HYGIENE AND BEHAVIOUR CHANGE COALITION (HBCC) ENDLINE REVIEW

IN

MANICALAND PROVINCE (MUTARE), MASVINGO PROVINCE (CHIVI), MIDLANDS PROVINCE (ZVISHAVANE) AND MASHONALAND WEST PROVINCE (NORTON)

ZIMBABWE

ACKNOWLEDGEMENT

The project team greatly appreciates Unilever and UKAID for financially supporting Care International in Zimbabwe to implement WASH project in four Provinces of Zimbabwe. The project came at a time when Zimbabwe was already battling with the COVID 19 pandemic and the target Districts represent some of the most vulnerable communities in Zimbabwe. The consultant is honoured and appreciates CARE International in Zimbabwe for choosing them among other consultants for the end line review. The team acknowledge Allison Prather, Dr. C. Heales and Mr E. Ochola for technical review. Special mention goes to Mr. L. Chowoita (Project Manager), Mr. M. Muzire (MEAL Specialist) and Ms B. Chiwandire (M & E Assistant) for technical and logistical support. The project team appreciates all the households and key stakeholders who participated in the review by providing invaluable information that made it possible to produce the report.

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ABREVIATIONS AND ACRONYMNS

COVID 19	Coronavirus Disease 2019
DSTv	Digital Satellite Television
FCDO	Foreign, commonwealth and development office
FGD	Focus Group Discussion
FM	Frequency Modulation
GBV	Gender Based Violence
HBCC	Hygiene and Behavior Change Coalition
KII	Key Informant Interview
PPE	Personal Protective Equipment
PWD	People with Disabilities
SMS	Short Message Service
SI	Statutory Instrument
TV	Television
UK AID	United Kingdom Aid
WASH	Water Sanitation and Hygiene
WHO	World Health Organisation

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF PLATES

APPENDICES

SECTION 1: EXECUTIVE SUMMARY

CARE International in UK secured funding from Unilever-DFID to implement a Hygiene and Behavior Change Coalition (HBCC) project. The project aimed to support communities respond to the Covid-19 pandemic through a multi-pronged approach. CARE International implemented an extensive mass media, digital and interpersonal hygiene promotion information and messaging campaign in communities and institutions supported by the provision of water supply and handwashing kits and infrastructure as well as relevant PPE, as per context.

In Zimbabwe, the project was implemented in four provinces of Manicaland (Buhera & Mutare districts), Masvingo (Zaka & Chivi districts), Midlands (Zvishavane & Mberengwa districts) and Mashonaland West (Norton district) over a period of one year. The aim of the project was to minimize the transmission of and harmful impact of COVID-19 by delivering inclusive and interactive gender responsive mass media and digital communications, supported by product availability and community interventions that improve personal and environmental hygiene practices, and reduce stigma and discrimination. As a culmination of the project led to this independent endline review of the outcomes and impacts of the project.

Objectives

To assess the overall behaviour change outcomes of the COVID-19 Hygiene Behaviour Change Campaign as per the Theory of Change and identify key lessons learned for the campaign and for future strategies in the Care Zimbabwe Hygiene Behaviour Change Communication program (HBCC).

Specifically, the end line review was carried out to;

1. Measure the behavioural outcomes, and determine how the project has contributed to these changes; with a special focus on how the project has generated positive changes in the lives of targeted women, girls, boys, and men; including vulnerable groups such as those living in remote locations as well as the elderly and people with disabilities
2. Identify unintended consequences of the project, both positive and negative; for target groups and others impacted.
3. Document the enabling factors and challenges or barriers that influenced project implementation; and
4. Provide evidence-based recommendations for all stakeholders for the future programming in light with the review findings, including specific recommendations in relation to gender equality/women's empowerment issues.
5. Understand community perception on the COVID-19 Vaccine and possibly explain the levels of uptake.

Methodology

A mixed method approach using quantitative and qualitative research methods using Wash`Em approach, was used in this end-line review. The study used two rapid assessment tools (hand washing demonstration, and disease perceptions) of the Wash'Em to understand behaviour. Key informant interviews were conducted with the District Environmental Health Officers (DEHOs) and Environmental Technicians and Community Volunteers and radio stations. The assessment also included reviewing of secondary information such as progress reports, KLAP survey reports, baseline report and Ministry of Health and Childcare update reports in Zimbabwe.

Sampling frame

Participants of the end-line review were drawn from the four purposefully sampled districts; Norton, Mutare, Zvishavene and Chivi. The districts are selected in such a way that all provinces, and rural and urban are represented. A purposive sampling procedure was employed in picking respondents

to the survey. Direct and indirect stakeholders and beneficiaries interacting with the HBCC project were targeted for data collection.

Quantitative Data- Household Questionnaire

A structured household questionnaire was administered in to 375 households in the 4 sampled districts. To establish sample size for household questionnaires, the Rao soft sample size calculator was used at 95% confidence level and 5% margin of error[1]. Assuming at least 50% response distribution, 375 households will be sampled. The target was to ensure that at 50% of the participants/ parents/ caregivers were women.

Data collection was collected using telephone calls questionnaires with the assistance of enumerators. The method was most ideal in Zimbabwean situation because of COVID 19 lock down restrictions. There was no physical contact with the respondents. The method was aided by the fact that Zimbabwe had 98.5% mobile connections as of January 2021[2].

Qualitative Data

WASH'Em data collection tools for disease perceptions and hand washing demonstrations and key informant interviews were used in collecting qualitative data in all the four districts.

Key Informant Interviews

The key informants include, 3 targeted Provincial radio station (Diamond FM, YA FM and Hevoi FM), 1 digital message service providers (VIAMO), 4 District Environmental Health Officers, 4 Environmental Health Technicians, and 12 Community Volunteers were consulted in the four sampled districts. Key informants provided expert opinion on what worked well, challenges and areas that needs improvements in future programming.

Hand washing Demonstrations

A sample of 28 hand washing demonstrations videos were taken, 14 in urban and the other 14 in rural districts. Hand washing demonstrations were taken to generate quick insights into whether a person's home and community environment enable or prevent hand washing practices. The assessment involved going into people's homes and understand how they washed their hands in a real-world setting. Hand washing demonstrations videos were taken and analysed using WASH`Em guideline tools. During the demonstrations, assessments was carried out on how people interact with objects (for example, soap and containers) and infrastructure (for example, hand washing facilities and water points) when hand washing. Majority of the hand washing demonstration participants in all districts (>70%) were women. Youths were 20% of the participants.

Focus Group Discussions

A total of 12 focus group discussions (FGDs) were conducted with members of the community in the respected districts using Disease Perception WASH'Em tools. In each district participants were grouped into men, women, and people living with disabilities. Focus group size ranged between 8-16 participants.

Data processing and analysis

Qualitative data collected in the form of hand washing demonstrations, and disease perception FDGs was uploaded and analysed in WASH'Em software. Quantitative data was transcribed and entered into Excel to facilitate data analysis. Expert judgement was used to analyse key informant interview data. For ease of interpretation and value addition of results, graphical presentations were done.

[1] http://www.raosoft.com/samplesize.html

[2] https://datareportal.com/reports/digital-2021-zimbabwe

Data was collated, analysed and synthesized. Running themes or patterns identified, interpreted and explained accordingly.

RESULTS AND DISCUSSION

Demographics

Household survey generated response from 375 participants. Over 60% of participants in all districts except in Zvishavane were women. In Zvishavane 51% of participants were men. 33% women were between 26-35 years old. Most men were between 36-45years age group. Most people were between 26-45 years' age groups. Average age of the participants was 41.4 years and most frequent participants were 38 years old. The oldest participant was 88 years old and the youngest was 16 years old.

Age Groups	18-25 years	26-35 years	36- 45years	46- 55 years	> 55 years
Men	14%	23%	30%	11%	22%
Women	13%	33%	26%	15%	14%

Education Status

More than 60% of the people in all the districts attained at least secondary education. Those with tertiary ranged from 3-28%, while those with no schooling at all ranged between 1-2%.

Knowledge and Understanding of hygiene related diseases and the COVID-19

- Knowledge of how COVID 19 pandemic is generally high amongst the communities in all the districts. All the consulted people (100%) in all the districts are aware that there is COVID 19 and that it is a deadly disease that has affected Zimbabwe and other countries.

What do you know about COVID-19

- Respondents were asked what they know about COVID-19 disease. More than 75% of people know about the symptoms of COVID 19 and the protection steps and self-care.
- This was a great improvement to baseline report that showed that approximately 50% of people had knowledge of the symptoms of COVID-19
- People reported that their knowledge of the risks and complications caused by COVID-19 improved as compared to 2020. This was supported by discussion with Community Volunteers who reported that before the project started, members of their communities thought that COVID 19 was a disease for the rich or for the white people in Europe or Asia.
- Knowledge of the risks and complications was aided by periods of COVID 19 influx and related deaths and lock downs.

Knowledge of the symptoms of COVID-19

- Respondents were asked what symptoms of COVID-19 they were aware of. Majority of people in all the district (> 90%) know fever, cough and shortness of breath as the main symptoms of COVID 19. There is however still limited knowledge of muscle pain and diarrhea as symptoms of COVID 19.
- During key informant interviews it was reported that knowledge of COVID-19 symptoms helped a lot in containing the COVID-19 situation, as those who tested positive were asked to quarantine until they fully recovered. Other symptoms that respondents reported are chest pains, soar and dry throat, fatigue, loss of appetite, flue, headache, back ache.

Knowledge of how COVID-19 spread

Respondents were asked to explain in what way does COVID- 19 spreads

- Most people in all the districts are very much aware that COVID-19 spreads by close contact with infected person (91% Norton, 100% Zvishavane, 100% Chivi and 97% in Mutare).
- Above 83% reported that COVID is spread by contact with contaminated objects or surface and over 70% of people know that COVID-19 can be spread by coughing and sneezing.

COVID 19 prevention

Respondents were asked ways they were using to prevent from contracting COVID- 19 disease. Majority of households prevent themselves from contracting COVID-19 disease a combination of methods.

- More than 90% of respondents in all districts reported that they practice social distance, clean their hands and wear face masks. The two practices were aided awareness raising through messages that people received on provincial radio stations, community volunteers and sms.
- Government also played a key role by legal enforcement of full and partial lockdowns, banning public social gatherings, encouraging handwashing, social distance and making it mandatory for people to wear of face masks in public places.
- Over 95% of people were observed to be wearing face masks and more than 65% of them wearing the masks correctly in public place.

Effectiveness of communication channels and access to information

People responded that they gained knowledge/ information through different channels including radios broadcast programs, van radio programs, sms and community volunteers. Each channel had its strength and shortcomings and they complemented each other.

