaying and being consumed by micro-organisms, to explain what happened to a person after death. This can be observed in Table 34 (see Appendix D). There are several potential explanations for such responses. First, these students may have simply concluded that this question sought a literal explanation. Throughout much of the survey, these students were less likely to provide idealistic responses to questions. Perhaps thoughts of a Christian heaven seem too idealistic to them. Another possible reason for this type of response involves the attachment that many within rural Zimbabwe have for their land. Matsine Secondary School students are primarily from agricultural families. These rural farmers are frequently lauded by the country's leadership and media as being "sons and daughters of the soil" (Zenenga 2003). It is quite possible that these students envision afterlife as a process of bonding with their country's land and soil, which many of their mothers and fathers fought and died for during the war of Independence against the Rhodesian colonialists. Another explanation for this type of responses is that the majority of these students consider death to be the "end of the road" for the individual, as one student quipped. They simply may not have an abiding faith in an afterlife.

By contrast, the majority of students from Marondera High School responded that there would be an afterlife in which the spirit of the deceased was called to judgment and delivered either to heaven or hell depending on their supposed goodness or badness while

on earth. This may indicate that Marondera High School students simply have a greater belief in Christianity. It may also signify that these individuals believe that a person should eventually be held accountable for their actions while on earth and sentenced accordingly in the afterlife.

Matsine Secondary School students were more likely than those from Marondera High School to give traditional responses to describe what happens to a person after he or she dies. Such responses included the deceased turning into a ghost, vampire or waking up during the evening. The evening is considered to be a time that is closely associated to witchcraft (Kileff 1997: 48). However, a higher percentage of these students gave biological or Christian responses to explain what they thought happened to people after they died. This could indicate that the traditional faith may be waning in the rural areas.

Policy Recommendations

Free and Compulsory Primary and Secondary Education

The data from this study indicate that students from the both the rural and peri-urban schools have a thorough understanding of the causes of HIV/AIDS as well as the consequences of unprotected sexual intercourse. 97.7% of these students provided mainstream medical explanations when asked to name to cause of HIV/AIDS. 98.9% of the students responded that those engaging in unprotected sex would be vulnerable to sexually transmitted diseases. These results contravene my position that rural students are more likely to give traditional explanations to causes and consequences relating to HIV/AIDS. It is important to determine where and how these students received this knowledge so that intervention workers can continue using this approach to reach other youth in the country.

The majority of students from each form reported that school teachers have been the first individuals to teach them about HIV/AIDS. 41.4% of the 481 students responding to this question claimed that teachers were their first source of HIV/AIDS information. The students' mothers received the second highest percentage of responses to this question. 19.7% of the students gave such a response. Rural students were more likely to name teachers as their first HIV/AIDS instructors. 47.4% of the students from Matsine Secondary School named teachers as their first instructors compared to 35.4% of those from Marondera High School. The majority of students from both schools (86.6%) reported that they received HIV/AIDS instruction on a weekly basis. It is quite possible that these individuals are receiving their weekly HIV/AIDS instruction in their schools, because HIV/AIDS education classes are now taught in many secondary schools. This

would indicate that school teachers are communicating HIV/AIDS information effectively to the students in both the rural and peri-urban areas.

The effectiveness of teachers as HIV/AIDS intervention workers is further supported by results from the Young Adult Survey (YAS). The youths participating in this survey regarded secondary school teachers as the "single most helpful sources of information on HIV/AIDS" (ZNFPC 2002). UNICEF reported that children unable to attend primary and secondary schools are among the most vulnerable of contracting HIV/AIDS (UNICEF 1999: 15).

Zimbabwe's Education Act of 1987 asserts that "every child has a right to education, though education is not compulsory" (Republic of Zimbabwe 1995: 12). This statement seems to be phrased euphemistically in that it does not note that children unable to pay tuition fees in Zimbabwe are often barred from attending primary and secondary education.

According to Article 28 of the U.N. Convention of the Rights of the Child, of which Zimbabwe is a signatory, primary education should be compulsory and free to all children. "The Government of Zimbabwe considers education a basic human right necessary for social and economic development. Compulsory education is the ultimate future aim as education is a pre-requisite to all forms of individual and national development" (50). Article 28 also encourages each state to develop different types of secondary education in which academic and vocational studies would be "available and accessible" to all children, and that financial assistance be provided as needed (UNICEF 1990). Unfortunately, the country has yet to mandate compulsory education standards.

Even though diverse types of secondary and tertiary education are available, very few are able to afford tuition fees to enroll in these schools.

It is my recommendation that the Republic of Zimbabwe seek international assistance, enabling the State to honor its 1990 pledge to the United Nations that will ensure that Article 28 is fulfilled, and primary and secondary education remain "available and accessible" to all children throughout the country. I propose that Zimbabwe appeal to Millennium Development Goal partners such as UNAIDS, UNICEF, WHO, and the United Nations Population Fund (UNFDA) for assistance in providing primary educational opportunities to all of its children. All of these organizations have branches in Harare, Zimbabwe. The Republic of Zimbabwe should point out to these partners that Target 3 of the Millennium Development Goals is to ensure that all children receive a complete primary school education by 2015 (The World Bank Group 2004).

Gender Equity in Primary and Secondary School Enrollment

The data from this study indicated that gender inequalities may be occurring at the rural school of Matsine Secondary School in terms of female enrollment. When comparing students from Forms 2, 3 and 4, females only made up 44.6% of all students enrolled. However, when comparing the two main groups being studied, Forms 3 and 4, females made up 47.7% of all students. This is more representative of national figures, which indicate that 47% of all secondary school students are females. (Central Statistics Office 34). Although the disparity between male and female enrollment percentages do not seem great, it should be noted that 51.5% of all Zimbabweans are females. Within the District of Hwedza, where Matsine Secondary School is located, females constitute

52.2% of the population (38). The results from this survey may indicate that traditional mores regarding gender roles may be affecting female enrollment at secondary schools.

The National Economic Planning Commission of Zimbabwe have pointed out that gender inequalities are more apparent within secondary schools. "The gender gap in enrollment ratios, although almost nonexistent in primary school level, is quite evident in secondary level and above…the gender imbalance in access to education invariably translates into gender inequity in other areas like employment and decisions making at household level" (NEPC 1998: 26).

By having limited access to formal education, females are handicapped in their abilities to read and discern HIV/AIDS information. Reports indicate that females have a substantially lower literacy rate than males. The adult illiteracy rates for males and females are 9.6% and 20.1%, respectively. Further, a UNAIDS study conducted with youth between the ages of 15-29 within 17 African and 4 Latin American countries indicated that those receiving more education tend to delay sexual activity use greater caution when they do have such experiences. SAFAIDS claims that individuals with more formal education are more likely to use protection during sexual encounters. "A pattern seen in both sexes was that people with more education were far more likely to protect themselves by using condoms for casual sex. An increase of even a few years of schooling translated into a rise in condom use, especially for girls (SAFAIDS 2002: 19).

I would propose that the Republic of Zimbabwe seek assistance from partners of the Millennium Development Goals in order to rectify any gender inequality for secondary school enrollment. The state should point out these partners that Target 4 of

the Millennium Development Goals seeks to eliminate any gender disparity occurring in primary and secondary school by 2005.

Developing a National Advocacy Campaign to Address Denial of HIV/AIDS

The data indicate that students from both the rural and peri-urban schools in this study are reluctant to accept that HIV/AIDS-related deaths may have occurred in their families. The majority of students in this study conceded knowing of someone in general who has died of HIV/AIDS. 76.3% of the 477 students responding to this question made such an acknowledgement. However, very few of these students acknowledged an AIDS-related death in their own family. Only 12.3% of the respondents indicated that a member of their own family had succumbed to this disease. A Rusing Island study conducted by Population Communication Africa with orphans in Nairobi, Kenya also found similar levels of denial. "Not one of 72 children who had recently lost one or both parents to AIDS was prepared to say that someone in their immediate family had died of the disease" (SAFAIDS 1999). The disparity between those who have lost parents and those willing to acknowledge an AIDS death in the family may indicate that students are in denial of this pandemic when it become personal. Tania Boler of the Action Aid Alliance refers to such denial as a 'them, not us' attitude. "One explanation for this is that people do not personalise HIV/AIDS as a problem but see t as something that only happens to other people in other places. They do not therefore see themselves as personally at risk" (Boler 2003: 16).