Channels of communication that contributed to the increased level of understanding of COVID-19 and their effectiveness

- Over 75% of people across all districts increased their knowledge through Community Volunteers
- Approximately 82% in urban districts gain knowledge on COVID-19 through van messaging/broadcasting. Feedback from FGDs was that the community volunteers and road shows attracted the attention of local residents and they could recall messages because the van was mobile and everyone experienced their presence have had more contact time per session than radio broadcasting.
- Van broadcast did not cover rural districts
- Over 80% of people confirmed that they made use of the sms they received from the project on COVID 19
- Discussions with local radio stations revealed that, van road shows were only limited terms of coverage as compared to other methods, for example radio broadcastings were able to be listened by over 1000 people in one session.
- Radio broadcasting was a communication channel that had high potential of covering largest number of people. For example Diamond FM covers the whole of Manicaland. Ya FM reached all of the over 93% of respondents in Zvishavane.
- Local communities reported that they were educated and received information about COVID 19 virus, its symptoms, prevention, COVID 19 national other countries statistics, the COVID-19. Vaccinations and myths around COVID 19 infection and vaccines.
- Approximately 90% of respondents can recall receiving at least 4 messages from the HBCC project through a nexus of communication channels. This showed that communication

channels were effective. Usually a person is mostly likely to use information that they can recall.

Access and use of COVID 19 related information

- More than 90% of people reported that it is now easy to access information on COVID 19.
- According to household participants and KII, access to information was made easier by HBCC project and intense government intervention programs such as nationwide lockdowns and vaccines rollout.
- 97% of men and 96% women responded that it now easier to access COVID 19 related information.
- ANOVA was carried out at 95% confidence level and since P>0.05, H0 was not rejected and conclusion was made that there is there is no significance difference in access to COVID 19 related information between men and women
- FGDs with people with disability (PWD) however revealed that it was a bit difficult for them to access the information and it's a bit difficult to measure the extent to which the project impacted their lives. The situation was worse for deaf people who for example could not listen to radio.

Influence of HBCC project on decision making

- Over 90% in all the districts felt that the HBCC project influenced them to adopt preventative measures against COVID 19. Over 98% of participants appreciated the contribution of the project to way they responded to COVID 19.
- Approximately 77% of women and 68% of men reported that the project influenced their decision making on COVID 19
- However, approximately 2% in Norton were either not sure or disagree that the project influenced their decisions towards COVID 19 prevention.
- Approximately 4% men and 2% women were not sure if the project influenced their decision making

Understanding what to do with COVID 19 related information

- Approximately 95% of respondents now understand what to do when they suspect that they have COVID 19. The situation was different before the start of the program.
- ***90% of women and men in all the districts understand information about what to do if one thinks he/she has Covid- 19.***
- KII added that although people are afraid of the virus, they no longer panic when their close family test positive.
- Over 70% of people are now able to judge if the information about COVID 19 in the media is reliable or not.
- However approximately 22% of women and 17% of men find it difficult to judge if the information about COVID-19 in the media is reliable.

- During FGDs and interviews with KII, it was reported that there is still a lot of misleading information on social media and part of it caused high resistant to COVID 19 vaccination.

Ability to follow COVID 19 related recommendations

- Over 70% are able to follow recommendations on how to protect themselves from COVID 19, when to stay at home from work/ schools and when to engage in social activities and when not to. This ability is an indicator that project is likely going to be sustainable.
- However, a significant number of people over 25% of both men and women find it difficult to understand recommendations on when to stay at home from work and when not to.
- Men (34 %) find it harder to stay at home than women (25%).
- This confirmed by Key Informants who reported economic hardships were forcing people to leave their homes. They said that majority of people in the urban area work in the informal sector and agriculture sector dominates the rural areas and work from hand to mouth, staying at homes means starvation for them.

Understanding and influence of the HBCC intervention

Approximately 99% confirm that their level of understanding and practicing hygiene related to COVID 19 improved compared to same time last year.

Disease Perception

Perception on COVID 19 illness and spread

- 83 % of all FGDs except for Mutare men did list COVID 19 among the 5 illness of greatest concern to their population.
- Other illnesses cited are malaria, cholera, diarrhoea, typhoid, cancer, sugar diabetes and high blood pressure (BP). Therefore, people in all the districts are likely to continue taking up prevention measures against COVID 19.
- 83% of FGDs thought that someone in their families could get COVID 19. Two focus group discussions in Norton and Mutare actually noted that it will happen.
- Participants in 10 out of the 12 FGDs believed that if someone did get COVID 19 from their families, it might result in serious illness or death. This shows that majority of people in all the target districts consider COVID 19 to be serious and are taking up preventative measures.80% believe that If they compare their families with other families everyone is at the same risk
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Perceived impacts of COVID 19 and local community's ability to act on them

- 75% of the focus group discussions in both rural districts perceived physical and mental health impacts of COVID 19 to individuals and families. People are predominantly worried by the health impacts of COVID 19.
- 75% of FGDs people perceive economic impact loss of income while sick

- 75% of FGDs people perceive productivity impact less mentally alert, less able to be productive, unable to attend school
- 75% of FGDs people feel like they would be socially excluded or judged for getting sick
- In 100% of FGDs people feel like they have the ability to reduce their chance of getting COVID19 (including by washing their hands)
- 100% of FGDs people think their handwashing practices have changed

Hand washing

Effect of HBCC project messages on handwashing

- All the participants in all districts except for Norton reported that messages they received from HBCC project influence an increase in their handwashing frequency.
- Only about 2% of the respondents in Norton District did not feel the influence of HBCC project.

Have handwashing place and its location

- Over 70% of respondents across all districts reported that they have some form of a hand washing place. There was a significant improvement in terms of availability of handwashing places and facilities as compared to baseline survey period were for example approximately 67% of rural districts reported to be lacking handwashing places.
- Most of the handwashing places in are however multifunctional.

Availability of soap at handwashing facilities

- 91% of respondents use water and soap to wash their hands across all districts
- However, degree of soap availability varies between rural and urban district (low and high income areas)
- 53% of households in Zvishavane and 69% in Chivi reported that they use soap daily, a significant improvement in the rural area if we compare with the baseline period in 2020.
- Communities are much aware of the importance of hand washing practices to prevent COVID-19 and other diseases.

Water availability at handwashing places/facilities

- Water for handwashing is always readily available in 90% of the households, a great improvement from the time of baseline survey.
- Water was readily available in all the visited households during handwashing demonstrations. Even though in some places households had to travel more than 1km to fetch water, they made sure that their hand washing facilities always had enough water.
- Access to water varied also among urban districts. For example, Mutare has access to clean and reliable water throughout the year, while Norton share water supply with Harare the capital city and sometimes faces water supply challenges.
- Women in Norton reported that they are most affected and at risk of COVID 19 infections because the majority rely on community water points.

Times for handwashing

- Over 96% of people in the project area wash their hands before eating, especially main meals like breakfast, lunch and dinner.
- Over 74% in all districts also wash their hands after defecation or using the toilet.
- There is improvement (approximately 60%) in handwashing before feeding children and after handling child stool/ changing nappies as compared to last year.
- However, there is still need for improvement in handwashing after changing children's nappies/ handling children stool especially in rural areas with 40% in Chivi and 45% in Mutare respectively

Relevance of the HBCC project to the needs of the targeted communities

- 85% of consulted people said the chosen communication channels were highly relevant.
- 68% across all districts said the hygiene promotional messages were relevant to their needs in responding to COVIID 19.
- Over 96% of the people reported that the timing of the intervention was highly relevant. This was supported by key informants. For example, District Environmental Health Officers said the project helped them a lot by filling the gap that the government was failing because of capacity challenges.
- Furthermore, government officials said that the project aligned very well with the government COVID 19 response strategy. The project complemented the national hygiene strategy and WHO International efforts to curb the spread of COVID 19.

Sustainability of hygiene practices and COVID 19 prevention measures

- Majority of participants in all the districts, 90% in Norton, 88% in Zvishavane, 85% in Chivi, 91% in Mutare said that they are able to continue washing hands regularly.
- Community volunteers and EHTs supported this claim saying that majority households are now able to wash their hands regularly.
- Over 70% reported that they valued the importance of social distance to prevent themselves from infectious diseases. KII however commended that social distance is usually affected by shortage of resources/ goods and services.
- However, the challenge that affects social distance is that services in some of the medical centres are slow and people run out of patience and at last fail to maintain social distances. At public transport stations like in Norton, when people wait in queues for too for ZUPCO[3] buses they end up breaking up the required social distance.
- Wearing a mask has been made mandatory by law and over 65% of people are now used to that.

COVID 19 vaccination in Zimbabwe

- As of 3 August 2021, there have been 122,652 confirmed cases of COVID-19 with 4,249 deaths, reported to WHO. A total of 3,772,579 vaccine doses have been administered, with 1.48 million people fully vaccinated representing 10%[4].
- According to Figure 18 and 19 daily vaccine doses and cumulative doses were very low. Acceptance of vaccines faced resistance in the first four months since its introduction that is March 2021 to June 2021.
- The country received its first 200 000 doses of Sinopharm in February 2021[5], but took more than 3 months to administer the vaccines.
- Several false information and myths were circulating in the social media people away. For example, some said in 2 years all vaccinated people will die, there are serious side effects to the virus.
- However, from June 2021 to August 2021 COVID 19 vaccine demand increased exponentially. Some of the reasons that were explained during interview with District Environmental Health and Environmental health technicians.

- There was COVID 19 spike in infection in June 2021 and number of deaths kept on increasing
- Government imposed nationwide lockdown and majority of people were vulnerable
- Vaccination campaigns by government and corporate

[3] Zimbabwe United Passengers Company (ZUPCO) is a government funded public buses and commuter mini-buses

[4] https://covid19.who.int/region/afro/country/zw

[5] https://www.enca.com/news/watch-zimbabweans-react-sinopharm-jab

- Government encouraged all its civil servants to be vaccinated and the corporate world followed. In rural areas traditional leaders were encouraged to encourage people within their jurisdictions

As a result, there was a sharp rise in number of people getting vaccinated in July and August 2021.

Enabling factors to the success of the project

The project was successful because a number of enabling factors;

- Project got support from existing convenient WASH government structures. Working with the DEHOs, EHTs and Community volunteers helped in aligning the project to government response plans and activities. In addition, these structures existed in the project areas for many years, hence their experience helped in the project penetration.
- Use of Provincial radio stations- The Provincial radio stations were designed to be closer to the people in terms of geographical coverage and social life. So the use of provincial radio stations such as Diamond FM related well with local communities e.g *Samanyika* people of Manicaland province
- Timing of the project was very convenient- The project came at a time when Zimbabwe was still coming to terms with COVID 19 pandemic outbreak and people had lot of unanswered questions about the virus, what it is, how it affects people, its cure and prevention. The project addressed topical issue COVID 19
- National Lock downs- National lockdowns helped by making people realise that COVID 19 was a serious disease and hence. This helped by making HBCC project to get the attention of people in the in the project area
- High level of mobile connectivity – There is high level of mobile phone connectivity in both urban and rural areas in Zimbabwe. This made it possible for SMS to reach out to as many people as possible

Challenges

The project experienced a number of challenges the can be used as lessons for future program

- Time allocated for the radio shows was very limited (15mins) per session. This did not give space for listeners to give feedback or ask questions during the sessions
- There was a limited number of community volunteers in each district. For example, having one community volunteer per ward made was a huge task because they have to cover large population and geography
- People living with disabilities were not covered by some interventions. For example, deaf people missed on radio broadcasting programs and the blind people were not considered in the sms communication channel.
- National lockdown side effects- national lock downs affected school attendance. It was difficulty to full exhaust support for schools because they were closed in several months within the project

CONCLUSION

It can be concluded based on the findings from the four sampled districts that HBCC was a highly successful project. Majority people are now aware of COVID 19, and its effects. Majority of people now how the virus spreads and prevention measures to use. HBCC project positively influenced the behaviour of people towards COVID 19 prevention and health and hygiene as majority of people are now able to wash their hands regularly with soap, mask up and properly wear their masks. However, the world, Zimbabwe included is still battling with COVID 19 pandemic, more awareness programs need to be carried out so that people do not relax and cause spike in infections again.

Recommendations

- The project came is coming to an end when the country has begun the critical vaccination program which has been also facing resistance. Mobilise resources to support behaviour change towards vaccination and to discredit myths circulating on the social media
- Increase airtime for radio shows from 15minutes to at least 30minutes to allow time for listeners to ask questions and presenters to respond
- Take radio journalists in some of the field work so that they can as well get to know of some COVID related issues on the ground and build topical issues to discuss during broadcasting
- In future increase the number of community volunteers to improve their coverage
- Expand the road shows to rural districts to improve their coverage
- Allocate budget for resources that should be used in supporting capacity development. For example, CARE should bring masks and sanitizers that they should give people during demonstrations and
- Increase components in the project design that cater for the needs of people living with disabilities. For example, some are blind and some are deaf so information and awareness raising should be able to reach out to them
- Support Community Volunteers with resources for example bicycles, that enable them to continue supporting and empowering their communities

SECTION 2: BACKGROUND OF THE STUDY

Coronavirus (COVID-19), an infectious disease caused by discovered coronavirus caused dramatic loss of human life worldwide and presents an unprecedented challenge to public health, food systems and the world of work. The economic and social disruption caused by the pandemic is devastating: tens of millions of people are at risk of falling into extreme poverty, while the number of undernourished people, currently estimated at nearly 690 million, could increase by up to 132 million by the end of the year[6]. The disease was first reported in Zimbabwe in March 2020. With 9 cases and 1 death in April 2020, the infections disease spread to the current level of 119,508 confirmed coronavirus (COVID-19) cases and 4,073 deaths as of August 14, 2021[7]. In responding to impending pandemic, CARE International in UK secured funding from Unilever-DFID to implement a Hygiene and Behavior Change Coalition (HBCC) project. The project was commenced to drive hygiene behavior change communication to the poor communities living in rural, urban and ID centers, across five countries: Zimbabwe, Rwanda, Somalia, Jordan and North Eastern Syria. The project aimed to support communities respond to the Covid-19 pandemic through a multi-pronged approach. CARE International implemented an extensive mass media, digital and interpersonal hygiene promotion information and messaging campaign in communities and institutions supported by the provision of water supply and handwashing kits and infrastructure as well as relevant PPE, as per context.

In Zimbabwe, the project was implemented in four provinces of Manicaland (Buhera & Mutare districts), Masvingo (Zaka & Chivi districts), Midlands (Zvishavane & Mberengwa districts) and Mashonaland West (Norton district) over a period of one year. The aim of the project was to minimizing the transmission of and harmful impact of COVID-19 by delivering inclusive and interactive gender responsive mass media and digital communications, supported by product availability and community interventions that improve personal and environmental hygiene practices, and reduce stigma and discrimination. As a culmination of the project led to this independent endline review of the outcomes and impacts of the project.

2.2 Endline review Objectives

The main purpose of the End Line Review was to assess the overall behaviour change outcomes of the COVID-19 Hygiene Behaviour Change Campaign as per the Theory of Change and identify key lessons learned for the campaign and for future strategies in the Care Zimbabwe Hygiene Behaviour Change Communication program (HBCC).

Specifically, the end line review was carried out to;

6. Measure the behavioural outcomes, and determine how the project has contributed to these changes; with a special focus on how the project has generated positive changes in the lives of targeted women, girls, boys, and men; including vulnerable groups such as those living in remote locations as well as the elderly and people with disabilities
7. Identify unintended consequences of the project, both positive and negative; for target groups and others impacted.
8. Document the enabling factors and challenges or barriers that influenced project implementation; and

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[6] https://www.who.int/news/item/13-10-2020-impact-of-covid-19-on-people%27s-livelihoods-their-health-and-our-food-systems

[7] Zimbabwe COVID: 119,508 Cases and 4,073 Deaths - World meter (worldometers.info)

9. Provide evidence-based recommendations for all stakeholders for the future programming in light with the review findings, including specific recommendations in relation to gender equality/women's empowerment issues.
10. Understand community perception on the COVID-19 Vaccine and possibly explain the levels of uptake.

The evaluation assessed the impact, effectiveness, efficiency and sustainability of the HBCC programme.

SECTION 3: METHODOLOGY

A mixed method approach using quantitative and qualitative research methods using Wash`Em approach, was used in this end-line review. The Wash'Em approach use 5 rapid assessment tools to understand behaviour. However, in this evaluation only 2 rapid assessment tools (hand washing demonstration, and disease perceptions) were used. Key hygiene baseline questions were posed to study participants. Key informant interviews were conducted with the District Environmental Health Officers (DEHOs) and Environmental Technicians and Community Volunteers. The assessment also included reviewing of secondary information such as progress reports, KLAP survey reports, baseline report and Ministry of Health and Childcare update reports in Zimbabwe.

3.1 Sampling frame

Participants of the end-line review were drawn from the four purposefully sampled districts.

Urban/ Peri-Districts	Rural Districts
Norton	Zvishavane
Mutare	Chivi

The districts are selected in such a way that all provinces, and rural and urban are represented. A purposive sampling procedure was employed in picking respondents to the survey. Direct and indirect stakeholders and beneficiaries interacting with the HBCC project were targeted for data collection.

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3.3.2 Hand washing Demonstrations

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Table 1: Distribution of hand washing demonstration participants

Sex	Norton	Mutare	Chivi	Zvishavane
Men	22%	20%	25%	24%
Women	78%	80%	75%	76

3.3.3 Focus Group Discussions

A total of 12 focus group discussions (FGDs) were conducted with members of the community in the respected districts using Disease Perception WASH'Em tools. In each district participants were grouped into men, women, and people living with disabilities. Focus group size ranged between 7-16 people participants.

Table 2: Distribution of focus group discussions

Focus Group Discussion	DISTRICTS				Total
	Norton	Mutare	Chivi	Zvishavane	
Women	1	1	1	1	4
Men	1	1	1	1	4
PWD[10]	1	1	1	1	4

[10] People Living with Disabilities

Plate 1:FGD with PWD on disease perception

Plate 2: FDG with women on disease perception

Plate 3: Men focus group discussion on diseases perception

Plate 4: FGD with women

Plate 1: FGD with men

Plate 2: FGD with PWD

Plate 3

3.4 Training, Pre-test and field work

A one-day training programme was held in each district on use of WASH'Em tools and household enumeration before the field work. The tools were pretested before actual data collection. Enumerators were trained on hands-on instructions on administering individual household questionnaire. The data collection team was introduced to their roles, data collection techniques (including verbal translation of questions into local language), and field preparations.

3.5 Data processing and analysis

Qualitative data collected in the form of hand washing demonstrations, and disease perception FDGs was uploaded and analysed in WASH'Em software. Quantitative data was transcribed and entered into Excel to facilitate data analysis. Expert judgement was used to analyse key informant interview data. For ease of interpretation and value addition of results, graphical presentations were done. Data was collated, analysed and synthesized. Running themes or patterns identified, interpreted and explained accordingly.

3.6 Ethical considerations

Authority to conduct the research study was sought with the responsible authorities in each district. Informed consent was obtained from all the participants including radio stations, mobile service providers and parents/ caregivers among other participants for all data collection. Data confidentiality was exercised by ensure that data was collected by trained and contracted professionals. Collected data was not shared by any person except the endline review team and Care International Team.

3.8 Endline Review Limitations

Zimbabwe is currently on level 4 lockdown in responding to COVID 19 because of spike in COVID 19 infections. Under the current lockdown, inter-city/town/municipality travels are banned. People are encouraged to stay at home, keep social distance, and regularly sanitize or wash their hands with soap. Government and companies have decongested their working places. It is mandatory for all people to wear face masks in public places. Because of the restrictions, schools are closed and most clinics and hospitals are overwhelmed by COVID 19 vaccination programs and attending to patience.

SECTION 4: KEY FINDINGS

4.1 Socio-demographic Survey

4.1.1 Demographics

Household survey generated response from 375 participants. Over 60% of participants in all districts except in Zvishavane were women. In Zvishavane 51% of participants were men (Figure 1). According to Table 3, 33% women were between 26-35 years old. Most men were between 36-45years age group. The most frequent participants were 38 years old. The oldest participant was 88 years old and the youngest was 16 years old.