Widespread stigmatization of HIVAIDS sufferers contributes to the state of denial affiliated with this disease. Helen Jackson of SAFAIDS explains that stigmatization occurs for a variety of reasons. "Stories abound of individuals being rejected and whole

families affected by AIDS, usually out of fear, confusion, shame, anger or blame; these feelings and attitudes need to be understood and changed" (Jackson 2002: 211). Many consider this disease to be the result of a promiscuous and immoral lifestyle. Some mistakenly believe that this disease can be spread through casual contact such as shaking hands. Traditionalists may believe that HIV/AIDS is caused by angry spirits or ancestors. The potential discrimination and rejection that HIV/AIDS sufferers may receive from community residents, close friends and even family members creates an environment in which people do not openly discuss this disease.

The most effective way to address stigmatization and denial is by promoting open dialogue about HIV/AIDS. This dialogue should be led at the national level through an aggressive advocacy campaign. Senegal and Uganda are among the very few countries that have led successful advocacy campaigns, resulting in a reduction of HIV infections. Helen Jackson asserted that Uganda's political leadership was a central reason for the country's success in combating the spread of this disease. "Political commitment and openness were key in turning the epidemic around" (SAFAIDS 2000). Researchers with the Synergy Project suggested that Uganda's ability to enlist support from many sectors in society also contributed to the reduction of this disease. "High-level political support fostered a multi-sectoral response, prioritizing HIV/AIDS and enlisting a wide variety of national participants in the "war" against HIV/AIDS" (Hogle et al. 2002).

The Government of Zimbabwe must take the lead role in cultivating the culture of acceptance towards HIV/AIDS. This will require that politicians begin speaking more openly about this disease. The government should invest in regular radio and television programming, featuring individuals willing to speak about HIV/AIDS. Population

Services International (PSI), which already sponsors several other popular television shows on the Zimbabwe Broadcasting Corporation (ZBC), should collaborate with the government in creating such programming. The government should obtain a health reporter for its nationally owned newspaper, *The Herald*, to ensure that columns about HIV/AIDS appear regularly. Intervention workers from local and international non-governmental organizations should also be asked to contribute bi-monthly articles to this newspaper, also.

It is important that Zimbabwe overcome the stigma of shame that is identified with AIDS-related deaths. Failing to acknowledge such deaths only perpetuates this state of denial. According to SAFAIDS, the media in Zimbabwe consistently reports that its citizens die either of a short or long illness, leaving the impression that no one really succumbs to this pandemic. "Daily newspapers carry columns of death notices, with pictures of young people who have died, but there is never a word about what they died of unless it was a road accident" (SAFAIDS 2002).

I recommend that the government attempt to recruit individuals suffering from HIV/AIDS who will willingly speak about their condition on radio and television shows. It is critical to advocacy efforts that the general public be exposed to courageous individuals willing to acknowledge their HIV status. The government should approach organizations such as the International Community of Women living with HIV/AIDS (ICW) in Zimbabwe, who have recommended the creation of programs that enable women to share their personal experiences of living with this disease (ICW 2002: ix). The government should try to also recruit nationally known figures willing to either speak acceptingly of this disease or acknowledge their own status. This will invariably

increase the perception among Zimbabweans that HIV infections can happen to anyone, and that there is no shame of suffering from such a disease.

I recommend that both the government and non-governmental organizations collaborate in an attempt to mobilize speaking tours for HIV/AIDS patients, who are willing to talk about their condition and interact with their audiences. These tours could be staged within schools, churches and civic meetings to help people understand the realities of this disease and the people who suffer from them. The government may consider providing anti-retroviral drugs to these individuals, which enable them to live longer and continue their advocacy work

I recommend that the government attempt to promote slogans and symbols that will foster acceptance of this disease. These slogans and symbols can be placed on billboards, t-shirts and in newspapers to promote greater acceptance and support for those suffering from HIV/AIDS. This tactic has been used effectively in South Africa by the Treatment Action Campaign (TAC) which is an HIV/AIDS intervention organization. Members from the TAC designed t-shirts with the words, "HIV Positive" on them. These shirts became quite popular within South Africa, attracting acceptance and endorsement of this cause from such popular figures as Nelson Mandela (Berresford 2002).

Collaboration between Primary Health Care and Traditional Healers

The data indicated that the majority of students (57.7%) from the rural and peri-urban schools believed that traditional healers could not help HIV/AIDS sufferers. Geographical location had a statistically significant impact on how the students' regarded traditional healers. Peri-urban students responded in higher percentages that traditional healers could either treat symptoms or cure patients with HIV/AIDS. This contravenes

my position that rural students would be more accepting traditional ideas and practices. 24.4% of the 471 students responding to this question believed that traditional healers could treat symptoms of HIV/AIDS sufferers. Only 1.3% of these students believed these individuals could cure those with this disease.

A sizable amount of students in the study (14.2%) also asserted that traditional healers actually worsened the condition of those living with HIV/AIDS. Some criticism included the harmful advice given by traditional healers, such as encouraging men to have sexual intercourse with a virgin. Others in this group accused these individuals of spreading diseases by cutting patients with unhygienic razor blades in an attempt to insert herbs into their bloodstream. A few of these students charged that the herbs used by traditional healers were useless and at times harmful. Although the herbs prescribed by traditional healers are natural, this does not necessarily mean they are harmless. Particular herbs can be quite potent and have negative affects upon an individual. "Anything strong enough to have pharmacological activity also carries the risk for toxicities…toxic impurities and incorrectly mixed herbs have sometimes resulted in kidney failure and even death (Underwood and Liu 2002).

UNAIDS has urged that practitioners of traditional medicine receive more supervision to curb incidences of malpractice. "When traditional healers engage in harmful practices, there is a public health responsibility to try to change these practices, which is only possible with dialogue and cooperation. Research has shown that traditional healers abstain from dangerous practices when educated about the risks" (UNAIDS 2000: 10). Traditional healers should be held to higher standards, because their practices can have grave consequences. The formal education levels of traditional healers

within Zimbabwe are exceptionally low. In 1997, 47.6% of the 7,348 traditional healers interviewed reported having no formal education. An additional 37.6% of these individuals had not completed their primary school education. Only 2.6% of these individuals had at least a secondary school education or more. These healers believe that their knowledge is inherited, rather than learned (Chavunduka 1997: 43). It is illegal for traditional healers to practice within Zimbabwe without a license. ZINATHA offers a one year training program for traditional healers, enabling these individuals to legally practice in their field.

Professor Chavunduka, president of the Zimbabwe National Traditional Healers Association, stated during an interview with the author that his organization had previously coordinated district and national workshops for traditional healers in order to increase their knowledge of HIV/AIDS and dissuade them from harmful practices such as encouraging sex with virgins. “The workshops had been effective in removing that belief,” he noted. Chavunduka stated that approximately 1000 of the estimated 30,000 traditional healers within Zimbabwe attended these workshops. He stated that the workshops were discontinued when funding had been exhausted. (Interview 2003).

I propose that the Republic of Zimbabwe seek funding from such international health organizations as the WHO or the Center for Disease Control (CDC) to continue the workshops that were previously conducted by ZINATHA. Raising the awareness of traditional healers about HIV/AIDS will help also to eventually increase the understanding of their patients about this pandemic. Professor Chuvunduka has insisted that some customs, which may render Zimbabweans susceptible to HIV/AIDS, can only be successfully addressed through the help of traditional healers, spirit mediums and

chiefs. “The advice given by traditional healers is taken seriously by many people; they are a highly trusted sources of support and information…Once these traditional healers see the need for social change, the will use their powerful positions to problem the needed sexual revolution” (Chavunduka 1990).