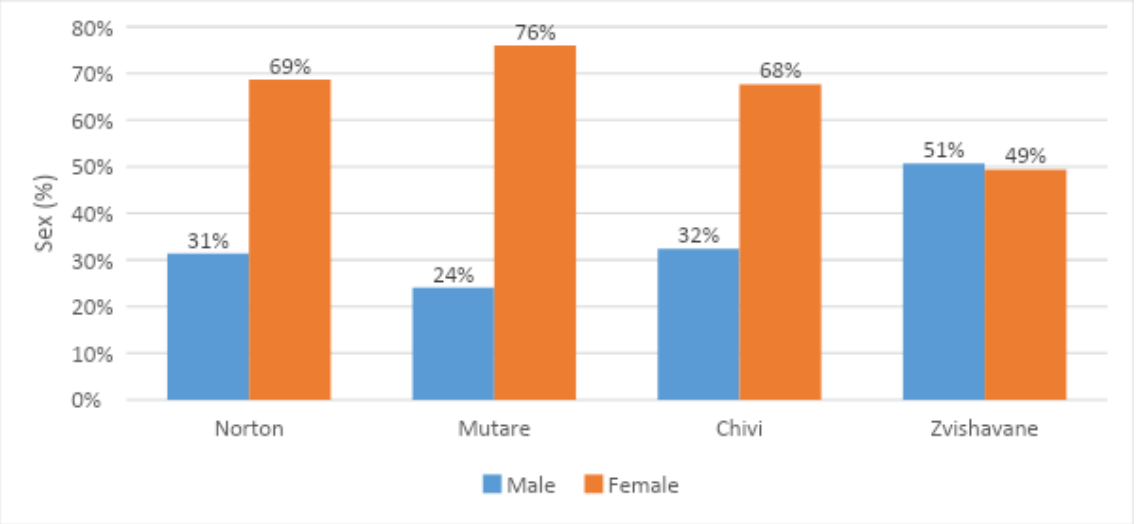

Figure 1: Sex of the respondents

Table 3: Age of the respondents

Age Groups	18-25 years	26-35 years	36- 45years	46- 55 years	> 55 years
Men	14%	23%	30%	11%	22%
Women	13%	33%	26%	15%	14%

4.1.2 Education Status

More than 60% of the people in all the districts attained at least secondary education. Those with tertiary ranged from 3-28%, while those with no schooling at all ranged between 1-2% as shown in Figure 2. The literacy level to understand COVID 19 awareness programs or promotions is therefore above high in all respective districts.

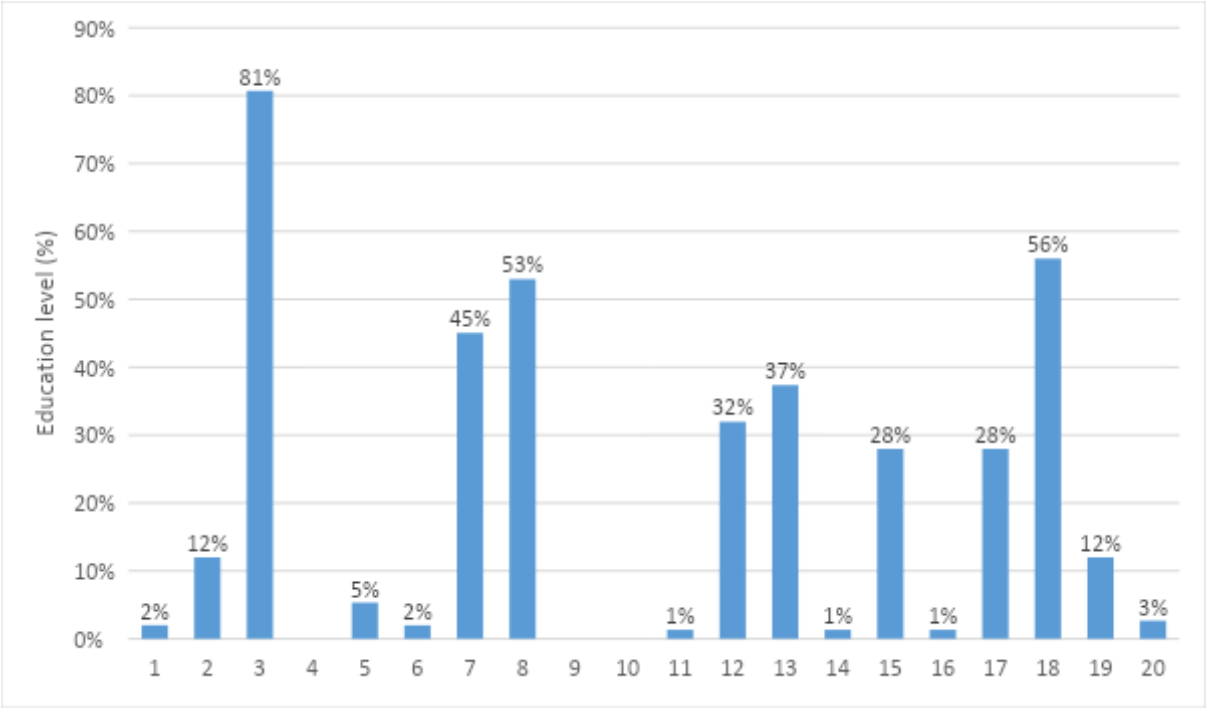

Figure 2: Education status in the four districts

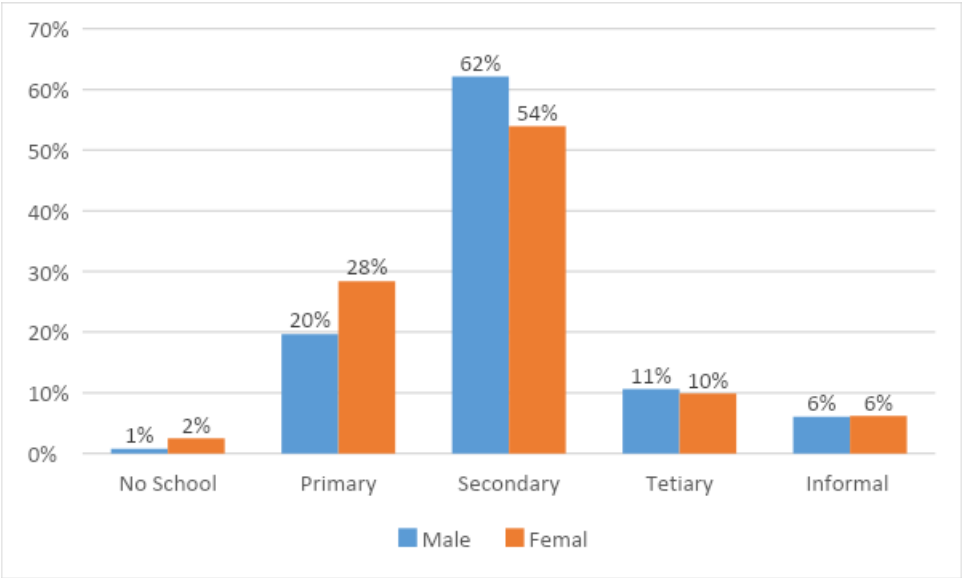

Figure 3: Sex aggregated education levels

4.2 Knowledge and Understanding of hygiene related diseases and the COVID-19

Knowledge of how COVID 19 pandemic is generally high amongst the communities in all the districts All the consulted people in all the districts are aware that there is COVID-19 and that it is a deadly disease that has affected Zimbabwe and other countries (Table 4). Both men and women in all the districts are aware of COVID- 19

Table 4: Knowledge of COVID 19

Districts	Norton	Mutare	Zvishavane	Chivi
Knowledge of COVID 19	100%	100%	100%	100%

4.2.1 What do you know about COVID 19

Figure 4 show that majority of households, more than 75% know about the symptoms of COVID 19 and the protection steps and self-care. People reported that their knowledge of the risks and complications caused by COVID 19 improved as compared to 2020. This was supported by discussion with Community Volunteers who reported that before the project started, members of their communities thought that COVID 19 was a disease for the rich or for the white people in Europe or Asia. Knowledge of the risks and complications was aided by periods of COVID 19 influx and related deaths and lock downs.

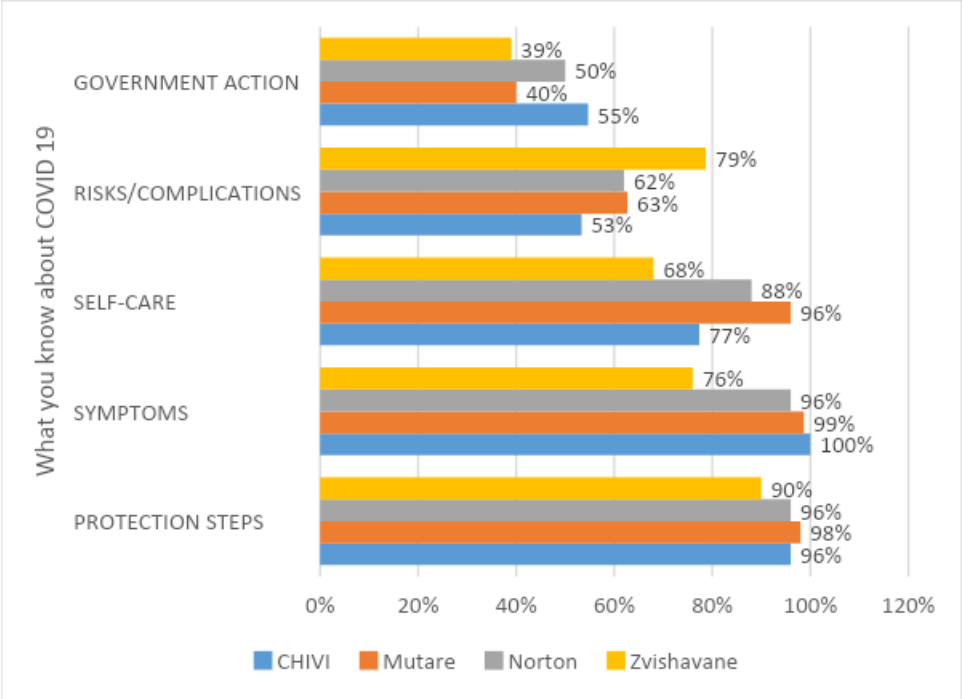

Figure 4: What the communities know about COVID 19

4.2.2 Knowledge of the symptoms of COVID 19

Majority of people in all the district (> 90%) know fever, cough and shortness of breath as the main symptoms of COVID 19. There is a gradual increase in the knowledge of other symptoms such as muscle pain, and diarrhea (Table 5). Knowledge of symptoms of COVID 19 helps in encouraging people to go and get tested and receive medication as early as possible when they test positive.

There was however limited knowledge of muscle pain and diarrhoea as symptoms of COVID 19. During key informant interviews it was reported that knowledge of COVID 19 symptoms helped a lot in containing the COVID 19 situation, as those who tested positive were asked to quarantine until they fully recovered.

Table 5: Knowledge of symptoms of COVID 19

Symptoms	Norton	Zvishavane	Mutare	Chivi
Fever	90%	89%	99%	100%
Cough	85%	81%	99%	97%
Shortness of breath	87%	81%	91%	84%
Breathing difficulties	83%	77%	93%	75%
Muscle Pain	41%	27%	29%	47%
Diarrhea	38%	27%	32%	65%
Others	55%	33%	7%	0%

Other symptoms that respondents reported are chest pains, soar and dry throat, fatigue, loss of appetite, flue, headache, back ache.

4.2.3 Knowledge of how COVID 19 spread

To prevent infections, it is important for people to know how COVID 19 spreads. Households were asked their knowledge on how the COVID 19 spreads. Table 6 show that most people in all the districts are very much aware that COVID 19 spreads by close contact with infected person and contact with contaminated objects or surface. Over 69% of people know that COVID 19 can be spread by coughing and sneezing.

Table 6: Knowledge of how COVID 19 spreads

District	Close contact with infected person	Contaminated object or surface	Infected droplets from cough or sneeze
Norton	91%	90%	82%
Zvishavane	100%	83%	69%
Chivi	100%	96%	71%
Mutare	97%	95%	73%

4.2.4 COVID 19 prevention

Majority of households prevent themselves from contracting COVID-19 disease a combination of methods to prevent from contracting COVID19 disease. More than 90% of respondents in all districts reported that they practice social distance, and wear face masks. The two practices were aided

awareness raising through messages that people received on provincial radio stations, community volunteers and sms. Government also played a key role by legal enforcement of full and partial lockdowns, banning public social gatherings, encouraging handwashing, social distance and making it mandatory for people to wear of face masks in public places. Only Mutare district has the slightly lower number of people who do not regularly wear face masks to protect themselves from contracting COVID 19. Covering of mouth when sneezing/ coughing was the least reported practice in all the districts.

Table 7: COVID 19 Prevention

District	Social Distance	Clean Hands Frequency	Covering mouth when sneezing or coughing	Wearing face Masks
Norton	90%	97%	70%	99%
Zvishavane	97%	88%	71%	97%
Chivi	96%	77%	63%	93%
Mutare	92%	97%	69%	82%

The same presentations methods that were being promoted in homes, were also mainstreamed in public places. During FGDs and interview with environmental health technicians, community volunteers and vendors at market places, HBBC made significant impact on hygiene behavior change in public places. Over 95% of people were observed to be wearing face masks and more than 65% of them wearing the masks correctly. Handwashing practices was enhanced by the availability of handwashing facilities that were provided by HBCC project (Plate1. The public handwashing facilities carried enough sanitizer to cater for populations at market places. By this timed last had no public handwashing facilities. Discussions with community volunteers revealed that vendors at market place used to bring their own small bottles of sanitizers and in most cases customers were not sanitized.

Plate 5: Handwashing facilities at vegetable markets *Plate 6: Handwashing facility at vegetable market*

4.3 Effectiveness of communication channels and access to information

4.3.1 Channels of communication that contributed to the increased level of understanding of COVID-19 and their effectiveness

According to Figure 5, people responded that they gained knowledge/ information through different channels including radios broadcast programs, van radio programs, sms and community volunteers. Each channel had its strenghgt and shortcomings and according to results in Figure 4, the channels complemented each other resulting in positive behavior change outcome of the project. Community Volunteers were one of the dominating channel of communication in the program at local level. Community volunteers did door to door education and support and they carried out trainings at market places. Another channel of communication that was effective in areas where it reached it out is van messaging/ road show. Over 84% of people increased level of understanding of COVID 19 because of these communication channels. Feedback from FGDs was that the community volunteers and road shows attracted the attention of local residents and they could recall messages because the van was mobile and everyone experienced their presence have had more contact time per session than radio broadcasting. However there are areas where Van Messaging did not reach out such as Norton and Rural districts in Masvingo Province (Figure 5).

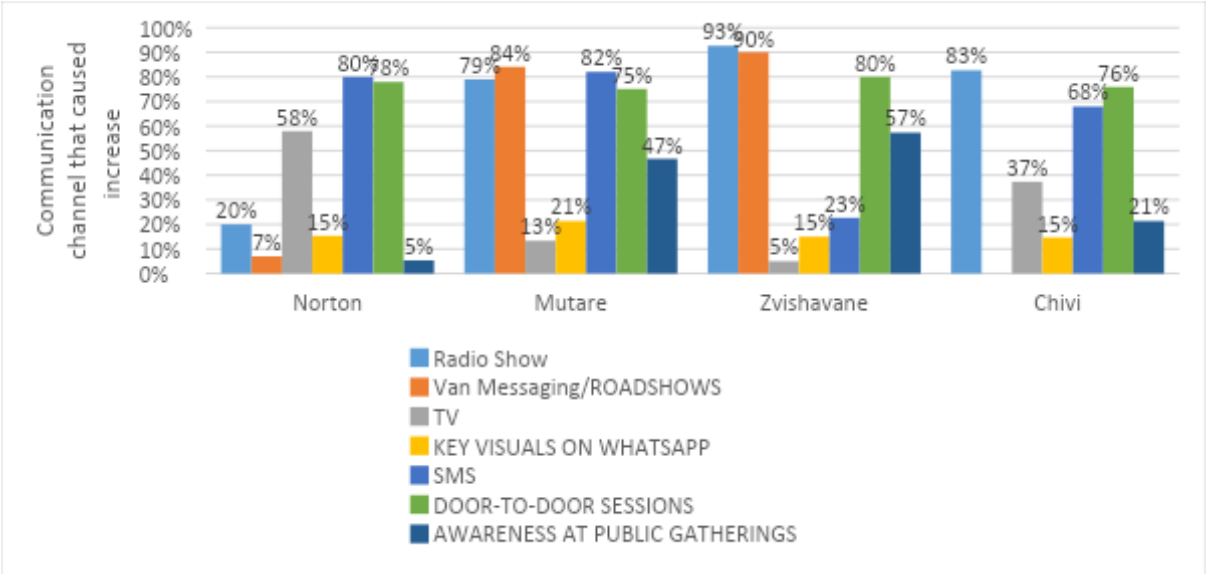

Figure 5: Information channels that contributed to the increased level of understanding of COVID 19

Discussions with local radio stations revealed that, van road shows were only limited terms of coverage as compared to other methods, for example radio broadcastings were able to be listerned by over 1000 people in one session.

Radio broadcasting was a communication channel that had high potential of covering largest number of people. For example Diamond FM covers the whole of Manicaland. Ya FM reached all of the over 93% of respondents in Zvishavane. In addition to this participants in the FGDs in Zvishavane reported that they are aware of the COVID-19 HBCC sessions held every Thursday at 1000hrs and could even recall the messages on handwashing and the password campaign. However concern was raised that the radio broadcasting sessions were short and did not give enough room for ask questions or participate in the sessions. For example Diamond FM reported that they were hosting 15 mins sessions with guests that HBCC provided and 15 mins were not enough to allow listiners to particiapte. Over 75% of people received hygiene promotion messages through SMS.

Local communities reported that they were educated and received information about COVID 19 virus, its symptoms, prevention, COVID 19 national other countries statistics, the COVID-19 Vaccinations and myths around COVID 19 infection and vaccines. Table 8 show that approximately 90% of respondents can recall receiving at least 4 messages from the HBCC project through a nexus of communication channels. This showed that communication channels were effective. Usually a person is mostly likely to use information that they can recall.

Table 8: Messages received from HBCC project

Messages received from the HBCC project	Percentage
People who remember at least 2 messages from the HBCC project.	2%
People who remember at least 3 messages from the HBCC project.	8%
People who remember at least 4 messages from the HBCC project.	90%

4.3.2 Access and use of COVID 19 related information

Households in all respective districts were asked how easy or difficult was it for them to find the information they needed related to COVID-19. According Figure 6, more than 90% of the sampled population found it easier to access information on COVID 19. According to household participants and KII, access to information was made easier by HBCC project and intense government intervention programs such as nationwide lockdowns and vaccines rollout. Table 9 show that both men and women found it easier to access the information. FGDs with people with disability (PWD) however revealed that it was a bit difficult for them to access the information and it's a bit difficult to measure the extent to which the project impacted their lives. The situation was worse for deaf people who for example could not listen to radio.

Access to information	Men	Women
Difficult	3%	4%
Easy	63%	63%

Very Easy	35%	34%

Table 9: Access to information by men and women

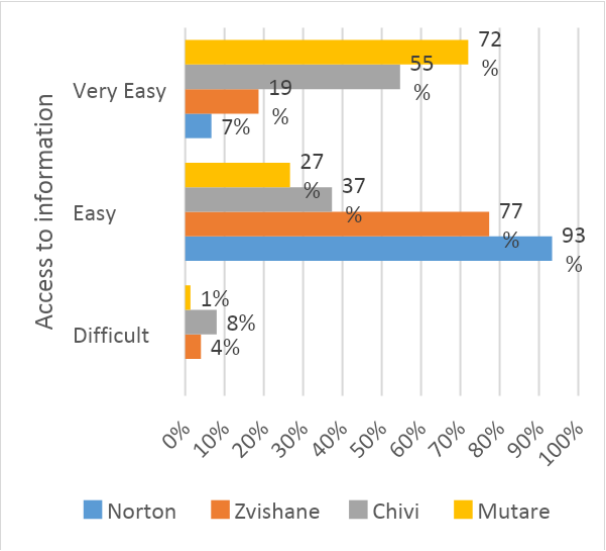

Figure 6: Access to information

Analysis of variance at 95% confidence interval was carried out on level of access to COVID 19 information between men and women.

H0: there is no significance difference in access to COVID 19 related information between men and women

H1: there is significant difference in access to COVID 19 related information between men and women

Table 10: Analysis of variance (ANOVA) of access to COVID information between men and women

SUMMARY

Groups	*Count*	*Sum*	*Average*	*Variance*
Men	132	306	2.318182	0.279667
Women	243	559	2.300412	0.285413

ANOVA

Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	0.027011	1	0.027011	0.095312	0.757702	3.86651
Within Groups	105.7063	373	0.283395			
Total	**105.7333**	**374**				

Therefore, since P>0.05, do not reject H0 and conclude that there is there is no significance difference in access to COVID 19 related information between men and women

4.3.3 Influence of HBCC project on decision making

Households were asked if they think HBCC programmes influenced them to adopt preventative measures against COVID-19. Majority of them over 90% in all the districts felt that the HBCC project influenced them to adopt preventative measures against COVID 19. Over 98% of participants appreciated the contribution of the project to way they responded to COVID 19. According to Figure 7 Approximately 2% in Norton were either not sure or disagree that the project influenced their decisions towards COVID 19 prevention.