I also propose that the government approach members of the primary health care field to encourage collaboration in the certification training sessions conducted by ZINATHA. The government should also seek funding, enabling ZINATHA to offer these traditional sessions at free or reduced costs to all traditional healers. It is important that those in position to disburse herbal medicines be required to have more formal education in this specialty field. The government should request assistance from the WHO, which has published herbal medicine guidelines that “covers cultivating, collecting and classifying plants, with recommendations on quality control, storage, labeling and distribution” (*Biotech Week* 2004). The WHO could participate in ZINATHA certification training sessions. They could also donate as many copies of its herbal medicine guidelines to ZINATHA as needed.

LIMITATIONS AND FUTURE RESEARCH

Limitations

There are obvious limitations when conducting studies within foreign countries for a relatively short period of time. I stayed in Zimbabwe for three months, which enabled me to visit several HIV/AIDS organizations, conduct several interviews and collect many books and other documents unavailable to me in the United States. In some cases, vital statistical information that I sought to needed supplement my data such as the population of all children of secondary school ages was not available.

My main limitation was in building a larger sample size. I had originally requested to conducted surveys in two schools, Matsine Secondary School and Marondera High School. Shortly before leaving for Zimbabwe, I requested and received approval to add another undetermined urban school to the survey. I wanted to determine whether responses to my survey would become gradually more traditional starting from the urban school and continuing to the peri-urban and then rural schools. Unfortunately, I visited Zimbabwe during a time in which the opposition political party organized a weeklong work boycott dubbed the "Final Push" (Mafundikwa 2003). This created tension and suspicion of foreigners within the capital city of Harare, where these protests were occurring and also where I wanted to recruit another school for this survey. Because of this factor, I found that school headmasters were extremely wary of inviting a complete stranger from a foreign country into their school to conduct this study.

Future Research

This study has revealed many other aspects of the HIV/AIDS epidemic in Zimbabwe that have peaked my interest. I hope to conduct more school surveys with a broader spectrum of students in rural, peri-urban and urban areas to continue further investigate the impact of traditional influences. I would like to conduct focus groups and interviews with Zimbabweans of diverse ages and areas of residence on the subject of denial and stigmatization to gain a better understanding of the reasons why dialogue of this pandemic is limited. I would also like to conduct focus groups with Zimbabweans between the ages of 15-29 on the subjects of condom use, dry sex and voluntary counseling and testing. Individuals in this age range are believed to have the highest rates of HIV infection, and I would like to receive more insight into the prevailing attitudes they have towards these aspects of the HIV/AIDS pandemic. Finally, I would like to conduct more interviews with traditional healers of various educational levels and from diverse areas of residence in order to receive a more representative perspective of their attitudes towards HIV/AIDS.

APPENDIX A
Questionnaire

Part I

1. What is your age _____ ?

2. What is your gender _____ ?

3. Number of brothers____ and sisters____ in your family?

4. Are your father (yes or no) _____ and mother (yes or no) _____still living?

5 What is or was the occupation of your

father_____ and mother_____ ?

6. How many years of formal education did your father _____ and mother_____ receive?

7. Which person in your immediate family (brother, sister, father, mother, grandmother and grandfather) has received the most education?_____

8. How much formal education did the person in question 7 receive? _____

9. What is your religion? _____

10. What church do you attend? _____

11. How often do you attend church? _____

12. How often do you pray? (tick one)

a. Several times a day _____

b. Once a day____

c. Several times a week____

d. Once a week____

e. Several times a month____

f. Once a month___

g. Almost never____

h. Never___

13. Do you know anyone who has died of AIDS? _____

14. Has anyone in your family died of AIDS? _____

15. When was the first time you heard about AIDS? _____

16. How many times have you been taught about AIDS? _____

17. Who was the first person who told you about AIDS? _____

Part II

Instructions: Please circle the letter of one answer from each question

1. Rudo lives in a rural area. She has been dating a boy named Peter for three years. Rudo wants to have a faithful relationship with Peter. However, Rudo just learned that Peter has another girlfriend who lives in the city. Rudo should be concerned about her health. She should get tested for AIDS.

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat.
D) I disagree very much.

2. Lovemore has been feeling very ill for three months. He has been having diarrhea constantly. Lovemore decided to visit a traditional healer in his village. The traditional healer told Lovemore that he would feel better once he appeased his ancestors. Lovemore will begin to feel better when he follows the instructions of the traditional healer:

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat
D) I disagree very much

3. Tendai wants to marry a girl named Loveness. Tendai and Loveness have both tested negative for HIV/AIDS. Tendai and Loveness both feel strong. However, Tendai is concerned because he recently saw a green mamba in a tree located near the home of Loveness' family. Tendai should not marry Loveness:

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat.
D) I disagree very much.

4. Tatenda lives in the city. She has been dating a boy named William for three years. Tatenda wants to have a faithful relationship with William. However, Tatenda has just learned that William has another girlfriend in the rural areas. Tatenda should be concerned about her health. She should get tested for AIDS:

A) I agree very much.
B) I agree somewhat.

C) I disagree somewhat.
D) I disagree very much.

5. Farai is a Christian. He goes to church every week. Farai has a very beautiful wife named Spiwe. Before Spiwe was married, she had several boyfriends. She has been very sick for the past six months. Farai should be concerned about his health. He should get tested for AIDS:

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat.
D) I disagree very much.

6. Rutendo is the most clever girl in her school. She always gets very good grades. Her boyfriend is not very clever. Her boyfriend has been complaining about having a headache and a sore throat for the past three months. Rutendo should be concerned about her health. She should get tested for AIDS:

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat.
D) I disagree very much.

7. Obert wants to marry a girl named Nyasha. Both Obert and Nyasha have tested negative for HIV/AIDS. However, when Obert went to visit the family of Nyasha, he saw a black cat sitting by the door of their house. Obert should not marry Nyasha.

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat.
D) I disagree very much.

8. Fungai feels very strong. He is very faithful to his wife. The traditional healer in Fungai's village said that he would bewitch Fungai because he will not appease his ancestors. Fungai should be concerned about his health. He should appease his ancestors:

A) I agree very much
B) I agree somewhat
C) I disagree somewhat.
D) I disagree very much.

9. Tatenda is the most foolish girl in school. She always gets very poor grades. Her boyfriend is very clever. However, he has been complaining about headaches and a sore throat for the past three months. Tatenda does not know why her boyfriend is feeling so poorly. Tatenda should be concerned about her health She should get tested for AIDS:

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat.
D) I disagree very much.

10. Trymore is not religious. He never goes to church. Trymore has a very beautiful wife named Tsitse. Before Tsitse was married, she had many boyfriends. She has been very sick for the past six months. Trymore should be concerned about his health. He should get tested for AIDS:

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat.
D) I disagree very much.

11. Chipo is the traditional healer of his village. His wife died two years ago after a long illness. Chipo has diarrhea sometimes. He believes that his ancestors will cure his diarrhea and make him strong again. Chipo will soon be cured. He should not be concerned about his health:

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat.
D) I disagree very much.

12. Farasai went to visit his medical doctor in the city when he began to feel ill. Now he feels well. However, the people in his village believe that he should have gone to the traditional healer first. Farasai should be concerned that his ancestors will hurt him:

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat.
D) I disagree very much.

13. An owl is sitting on the top of Trymore's house every night. His neighbors believe that something very bad is going to happen to him. Trymore should go to the traditional healer for protection.

A) I agree very much.
B) I agree somewhat.
C) I disagree somewhat.
D) I disagree very much.

Part III.

1. What is the real cause of HIV/AIDS?

_____

_____

_____

_____

2. How can traditional healers help a person with AIDS?

_____

_____

_____

_____

3. What is the best way to avoid getting HIV/AIDS?

_____

_____

_____

_____

4. What happens to a person who does not protect himself or herself during intercourse?

_____

_____

_____

_____

5. What happens to a person after he or she dies?

_____

_____

_____

APPENDIX B

Tables from Part I of the Survey: Demographics Questions

Table 1: Gender dispersion of students from Matsine Secondary School and Marondera High School

	MALES		FEMALES		TOTAL	
School	N	%	N	%	N	%
Matsine-2	28	58.3	20	41.7	48	100%
Matsine-3	63	57.3	47	42.7	110	100%
Matsine-4	33	43.4	43	56.6	76	100%
Marondera-3	60	48.4	64	51.6	124	100%
Marondera-4	61	51.3	58	48.7	119	100%
% of Total	**51.4%**		**48.6%**			

Table 2a: Age dispersion of students from Matsine Secondary School and Marondera High School

			SCHOOLS					Total
AGE			Matsine-3	matsine-4	marondera-3	marondera-4	matsine-2	
	12	Count	0	0	0	0	4	4
		%	.0%	.0%	.0%	.0%	8.3%	.8%
	13	Count	2	0	1	0	14	17
		%	1.8%	.0%	.8%	.0%	29.2%	3.5%
	14	Count	6	6	26	0	19	57
		%	5.5%	7.7%	20.8%	.0%	39.6%	11.9%
	15	Count	32	17	81	13	7	150
		%	29.1%	21.8%	64.8%	10.8%	14.6%	31.2%
	16	Count	38	10	17	67	3	135
		%	34.5%	12.8%	13.6%	55.8%	6.3%	28.1%
	17	Count	24	27	0	36	0	87
		%	21.8%	34.6%	.0%	30.0%	.0%	18.1%
	18	Count	6	12	0	4	1	23
		%	5.5%	15.4%	.0%	3.3%	2.1%	4.8%
	19	Count	1	2	0	0	0	3
		%	33.3%	66.7%	.0%	.0%	.0%	100.0%
	20	Count	1	3	0	0	0	4
		%	.9%	3.8%	.0%	.0%	.0%	.8%
	Total	Count	0	1	0	0	0	1
		%	.0%	1.3%	.0%	.0%	.0%	.2%
		Count	110	78	125	120	48	481
		%	22.9%	16.2%	26.0%	24.9%	10.0%	100.0%

Table 2b: Mean and median ages of Students from Matsine Secondary School and Marondera High School

SCHOOL	Mean Age	N	Std. Deviation	Median	Range
Matsine-3	15.94	110	1.160	16.00	7
Matsine-4	16.58	78	1.533	17.00	7
Marondera-3	14.91	125	.609	15.00	3
Marondera-4	16.26	120	.692	16.00	3
Matsine-2	13.90	48	1.171	14.00	6
Total	15.65	481	1.316	16.00	9

Table 3: Median number of siblings in families of students from Matsine Secondary School and Marondera High School

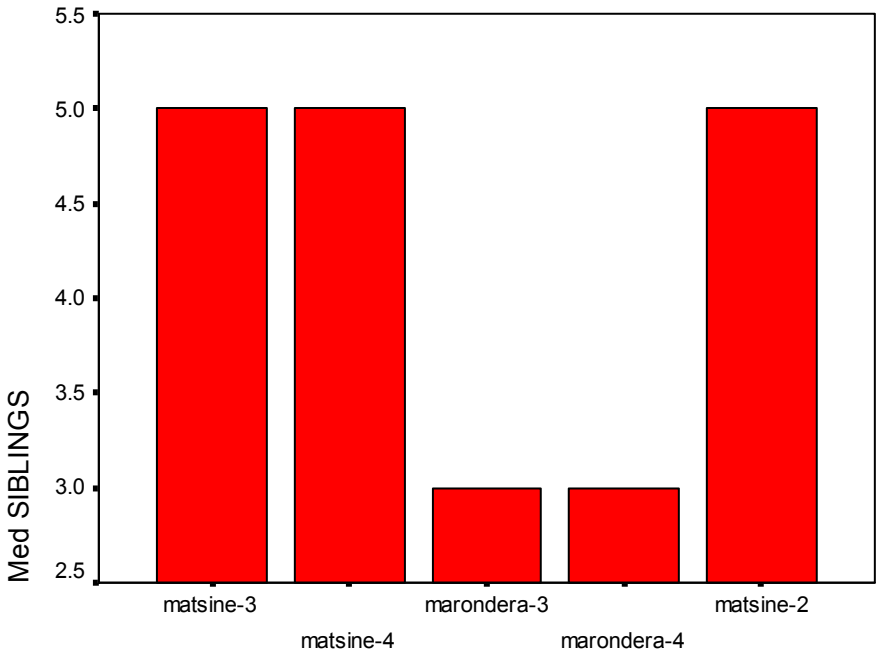

Table 4: Life expectancy for fathers of students from Matsine Secondary School and Marondera High School

	FATHER STILL ALIVE		FATHER DECEASED		TOTAL		% of Total
Schools	N	%	N	%	N	%	N
Matsine-2	27	56.3%	21	43.8%	48	100%	10%
Matsine-3	75	68.2%	35	31.8%	110	100%	23%
Matsine-4	58	74.4%	20	25.6%	78	100%	16.3%
Marondera-3	108	87.1%	16	12.9%	124	100%	25.9%
Marondera-4	102	85.7%	17	14.3%	119	100%	24.8%
Total	370	77.2%	109	22.8%			

Table 5: Life expectancy for mothers of students from Matsine Secondary School and Marondera High School

	MOTHER STILL ALIVE		MOTHER DECEASED		TOTAL		% of Total
Schools	N	%	N	%	N	%	N
Matsine-2	39	81.3%	9	18.8	48	100%	10.1%
Matsine-3	88	80.7%	21	19.3	109	100%	22.9%
Matsine-4	65	84.4%	12	15.6	77	100%	16.1%
Marondera-3	117	94.4%	7	5.6	124	100%	26%
Marondera-4	103	86.6%	16	13.4	119	100%	24.9%
Total	414	86.6%	64	13.4%	478	100%	

Table 6a: Occupations of fathers of students from Matsine Secondary School and Marondera High School

OCCUPATONS OF FATHERS										
	Tech/ Prof	**Business Owner/ Mgr.**	**Skilled labor**	**Unskilled Labor**	**Govt. Service**	**Service Industry**	**Clerical**	**Unemployed**	**N/A**	**Total**
Matsine-2										
Count	5	0	6	22	4	8	1	0	2	46
%	10.4%	.0%	12.5%	45.8%	8.3%	16.7%	2.1%	.0%	4.1%	9.5%
Mastine-3										
Count	12	11	23	29	7	11	3	0	14	110
%	10.9%	10%	20.9%	26.4%	6.4%	10%	2.7%	.0%	12.7%	22.8%
Matsine-4										
Count	7	5	17	34	6	5	1	0	3	78
%	9%	6.4%	21.8%	43.6%	7.7%	6.4%	1.3%	.0%	3.8%	16.2%
Marondera3										
Count	53	27	8	5	14	6	2	0	11	126
%	42.1%	21.4%	6.3%	4%	11.1%	4.8%	1.6%	.0%	8.7%	26.1%
Marondera4										
Count	38	27	5	7	20	5	2	0	16	120
%	9%	22.5%	4.2%	5.8%	16.7%	4.2%	1.7%	.0%	13.3%	24.9%
Total										
Count	115	70	59	97	51	35	9	0	46	482
%	23.9%	14.5%	12.2%	20.1%	10.6%	7.3%	1.9%	0%	9.5%	

Table 6b: Occupations of mothers of students from Matsine Secondary School and Marondera High School

OCCUPATIONS OF MOTHERS										
	Tech/Prof	**Business owner/mgr.**	**Skilled labor**	**Unskilled Labor**	**Govt. Service**	**Service Industry**	**Clerical**	**Unemployed**	**N/A**	**Total**
Matsine-2										
Count	1	0	2	7	0	1	0	37	0	48
%	2.1%	.0%	4.2%	14.6%	.0%	2.1%	.0%	77.1%	.0%	10%
Mastine-3										
Count	3	1	6	21	0	4	0	67	8	110
%	2.7%	.9%	5.5%	19.1%	.0%	3.6%	.0%	60.9%	7.3%	22.9%
Matsine-4										
Count	1	2	4	29	1	4	1	33	3	78
%	1.3%	2.6%	5.1%	37.2%	1.3%	5.1%	1.3%	42.3%	3.8%	16.2%
Marondera3										
Count	44	14	19	4	4	4	8	21	0	126
%	34.9%	11.1%	15.1%	3.2%	3.2%	3.2%	6.3%	17.6%	.0%	26.2%
Marondera4										
Count	41	5	11	5	4	6	12	21	14	119
%	34.5%	4.2%	9.2%	4.2%	3.4%	5%	10.1%	17.6%	11.8%	24.7%
Total										
Count	90	22	42	66	9	19	21	179	33	481
%	18.7%	4.6%	8.7%	13.7%	1.9%	4%	4.4%	37.2%	6.9%	