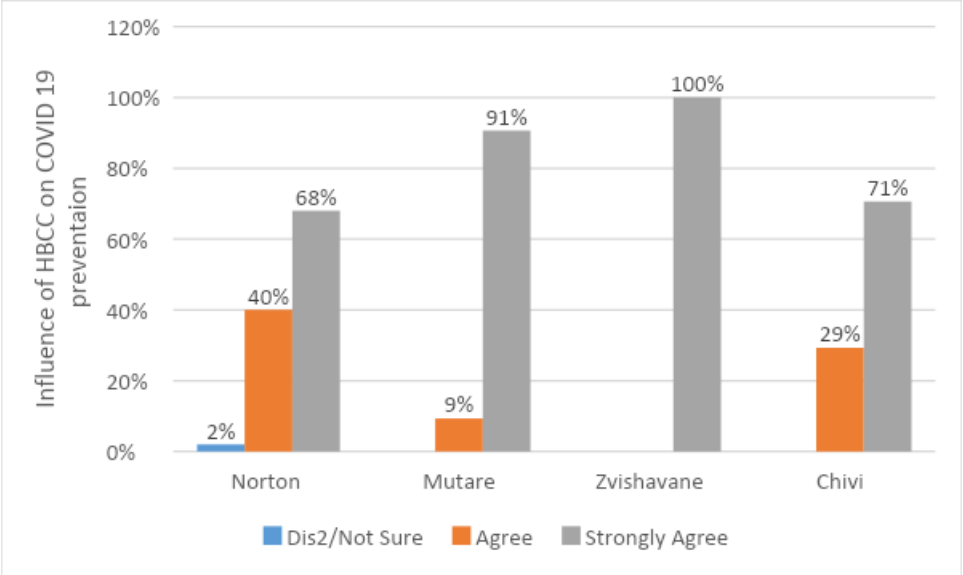

Figure 7: Decision making on COVID 19 prevention

Figure 8 show that HBCC project influenced more women than men. Generally, the population of women is higher than man and women play a pivotal role in the health and hygiene of their homes. Furthermore, it is women who are majority at market places especially vegetable markets and women represents the majority of people who go to fetch water at water points in Norton District and all rural districts. Therefore, influencing women`s behavior towards hygiene and COVID 19 presentation means influencing the community. Approximately 4% of men and 1% women were not sure of the influence of COVID 19 project.

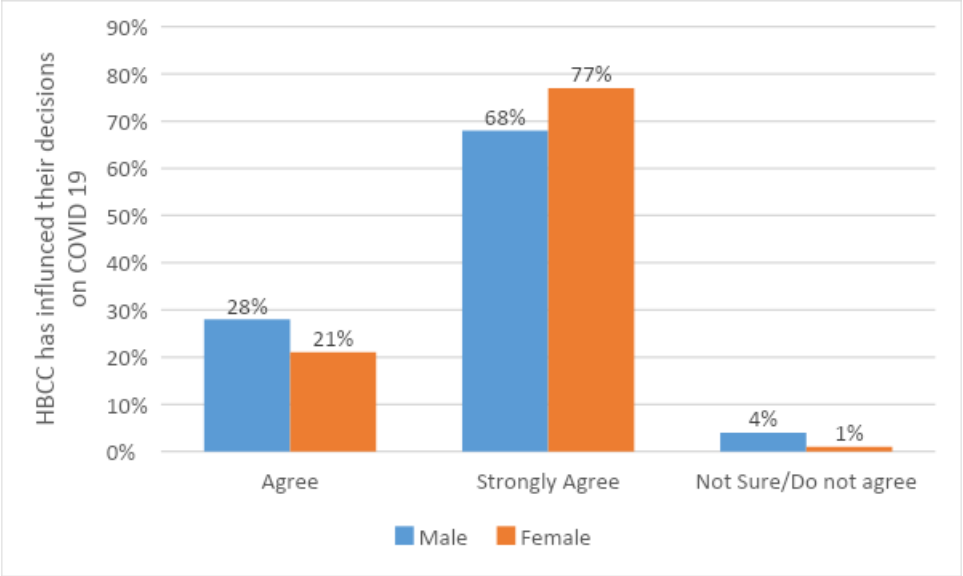

Figure 8: Decision making on COVID 19 prevention according to gender

4.3.4 Understanding what to do with COVID 19 related information

The evaluation exercise assessed level of understanding and decision making based on the available information. According to Figure 9, over 95% of respondents now understand what to do when they suspect that they have COVID 19. The situation was different before the start of the program. KII aided that although people are afraid of the virus, they no longer panic as they used to do when they tested positive. Over 70% responded that they are now able to judge if the information about COVID 19 in the media is reliable or not. However, during FGDs and interviews with K11, it was reported that there is still a lot of misleading information on social media and part of it caused high resistant to COVID 19 vaccination. Approximately 18% face challenges in judging whether information about COVID 19 in media is true or false. Situation is worse in rural districts.

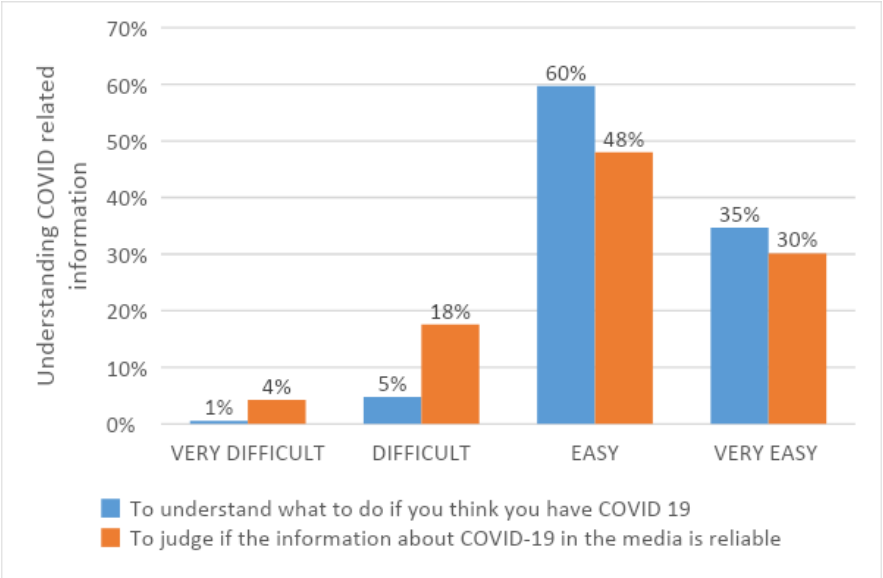

Figure 9: Understanding COVID 19 information

Table 11 show that more than 90% of women and men in all the districts understand information about what to do if one thinks he/she has Covid- 19. However approximately 22% of women and 17% of men find it difficult to judge if the information about COVID-19 in the media is reliable. Further discussion revealed that a lot of contradicting and false information has been circulating in the social media thereby confusing some of the people.

Table 11: Understanding COVID 19 information

SEX	Level	Understand information about what to do if you think you have Covid-19?	To judge if the information about Covid-19 in the media is reliable
Men	Very Easy	33%	34%
	Easy	65%	49%
	Difficult	2%	16%
	Very Difficult	1%	1%
Women	Very Easy	36%	30%
	Easy	58%	48%
	Difficult	5%	18%
	Very Difficult	1%	4%

4.3.5 Ability to follow COVID 19 related recommendations

Knowledge of COVID 19 is not enough to fight the pandemic, but application is one of the key indicator of hygiene behavior change. Figure 11 show that majority of people, over 70% are able to follow recommendations on how to protect themselves from COVID 19, when to stay at home from

work/ schools and when to engage in social activities and when not to. This ability is an indicator that project is likely going to be sustainable.

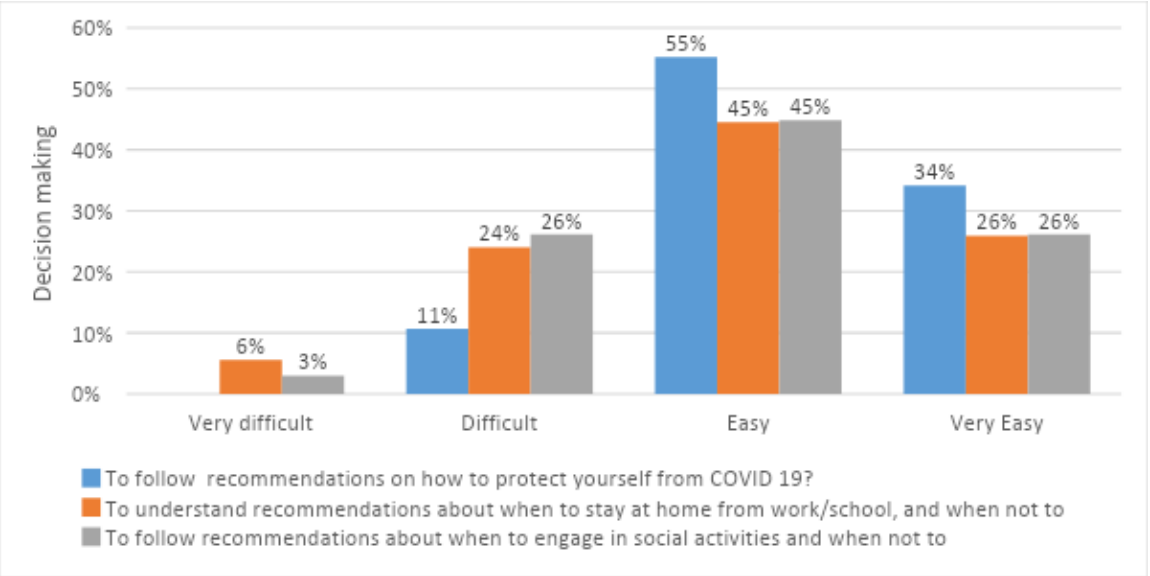

Figure 11: Ability to follow COVID 19 related recommendations

Table 12 show that majority of men and women in the project area are now able to follow recommendations on how to protect themselves from COVID- 19. However, a significant number of people over 25% of both men and women find it difficult to understand recommendations on when to stay at home from work and when not to. Approxiamtely 25-30% of people find it difficult to follow recommendations about when to engage in social activities and when not to. Men (34 %) find it harder to stay at home than women (25%). Key informants reported that people are forced by economic challenges to leave their homes because majority are in the informal sector and the work from hand to mouth.