Table 7: Most highly educated family member of students from Matsine Secondary School and Marondera High School

			SCHOOLS					Total
MOST EDUCATED PERSON IN THE FAMILY			1.00 Matsine-3	2.00 Matsine-4	3.00 Marondera-3	4.00 Marondera-4	5.00 Matsine 2	
	1.00 brother	Count	52	32	23	21	11	139
		%	47.7%	41.6%	19.2%	18.3%	22.9%	29.6%
	2.00 sister	Count	21	23	16	11	7	78
		%	19.3%	29.9%	13.3%	9.6%	14.6%	16.6%
	3.00 father	Count	25	12	48	55	17	157
		%	22.9%	15.6%	40.0%	47.8%	35.4%	33.5%
	4.00 mother	Count	5	7	14	12	3	41
		%	4.6%	9.1%	11.7%	10.4%	6.3%	8.7%
	5.00 grandmother	Count	0	1	0	0	0	1
		%	.0%	1.3%	.0%	.0%	.0%	.2%
	6.00 grandfather	Count	5	2	1	4	1	13
		%	4.6%	2.6%	.8%	3.5%	2.1%	2.8%
	8.00 uncle	Count	1	0	0	0	0	1
		%	.9%	.0%	.0%	.0%	.0%	.2%
	9.00 mother and father	Count	0	0	16	10	9	35
		%	.0%	.0%	13.3%	8.7%	18.8%	7.5%
	10.00 aunt	Count	0	0	1	1	0	2
		%	.0%	.0%	.8%	.9%	.0%	.4%
	11.00 mother and father	Count	0	0	1	0	0	1
		%	.0%	.0%	.8%	.0%	.0%	.2%
	12.00 self	Count	0	0	0	1	0	1
		%	.0%	.0%	.0%	.9%	.0%	.2%
Total		Count	109	77	120	115	48	469
		%	100%	100%	100%	100%	100%	100%

Table 8: Churches attended by students from Matsine Secondary School and Marondera High School

CHURCH ATTENDED		SCHOOLS					Total
		1.00 matsine-3	2.00 matsine-4	3.00 marondera-3	4.00 marondera-4	5.00 matsine-2	
1 Catholic	Count	19	15	19	20	8	81
	%	17.4%	19.5%	15.8%	17.2%	16.7%	17.2%
2 Seventh Day Adventist	Count	2	4	9	8	1	24
	%	1.8%	5.2%	7.5%	6.9%	2.1%	5.1%
3 Jehovah's Witness	Count	0	0	2	1	1	4
	%	.0%	.0%	1.7%	.9%	2.1%	.9%
4 Indigenous Christian Churches	Count	39	27	23	32	18	139
	%	35.8%	35.1%	19.2%	27.6%	37.5%	29.6%
5 Anglican	Count	15	17	20	16	7	75
	%	13.8%	22.1%	16.7%	13.8%	14.6%	16.0%
6 Other Christian Churches	Count	2	0	22	8	0	32
	%	1.8%	.0%	18.3%	6.9%	.0%	6.8%
7 Salvation Army	Count	2	3	2	1	4	12
	%	1.8%	3.9%	1.7%	.9%	8.3%	2.6%
8 Methodist	Count	18	9	22	24	2	75
	%	16.5%	11.7%	18.3%	20.7%	4.2%	16.0%
9 Church of Christ	Count	11	0	1	2	3	17
	%	64.7%	.0%	5.9%	11.8%	17.6%	100.0%
10 Traditional Religion	Count	1	2	0	1	4	8
	%	.9%	2.6%	.0%	.9%	8.3%	1.7%
11 Moslem	Count	0	0	0	2	0	2
	%	.0%	.0%	.0%	1.7%	.0%	.4%
12 No church	Count	0	0	0	1	0	1
	%	.0%	.0%	.0%	.9%	.0%	.2%
Total	Count	109	77	120	116	48	470
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 9: Religions of students from Matsine Secondary School and Marondera High School.

			RELIGION				
			1 Christianity	2 Indigenous Christian	3 Traditional	4 Muslim	Total
SCHOOL	1.00 Matsine-3	Count	69	39	1	0	109
		%	63.3%	35.8%	.9%	.0%	100%
	2.00 Matsine-4	Count	48	28	2	0	78
		%	61.5%	35.9%	2.6%	.0%	100%
	3.00 Marondera-3	Count	104	22	0	0	126
		%	82.5%	17.5%	.0%	.0%	100%
	4.00 Marondera-4	Count	84	32	2	2	120
		%	70.0%	26.7%	1.7%	1.7%	100%
	5.00 Matsine-2	Count	26	18	4	0	48
		%	54.2%	37.5%	8.3%	.0%	100%
Total		Count	331	139	9	2	481
		%	68.8%	28.9%	1.9%	.4%	100%

Table 10: Frequency of church attendance of students from Matsine Secondary School and Marondera High School

			FREQUENCY OF CHUCH ATTENDANCE					
			once a day	**one or more times a week**	**one or more times a month**	**very little every year**	**never**	**Total**
SCHOOLS	**Matsine-3**	**Count**	22	75	3	0	0	100
		%	22.0%	75.0%	3.0%	.0%	.0%	100.0%
	Matsine-4	**Count**	5	68	1	1	0	75
		%	6.7%	90.7%	1.3%	1.3%	.0%	100.0%
	Marondera-3	**Count**	2	98	8	10	0	118
		%	1.7%	83.1%	6.8%	8.5%	.0%	100.0%
	Marondera-4	**Count**	1	78	13	9	1	102
		%	1.0%	76.5%	12.7%	8.8%	1.0%	100.0%
	Matsine-2	**Count**	0	40	1	0	0	41
		%	.0%	97.6%	2.4%	.0%	.0%	100.0%
Total		**Count**	30	359	26	20	1	436
		%	6.9%	82.3%	6.0%	4.6%	.2%	100.0%

Table 11: Frequency in which students from Matsine Secondary School and Marondera High School pray

			FREQUENCY OF PRAYER					Total
			once a day	one or more times a week	one or more times a month	very little each year	never	
SCHOOLS	**Matsine-3**	**Count**	68	35	6	0	0	109
		%	62.4%	32.1%	5.5%	.0%	.0%	100.0%
	Matsine-4	**Count**	38	33	3	0	3	77
		%	49.4%	42.9%	3.9%	.0%	3.9%	100.0%
	Marondera-3	**Count**	101	19	5	1	0	126
		%	80.2%	15.1%	4.0%	.8%	.0%	100.0%
	Marondera-4	**Count**	81	30	7	0	1	119
		%	68.1%	25.2%	5.9%	.0%	.8%	100.0%
	Matsine-2	**Count**	24	17	2	1	4	48
		%	50.0%	35.4%	4.2%	2.1%	8.3%	100.0%
Total		**Count**	312	134	23	2	8	479
		%	65.1%	28.0%	4.8%	.4%	1.7%	100.0%

Table 12: Students from Matsine Secondary School and Marondera High School who know someone they believe died of AIDS

	Knows someone who has died of HIV/AIDS	**Does not know anyone who has died of HIV/AIDS**	**Not sure if they know someone who has died of HIV/AIDS**	**Total**
Matsine-2				
Count	40	8	0	48
%	83.3%	16.7%	.0	10.1%
Matsine-3				
Count	74	35	0	109
%	67.9%	32.1%	.0	22.9%
Matsine-4				
Count	64	13	0	77
Percentage	83.1%	16.9%	.0	16.1%
Marondera-3				
Count	88	35	0	124
Percentage	71%	28.2%	.0	26.%
Marondera-4				
Count	98	21	1	119
Percentage	82.4%	17.6%	.8	24.9%
Total				
Count	364	112	1	477
Percentage	76.3%	23.5%	.2%	100%