Table 12: Ability to follow recommendations by men and women

SEX	Level	To follow the recommendations on how to protect yourself from COVID-19	To understand recommendations about when to stay at home from work/school, and when not to	To follow recommendations about when to engage in social activities, and when not to
Men	Very Easy	36%	22%	29%
	Easy	54%	44%	46%
	Difficult	10%	28%	22%
	Very Difficult	0%	6%	3%
Women	Very Easy	35%	29%	25%
	Easy	55%	46%	45%

	Difficult	10%	20%	25%
	Very Difficult	0%	5%	5%

4.3.6 Understanding and influence of the HBBC intervention

Figure 12 show that the level of understanding and practicing hygiene related to COVID 19 improved compared to same time last year. Approximately 99% of the respondents said they understand and the way they carry out hygiene practice has improved. The was high improvement in understanding by both men and women.

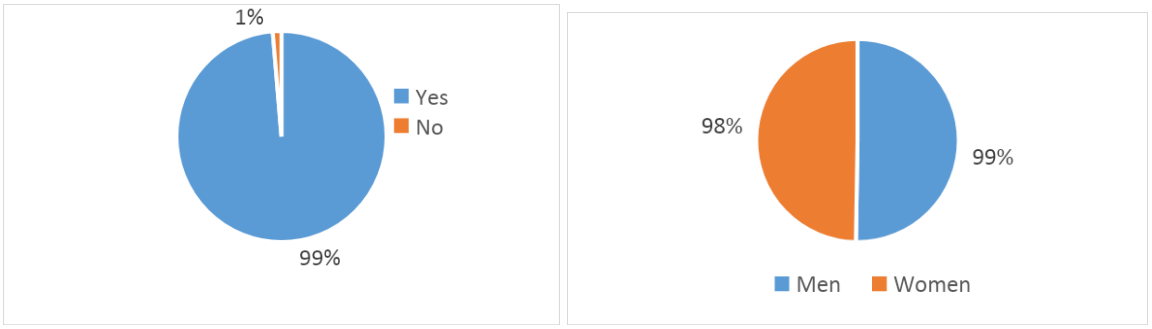

Figure 12: Improved level of understanding and practicing of hygiene related to COVID 19 pandemic

4.4. Disease Perception

A combination of focus group discussions and individual questionnaires helped to solicit information on the perception towards COVID 19 and other hygiene related diseases by people in the targeted districts. Results in Table 13 &14 were generated using WASH'Em[11] diseases perception standard tables. Three disease perception FGDs (men, women, people living with disabilities) were held in each of the four districts. For each FGD, a score of '1' was given to each question if the answer did emerge and was left blank if the answer did not emerge. Given that a total of 12 FGD were held, 12 became the highest total score that most closely reflects the answer that participants gave. Responses that are likely to be more important are highlighted in orange and were selected in this analysis. Detailed analysis of disease perception is in Appendix….

Table 13: Perception on COVID 19 illness and spread

Question	YES/NO	Total Score	Interpretation
Was COVID19 one of the 5 illnesses of greatest concern to your population?	Yes	11	All focus FGDs except for Mutare men did not list COVID 19 among the 5 illness of greatest concern to their population. People who perceive COVID19 to be an important health issue affecting them are more likely to be receptive to hygiene promotion programs and more likely to practice good hygiene. Other illness cited are malaria, cholera, diarrhoea, typhoid, cancer, sugar diabetes and high blood pressure (BP). Therefore, people in all the districts are likely continue taking up prevention measures against COVID 19.

[11] WASH'Em Diseases Perception: https://app.washem.info/rapid-assessments

Do you think that someone in your family could get COVID19 in the next 6 months?	I think it might happen	10	Participants in most focus group discussions thought that someone in their families could get COVID 19. Two focus group discussions in Norton and Mutare actually scored that it will happen. It was however established during focus discussions that there are myths that are influencing communities, e.g. someone said because of high temperatures in Zimbabwe people were feeling that they were not going to get COVID, some thought that black people are resistant to the disease. Such kinds of beliefs can be a barrier to COVID 19 hygiene behaviour change. If people think they might get COVID19, they could be open to learning how to take preventative action.
If someone in your family did get COVID19, do you think it could result in serious illness or death?	I think it might happen	10	Participants in 10 FDGs believed that if someone did get COVID 19 from their families, it might result in serious illness or death. The other two remaining groups were of the view that if someone in their families get COVID 19 it will result in serious illness. If people do not consider COVID19 to be serious then they will be less likely to want to take preventative action. Results therefore show that people in the target districts consider COVID 19 to be serious and are taking up preventative measures.
If you compare your family with other families who live near you, who is more likely to get COVID19 in the next 6 months?	Everyone is at the same risk	10	This may indicate that people feel their circumstances are similar to those around them and that who gets COVID19 is random. During discussions some participants reported that they are afraid and at risk from returning residents from other countries, especially South Africa. Perceiving that everyone is at risk is has been encouraging people in all Districts to respond positively to HBCC behaviour change and hygiene promotion. People are now aware that although anyone can get COVID 19, it is not completely random and can be prevented.

Table 14: Perceived impacts of COVID 19 and local community`s ability to act on them

Question	YES/NO	Total Score	Interpretation
What were some of the perceived impacts of COVID19? (more than one answer may be true for this question)	Physical or mental health impacts for the individual or family.	7	75% of the focus group discussions in both rural districts perceived physical and mental health impacts of COVID 19 to individuals and families. People are predominantly worried by the health impacts of COVID 19.
	An economic impact loss of income while sick	7	People are not only worried about the health impacts of COVID 19. People reported that they are all victims of economic impacts as a result of COVID 19. Some said a lot of people lost their jobs during COVID 19 lockdowns.
	A productivity impact less mentally alert, less able to be productive, unable to attend school	7	People are not only worried about the health impacts of covid19. Heightening the cognitive impact of COVID 19 could be an effective way to motivate handwashing. People now know that it is very important to prevent COVID 19 so as to reduce related economic impacts.

	A social impact — people feel like they would be socially excluded or judged for getting sick	9	People are not only worried about the health impacts of COVID 19. The desire of not wanting to be socially excluded increased implementation of prevention measures such as handwashing and wearing of face masks. They also reported that they were educated on how to respond to family members who tested positive without socially excluding them.
Did people think that they can take action to prevent COVID19? (more than one answer may be true for this question)	Yes — people feel like they have the ability to reduce their chance of getting COVID19 (including by washing their hands)	12	In all FGDs people felt that they have the ability to reduce their chances of getting COVID 19. This means people know what they should do and feel that there are no major barriers to hand washing. It means people will be respond positively to hygiene promotion.
Do people think their handwashing practices have changed? (more than one answer may be true for this question)	More often — because they are afraid of disease	12	When there is a new disease outbreak in a region (such as COVID 19) this typically causes fear and a short-term rise in rates of handwashing. Such increases, unfortunately, do not normally last. As soon as fear decreases, so does handwashing. This was reported as a situation that happened towards festive season in 2020, most people relaxed and there was a spike in infections that forced the government of Zimbabwe to lock down in January 2021. Even though there is still more work to be done in dealing with behaviour change that causes complacency, results from stakeholder interviews show that HBCC project made an

			effort in complementing government programs to influence communities to make good hygiene especially handwashing a lifestyle.

4.4.0 Hand washing

4.4.1 Effect of HBCC project messages on handwashing

All the participants in all districts except for Norton reported that messages they received from HBCC project influence an increase in their handwashing frequency. Only about 2% of the respondents in Norton District did not feel the influence of HBCC project.

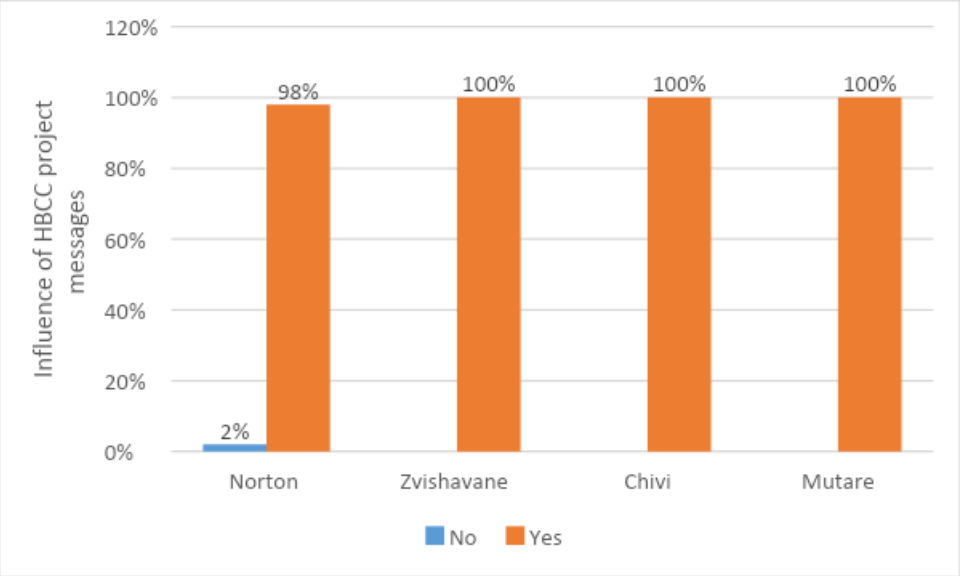

Figure 12 Effect of the messages from HBCC project on handwashing frequency

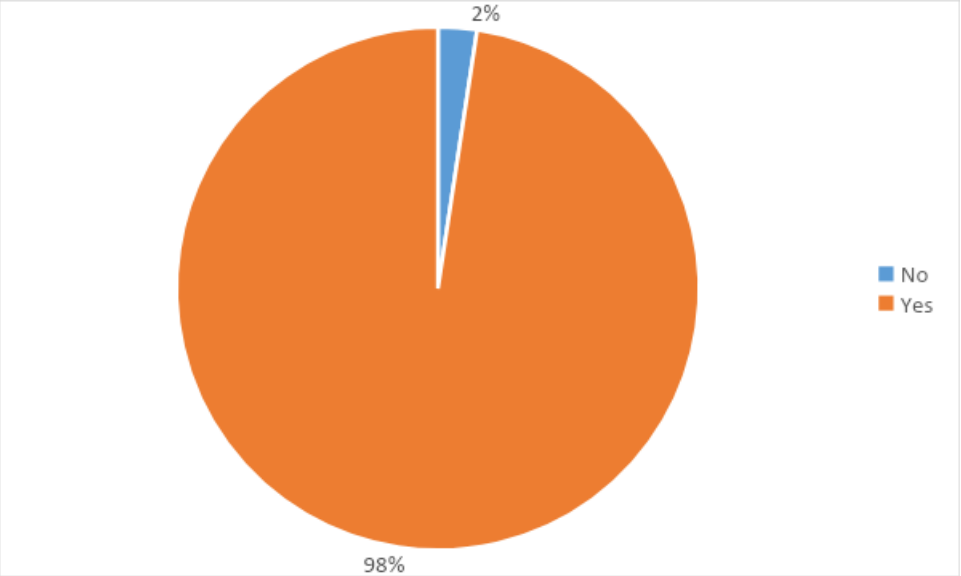

Figure 13:Satisfaction level by the quality and quantity of information/hygiene materials received

4.4.2 Have handwashing place and its location

According to Figure14, over 70% of respondents across all districts reported that they have hand washing place. There was a significant improvement in terms of availability of handwashing places and facilities as compared to baseline survey period were for example approximately 67% of rural districts reported to be lacking handwashing places. Most of the handwashing places in Mutare and Zvishavane district are multifunctional (used for handwashing, and is used for other things like cleaning in or laundry). During field work, a wide range of hand washing places and facilities were observed. These include use of dish and cup, plastic containers and reused juice bottles and sinks. During hand washing demonstrations most participants were confident and were able to wash hand the correct way. This a notable improvement considering that the baseline report capture cases were participants were hesitant and some failing to locate where they placed soap. Handwashing demonstrations show that majority of households wash their hands regularly. Participants gave credit to the HBCC projects and government efforts through national lockdowns and awareness raising as drivers for behavior change. Figure 15 show that 91% of those with handwashing places use water and soap to wash their hands. Asked how often they used soap for handwashing, approximately 90% of urban districts have soap daily available for hand washing.