Table 13: Students from Matsine Secondary School and Marondera High School who know someone in their family that they believe died of AIDS

	Knows family member who has died of HIV/AIDS	**Does not know of family member who has died of HIV/AIDS**	**Not sure if they know of a family member who has died of HIV/AIDS**	**Total**
Matsine-2				
Count	4	43	1	48
%	8.3%	89.6%	2.1%	10.1%
Matsine-3				
Count	9	99	0	108
%	8.3%	91.7%	.0	22.9%
Matsine-4				
Count	11	66	0	77
Percentage	14.3%	85.7%	.0	16.1%
Marondera-3				
Count	15	99	8	122
Percentage	12.3%	81.1%	6.6%	26.%
Marondera-4				
Count	19	94	3	116
Percentage	16.4%	81%	2.6%	24.9%
Total				
Count	58	401	12	471
Percentage	12.3%	85.1%	2.5%	100%

Pearson Chi-Square = .026 (this figure is less than .05)

Table 14a: Median year in which students from Matsine Secondary School and Marondera High School were first exposed to HIV/AIDS instruction

		AIDSKY	SCHOOL
N	Valid	438	482
	Missing	44	0
Median		1997.00	3.0000

Table 14b: Dispersion of median years in which students from Matsine Secondary School and Marondera High School were first exposed to HIV/AIDS instruction

YEAR IN WHICH STUDENT WAS TAUGHT ABOUT HIV/AIDS		SCHOOLS					Total
		Matsine -3	Matsine -4	Marondera-3	Marondera - 4	Matsine-2	
1988	Count	1	0	0	0	0	1
	%	.9%	.0%	.0%	.0%	.0%	.2%
1989	Count	1	1	0	0	0	2
	%	.9%	1.3%	.0%	.0%	.0%	.5%
1990	Count	2	1	0	2	2	7
	%	1.9%	1.3%	.0%	1.9%	4.2%	1.6%
1991	Count	1	2	0	2	1	6
	%	.9%	2.6%	.0%	1.9%	2.1%	1.4%
1992	Count	3	5	1	5	1	15
	%	2.8%	6.4%	1.0%	4.8%	2.1%	3.4%
1993	Count	2	4	4	7	2	19
	%	1.9%	5.1%	3.9%	6.7%	4.2%	4.3%
1994	Count	8	4	12	11	0	35
	%	7.5%	5.1%	11.8%	10.6%	.0%	8.0%
1995	Count	15	8	15	13	3	54
	%	14.2%	10.3%	14.7%	12.5%	6.3%	12.3%
1996	Count	14	9	11	25	5	64
	%	13.2%	11.5%	10.8%	24.0%	10.4%	14.6%
1997	Count	23	13	17	14	6	73
	%	21.7%	16.7%	16.7%	13.5%	12.5%	16.7%
1998	Count	16	9	16	9	12	62
	%	15.1%	11.5%	15.7%	8.7%	25%	14.2%
1999	Count	13	13	16	11	9	62
	%	12.3%	16.7%	15.7%	10.6%	18.8%	14.2%
2000	Count	4	9	7	5	6	31
	%	3.8%	11.5%	6.9%	4.8%	12.5%	7.1%
2001	Count	3	0	2	0	0	5
	%	2.8%	.0%	2.0%	.0%	.0%	1.1%
2002	Count	0	0	1	0	1	2
	%	.0%	.0%	1.0%	.0%	2.1%	.5%
Total	Count	106	78	102	104	48	438
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %

Table 15: Frequency in which students from Matsine Secondary School and Marondera High School are taught about HIV/AIDS.

			Frequency of HIV/AIDS Instruction					
			daily	weekly	monthly	Yearly	never	Total
SCHOOLS	**Matsine-3**	Count	1	96	4	8	0	109
		%	.9%	88.1%	3.7%	7.3%	.0%	100.0%
	Matsine-4	Count	0	76	0	2	0	78
		%	.0%	97.4%	.0%	2.6%	.0%	100.0%
	Marondera-3	Count	6	102	2	14	0	124
		%	4.8%	82.3%	1.6%	11.3%	.0%	100.0%
	Marondera-4	Count	10	92	1	15	1	119
		%	8.4%	77.3%	.8%	12.6%	.8%	100.0%
	Matsine-2	Count	0	48	0	0	0	48
		%	.0%	100.0%	.0%	.0%	.0%	100.0%
Total		Count	17	414	7	39	1	478
		%	3.6%	86.6%	1.5%	8.2%	.2%	100.0%

Table 16: First person who taught students from Matsine Secondary School and Marondera High School about HIV/AIDS

Sources of Information		SCHOOL					Total
		matsine-3	matsine-4	marondera-3	marondera-4	matsine-2	
Teacher	Count	43	40	47	37	29	196
	%	39.1%	51.3%	38.5%	32.2%	60.4%	41.4%
Father	Count	7	1	5	5	6	24
	%	6.4%	1.3%	4.1%	4.3%	12.5%	5.1%
Mother	Count	13	8	36	31	5	93
	%	11.8%	10.3%	29.5%	27.0%	10.4%	19.7%
Mother and Father	Count	8	1	10	2	0	21
	%	7.3%	1.3%	8.2%	1.7%	.0%	4.4%
Minister	Count	0	0	0	1	0	1
	%	.0%	.0%	.0%	.9%	.0%	.2%
Traditional Healer	Count	0	0	0	1	0	1
	%	.0%	.0%	.0%	.9%	.0%	.2%
Friends	Count	8	5	2	5	1	21
	%	7.3%	6.4%	1.6%	4.3%	2.1%	4.4%
Media	Count	0	0	9	11	0	20
	%	.0%	.0%	7.4%	9.6%	.0%	4.2%
Aunt	Count	2	9	0	2	0	13
	%	1.8%	11.5%	.0%	1.7%	.0%	2.7%
Doctor/Nurse/ Health Professional	Count	16	7	1	2	2	28
	%	14.5%	9.0%	.8%	1.7%	4.2%	5.9%
Uncle	Count	4	0	0	4	0	8
	%	3.6%	.0%	.0%	3.5%	.0%	1.7%
Brother	Count	8	2	1	1	2	14
	%	7.3%	2.6%	.8%	.9%	4.2%	3.0%
Sister	Count	1	1	3	3	2	10
	%	.9%	1.3%	2.5%	2.6%	4.2%	2.1%
Do not remember/not sure	Count	0	0	5	4	0	9
	%	.0%	.0%	4.1%	3.5%	.0%	1.9%
Other Person	Count	0	4	2	5	0	11
	%	.0%	5.1%	1.6%	4.3%	.0%	2.3%
Grandmother	Count	0	0	1	1	1	3
	%	.0%	.0%	.8%	.9%	2.1%	.6%
Total	Count	110	78	122	115	48	473
	% of Total	23.3%	16.5%	25.8%	24.3%	10.1%	100.0%

APPENDIX C

Tables from Part II of the Survey: Hypothetical Questions

Table 17: A comparison of students from Matsine Secondary School and Marondera High School who agree and disagree that a person should get HIV tested after discovering that their partner has been unfaithful with someone in the urban area of Zimbabwe

					Total
			Student Agreed	**Student Disagreed**	
SCHOOLS	**1.00 matsine-3**	Count	88	17	105
		%	83.8%	16.2%	100.0%
	2.00 matsine-4	Count	61	15	76
		%	80.3%	19.7%	100.0%
	3.00 marondera-3	Count	119	4	123
		%	96.7%	3.3%	100.0%
	4.00 marondera-4	Count	104	15	119
		%	87.4%	12.6%	100.0%
	5.00 matsine-2	Count	41	7	48
		%	85.4%	14.6%	100.0%
		Count	413	58	471
		%	87.7%	12.3%	100.0%
		% of Total	87.7%	12.3%	100.0%

Pearson Chi-Square = .026 (this figure is less than .05)

Table 18: A comparison of students from Matsine Secondary School and Marondera High School who believe that a traditional healer has the ability to bewitch a person

			Students Agreed	Students Disagreed	Total
SCHOOL	**Matsine-3**	Count	27	79	106
		% SCHOOL	25.5%	74.5%	100.0%
	Matsine-4	Count	46	32	78
		% SCHOOL	59.0%	41.0%	100.0%
	Marondera-3	Count	3	121	124
		% SCHOOL	2.4%	97.6%	100.0%
	Marondera-4	Count	14	106	120
		% SCHOOL	11.7%	88.3%	100.0%
	Matsine-2	Count	5	43	48
		% SCHOOL	10.4%	89.6%	100.0%
Total		Count	95	381	476
		%	20.0%	80.0%	100.0%
		% of Total	20.0%	80.0%	100.0%

Pearson Chi-Square = .000 (this figure is less than .05)

Table 19: A comparison of students from Matsine Secondary School and Marondera High School who agree and disagree that a snake represents an ominous symbol of misfortune

					Total
			Student Agreed	**Student Disagreed**	
SCHOOLS	**Matsine-3**	Count	24	85	109
		%	22.0%	78.0%	100.0%
	Matsine-4	Count	16	61	77
		%	20.8%	79.2%	100.0%
	Marondera-3	Count	8	115	123
		%	6.5%	93.5%	100.0%
	Marondera-4	Count	7	113	120
		%	5.8%	94.2%	100.0%
	Matsine-2	Count	17	31	48
		%	35.4%	64.6%	100.0%
Total		Count	72	405	477
		% of Total	15.1%	84.9%	100.0%

Pearson Chi-Square = .000 (this figure is less than .05)

Table 20: A comparison of students from Matsine Secondary School and Marondera High School who believe and disbelieve that a person should get HIV tested after discovering their partner has been unfaithful in a rural area of Zimbabwe

					Total
			Student Agreed	**Student Disagreed**	
SCHOOLS	**Matsine-3**	**Count**	86	24	110
		%	78.2%	21.8%	100.0%
	Matsine-4	**Count**	64	14	78
		%	82.1%	17.9%	100.0%
	Marondera-3	**Count**	116	8	124
		%	93.5%	6.5%	100.0%
	Marondera-4	**Count**	103	16	119
		%	86.6%	13.4%	100.0%
	Matsine-2	**Count**	28	20	48
		%	58.3%	41.7%	100.0%
Total		**Count**	397	82	479
		% of Total	82.9%	17.1%	100.0%

Pearson Chi-Square = .000 (this figure is less than .05)

Table 21: A comparison of students from Matsine Secondary School and Marondera High School who believe and disbelieve that a person's Christian faith will protect them from contracting HIV/AIDS

			FARAI2		
			Student Agreed	**Student Disagreed**	**Total**
SCHOOLS	**Matsine-3**	Count	98	12	110
		% within SCHOOL	89.1%	10.9%	100.0%
	Matsine-4	Count	69	9	78
		% within SCHOOL	88.5%	11.5%	100.0%
	Marondera-3	Count	123	2	125
		% within SCHOOL	98.4%	1.6%	100.0%
	Marondera-4	Count	117	3	120
		% within SCHOOL	97.5%	2.5%	100.0%
	Matsine-2	Count	45	3	48
		% within SCHOOL	93.8%	6.3%	100.0%
Total		Count	452	29	481
		% of Total	94.0%	6.0%	100.0%

Pearson Chi-Square = .003 (this figure is less than .05)

Table 22: A comparison of students from Matsine Secondary School and Marondera High School who believe and disbelieve that a person's intelligence level will affect their chances of contracting HIV/AIDS

			RUTENDO2		
			Student Agreed	**Student Disagreed**	**Total**
SCHOOLS	**Matsine-3**	Count	53	56	109
		%	48.6%	51.4%	100.0%
	Matsine-4	Count	43	35	78
		%	55.1%	44.9%	100.0%
	Marondera-3	Count	58	67	125
		%	46.4%	53.6%	100.0%
	Marondera-4	Count	65	55	120
		%	54.2%	45.8%	100.0%
	Matsine-2	Count	26	22	48
		%	54.2%	45.8%	100.0%
Total		Count	245	235	480
		%	51.0%	49.0%	100.0%

Pearson Chi-Square = .643 (this figure is more than .05)

Table 23: A comparison of students from Matsine Secondary School and Marondera High School who believe and disbelieve that a black cat represents an ominous symbol of misfortune

			recoded obert2a		
			Student Agreed	**Student Disagreed**	**Total**
SCHOOLS	**Matsine-3**	Count	19	89	108
		%	17.6%	82.4%	100.0%
	Matsine-4	Count	27	48	75
		%	36.0%	64.0%	100.0%
	Marondera-3	Count	10	114	124
		%	8.1%	91.9%	100.0%
	Marondera-4	Count	14	106	120
		%	11.7%	88.3%	100.0%
	Matsine-2	Count	13	34	47
		%	27.7%	72.3%	100.0%
Total		Count	83	391	474
		%	17.5%	82.5%	100.0%

Pearson Chi-Square = .000 (this figure is less than .05)

Table 24*:* A comparison of students from Matsine Secondary School and Marondera High School who believe and disbelieve that a traditional healer can bewitch another individual

			FUNGAI2		
			Student Agreed	**Student Disagreed**	**Total**
SCHOOLS	**Matsine-3**	Count	34	75	109
		%	31.2%	68.8%	100.0%
	Matsine-4	Count	33	44	77
		%	42.9%	57.1%	100.0%
	Marondera-3	Count	5	119	124
		%	4.0%	96.0%	100.0%
	Marondera-4	Count	17	100	117
		%	14.5%	85.5%	100.0%
	Matsine-2	Count	19	29	48
		%	39.6%	60.4%	100.0%
Total		Count	108	367	475
		%	22.7%	77.3%	100.0%

Pearson Chi-Square = .000 (this figure is less than .05)

Table 25: A comparison of students from Matsine Secondary School and Marondera High School who believe and disbelieve that a person of lesser intelligence is more vulnerable to contracting HIV/AIDS

			TATENDAB		**Total**
			Student Agreed	**Student Disagreed**	
SCHOOLS	**Matsine-3**	Count	56	52	108
		%	51.9%	48.1%	100.0%
	Matsine-4	Count	44	34	78
		%	56.4%	43.6%	100.0%
	Marondera-3	Count	72	52	124
		%	58.1%	41.9%	100.0%
	Marondera-4	Count	62	57	119
		%	52.1%	47.9%	100.0%
	Matsine-2	Count	36	12	48
		%	75.0%	25.0%	100.0%
Total		Count	270	207	477
		%	56.6%	43.4%	100.0%

Pearson Chi-Square = .069 (this figure is more than .05)

Table 26: A comparison of students from Matsine Secondary School and Marondera High School who believe and disbelieve that a person's lack of religion will make him more vulnerable to contracting HIV/AIDS

			TRYMORE2		
			Student Agreed	**Student Disagreed**	**Total**
SCHOOLS	**Matsine-3**	Count	83	24	107
		%	77.6%	22.4%	100.0%
	Matsine-4	Count	64	14	78
		%	82.1%	17.9%	100.0%
	Marondera-3	Count	119	3	122
		%	97.5%	2.5%	100.0%
	Marondera-4	Count	111	8	119
		%	93.3%	6.7%	100.0%
	Matsine-2	Count	44	4	48
		%	91.7%	8.3%	100.0%
Total		Count	421	53	474
		%	88.8%	11.2%	100.0%

Pearson Chi-Square = .000 (this figure is less than .05)

Table 27*:* A comparison of students from Matsine Secondary School and Marondera High School who believe and disbelieve that a traditional healer is able to cure himself of an illness by appeasing ancestors

			CHIPO2		**Total**
			Student Agreed	**Student Disagreed**	
SCHOOLS	**Matsine-3**	Count	40	69	109
		%	36.7%	63.3%	100.0%
	Matsine-4	Count	20	57	77
		%	26.0%	74.0%	100.0%
	Marondera-3	Count	19	104	123
		%	15.4%	84.6%	100.0%
	Marondera-4	Count	16	103	119
		%	13.4%	86.6%	100.0%
	Matsine-2	Count	27	21	48
		%	56.3%	43.8%	100.0%
Total		Count	122	354	476
		%	25.6%	74.4%	100.0%

Pearson Chi-Square = .000 (this figure is less than .05)

Table 28: A comparison of students from Matsine Secondary School and Marondera High School who believe and disbelieve that ancestors have the power to bewitch a person

			FARASAI2		
			Student Agreed	**Student Disagreed**	**Total**
SCHOOLS	**Matsine-3**	Count	31	78	109
		%	28.4%	71.6%	100.0%
	Matsine-4	Count	36	41	77
		%	46.8%	53.2%	100.0%
	Marondera-3	Count	15	109	124
		%	12.1%	87.9%	100.0%
	Marondera-4	Count	15	103	118
		%	12.7%	87.3%	100.0%
	Matsine-2	Count	5	43	48
		%	10.4%	89.6%	100.0%
Total		Count	102	374	476
		%	21.4%	78.6%	100.0%

Pearson Chi-Square = .000 (this figure is less than .05)

Table 29: A comparison of students from Matsine Secondary School and Marondera High School who believe and disbelieve that owls represent an ominous symbol of misfortune

			OWL2		
			Student Agreed	**Student Disagreed**	**Total**
SCHOOLS	**Matsine-3**	Count	51	58	109
		%	46.8%	53.2%	100.0%
	Matsine-4	Count	49	27	76
		%	64.5%	35.5%	100.0%
	Marondera-3	Count	17	108	125
		%	13.6%	86.4%	100.0%
	Marondera-4	Count	32	87	119
		%	26.9%	73.1%	100.0%
	Matsine-2	Count	27	21	48
		%	56.3%	43.8%	100.0%
Total		Count	176	301	477
		%	36.9%	63.1%	100.0%

Pearson Chi-Square = .000 (this figure is less than .05)

APPENDIX D
Open-Ended Questions

Table 30: A comparison of what students from Matsine Secondary School and Marondera High School believe to be the cause HIV/AIDS

SCHOOLS			The Real Cause of HIV/AIDS				
			Mainstream Medical/ Biological	Personal/ Sociological Explanation	Spiritual Explanation	Not sure	Total
	matsine-3	Count	108	1	0	1	110
		%	98.2%	.9%	.0%	.9%	100.0%
	matsine-4	Count	75	0	0	1	76
		%	98.7%	.0%	.0%	1.3%	100.0%
	marondera-3	Count	123	3	0	0	126
		%	97.6%	2.4%	.0%	.0%	100.0%
	marondera-4	Count	112	1	1	3	117
		%	95.7%	.9%	.9%	2.6%	100.0%
	matsine-2	Count	47	0	0	0	47
		%	100.0%	.0%	.0%	.0%	100.0%
Total		Count	465	5	1	5	476
		%	97.7%	1.1%	.2%	1.1%	100.0%

Pearson Chi-Square = .523 (this figure is more than .05)

Table 31: A comparison of what students from Matsine Secondary School and Marondera High School believe regarding a traditional healer's ability to assist HIV/AIDS sufferers

			Traditional Healer's Ability to Help HIV/AIDS Sufferer					
			Cannot help	Makes Situation Worse	Treats Symptoms	Cures Disease	Not sure	Total
SCHOOL	matsine-3	Count	83	9	14	1	1	108
		%	76.9%	8.3%	13.0%	.9%	.9%	100.0%
	matsine-4	Count	55	7	15	0	1	78
		%	70.5%	9.0%	19.2%	.0%	1.3%	100.0%
	marondera-3	Count	47	34	35	3	1	120
		%	39.2%	28.3%	29.2%	2.5%	.8%	100.0%
	marondera-4	Count	58	17	35	5	2	117
		%	49.6%	14.5%	29.9%	4.3%	1.7%	100.0%
	matsine-2	Count	29	0	16	2	1	48
		%	60.4%	.0%	33.3%	4.2%	2.1%	100.0%
Total		Count	272	67	115	11	6	471
		%	57.7%	14.2%	24.4%	2.3%	1.3%	100.0%

Pearson Chi-Square = .000 (this figure is less than .05)

Table 32: A comparison of what students from Matsine Secondary School and Marondera High School consider as the best means to avoid HIV/AIDS infections

			The Best Way to Avoid HIV/AIDS					Total
			matsine-3	matsine-4	Marondera-3	maronder a-4	matsine-2	
AVOIDAID	Abstinence	Count	54	44	83	85	24	290
		%	49.1%	56.4%	65.9%	70.8%	50.0%	60.2%
	Condom Use	Count	20	12	10	11	4	57
		%	18.2%	15.4%	7.9%	9.2%	8.3%	11.8%
	Fidelity	Count	31	18	26	19	20	114
		%	28.2%	23.1%	20.6%	15.8%	41.7%	23.7%
	Get self/partner tested	Count	2	0	2	0	0	4
		%	1.8%	.0%	1.6%	.0%	.0%	.8%
	Practice Christianity	Count	0	0	3	1	0	4
		%	.0%	.0%	2.4%	.8%	.0%	.8%
	Appease Ancestors	Count	0	0	0	1	0	1
		%	.0%	.0%	.0%	.8%	.0%	.2%
	No response	Count	3	3	2	2	0	10
		%	2.7%	3.8%	1.6%	1.7%	.0%	2.1%
	Don't share razor blades/needles	Count	0	1	0	1	0	2
		%	.0%	1.3%	.0%	.8%	.0%	.4%
Total		Count	110	78	126	120	48	482
		%	22.8%	16.2%	26.1%	24.9%	10.0%	100.%

Pearson Chi-Square = .032 (this figure is less than .05)

Table 33: A comparison in what students from Matsine Secondary School and Marondera High School believe to be the consequences of unprotected sex

			Consequences of Unprotected Sex				Total
			Physical Consequences	Emotional Consequences	Traditional Spiritual Consequences	No consequences/ sexual pleasure	
SCHOOL	matsine-3	Count	106	0	1	0	107
		%	99.1%	.0%	.9%	.0%	100.0%
	matsine-4	Count	76	0	0	0	76
		%	100.0%	.0%	.0%	.0%	100.0%
	marondera-3	Count	121	0	0	1	122
		%	99.2%	.0%	.0%	.8%	100.0%
	marondera-4	Count	114	2	1	0	117
		%	97.4%	1.7%	.9%	.0%	100.0%
	matsine-2	Count	47	0	0	0	47
		%	100.0%	.0%	.0%	.0%	100.0%
Total		Count	464	2	2	1	469
		%	98.9%	.4%	.4%	.2%	100.0%

Pearson Chi-Square = .520 (this figure is more than .05)

Table 34: A comparison in what students from Matsine Secondary School and Marondera High School belief will happen to people after they die

			Belief in Afterlife						Total
			Biological explanation	Christian explanation	Traditional explanation	Not sure	Other Spiritual/ Religious explanation	Sociological explanation	
SCHOOL	matsine-3	Count	60	24	2	3	5	8	102
		%	58.8%	23.5%	2.0%	2.9 %	4.9%	7.8%	100%
	matsine-4	Count	37	21	9	1	4	2	74
		%	50.0%	28.4%	12.2%	1.4 %	5.4%	2.7%	100%
	marondera-3	Count	16	82	1	1	8	11	119
		%	13.4%	68.9%	.8%	.8%	6.7%	9.2%	100%
	marondera-4	Count	31	64	1	5	6	9	116
		%	26.7%	55.2%	.9%	4.3 %	5.2%	7.8%	100%
	matsine-2	Count	13	21	7	1	3	2	47
		%	27.7%	44.7%	14.9%	2.1 %	6.4%	4.3%	100%
Total		Count	157	212	20	11	26	32	458
		%	34.3%	46.3%	4.4%	2.4 %	5.7%	7.0%	100%

Pearson Chi-Square = .000 (this figure is less than .05)

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