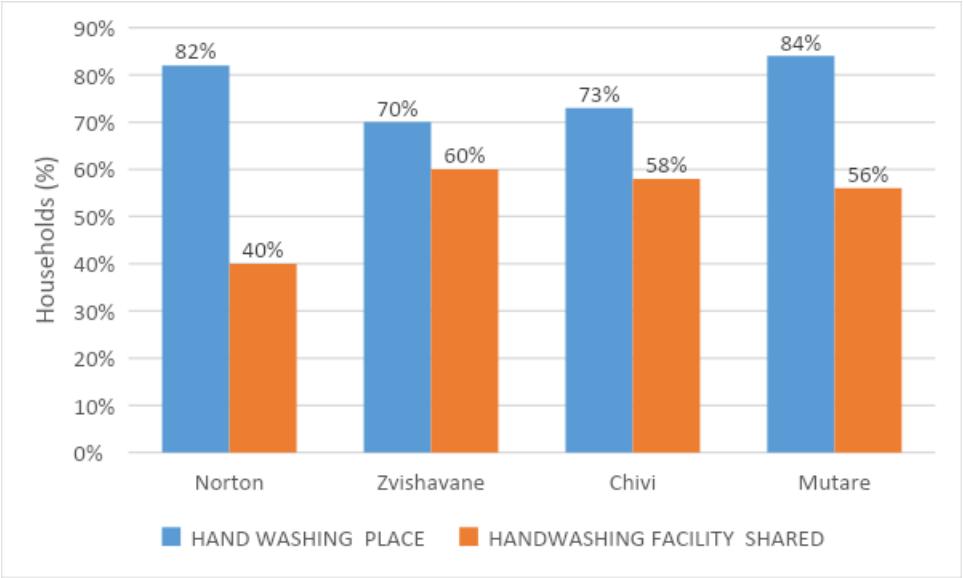

Figure 15: Availability of handwashing place and use

4.4.3 Availability of soap at handwashing facilities

Rural districts had a higher number of households who sometimes struggle to access soap for handwashing. Approximately 45% in Zvishavane and 27% in Chivi (both rural districts sometimes

wash hands with soap and sometimes without soap). During hand washing demonstrations, soap was available in over 90% of the households. Washing hands without soap or ash increases risks of COVID 19. Communities are much aware of the importance of hand washing practices to prevent COVID 19 and other diseases.

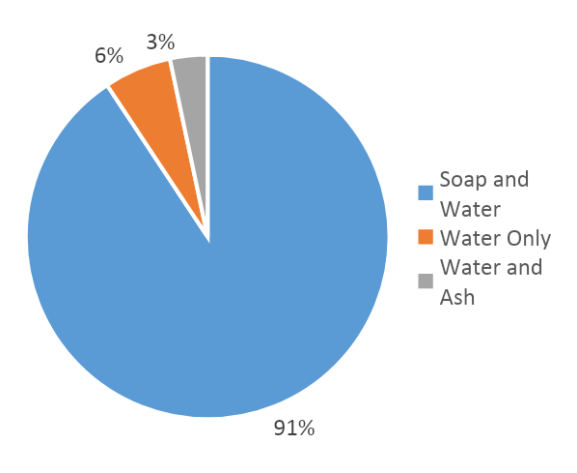

Figure 16: What is used for handwashing

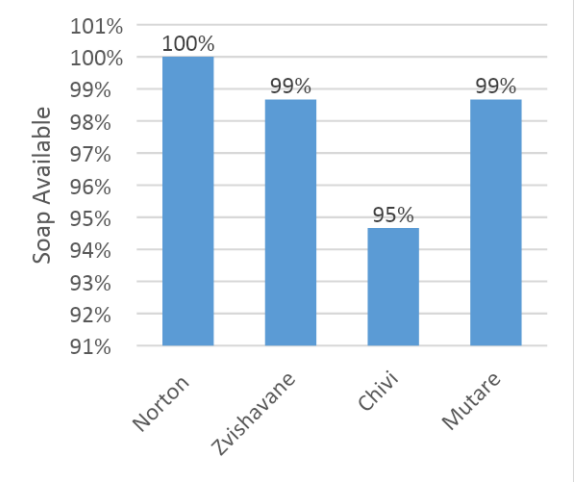

Figure 17: Soap availability for handwashing

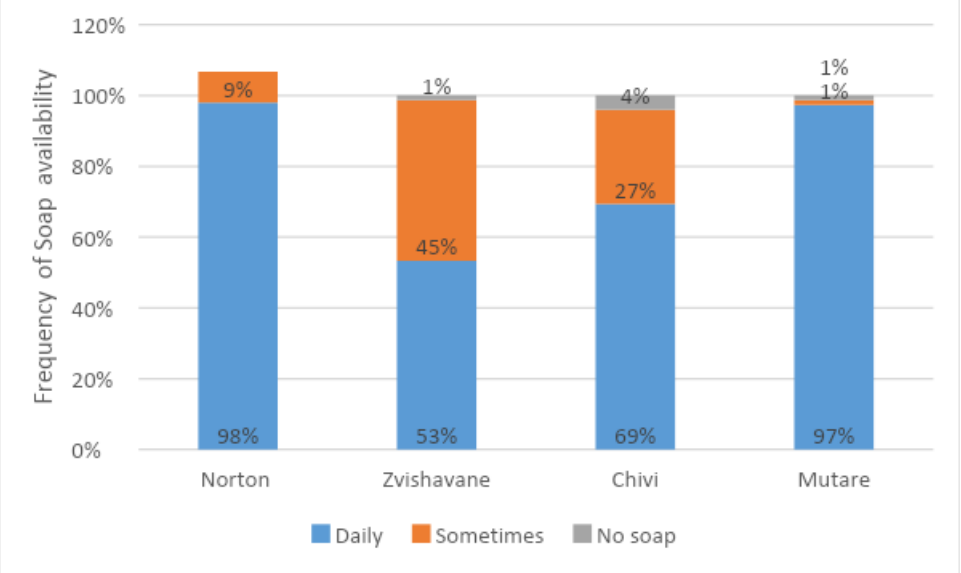

Figure 18: Degree of availability of soap at handwashing place

4.4.4 Water availability at handwashing places/facilities

Figure 18 show that water for handwashing is always readily available in of 90% of the households, a great improvement from the time of baseline survey. Water was readily available in all the visited households during handwashing demonstrations. Even though in some places households had to travel more than 1km to fetch water, they made sure that their hand washing facilities had enough water always. Access to water varied also among urban districts. For example, Mutare has access to clean and reliable water through the year, while as Norton share water supply with Harare the capital

city and sometimes face water supply challenges. Women in Norton reported that they are most affected and at risk of COVID 19 infections because majority rely on community water points. Community water points go against the social distance prevention measure. People in those situation indicated that they are unable to stop going to water points because water is life.

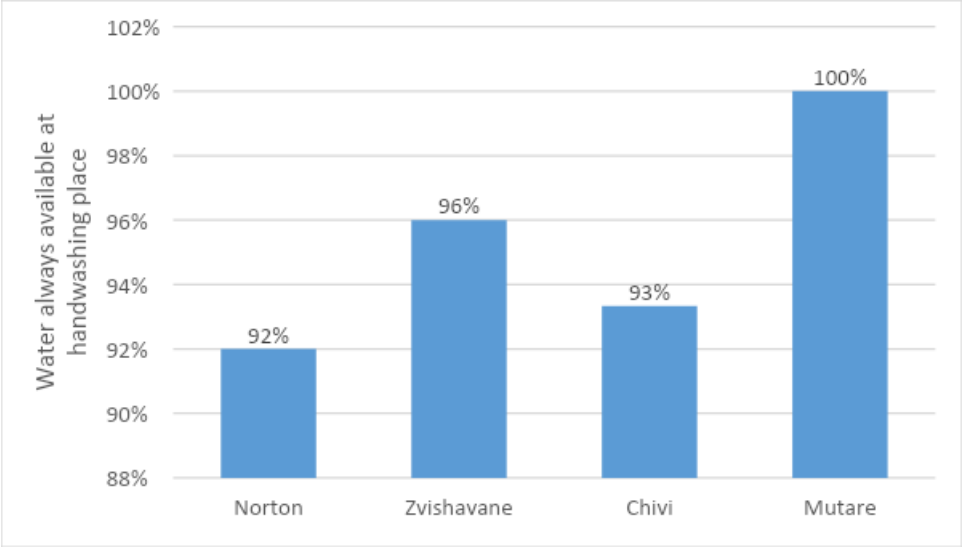

Figure 19:Water availability at handwashing place

4.4.5 Times for handwashing

Having access to handwashing place and soap is not enough, members of households should have knowledge of when to wash their hands to them from infections and should actually practice handwashing. Table 15 show over 96% of people in the project area wash their hands before eating, especially main meals like breakfast, lunch and dinner. Majority of people, over 95% in all districts also wash their hands after defecation or using the toilet. The is improvement in handwashing before feeding children and after handling child stool/ changing nappies as compared to last year. However, according to table 5, only 25%-40% of households wash their hands before feeding children or after changing a nappy or handling child`s stool.

Table 15: Times for handwashing

What moments did you wash hands yesterday	Norton	Zvishavane	Chivi	Mutare
Before eating	96%	99%	100%	97%
Before Cooking/ Meal preparation	50%	43%	73%	93%
After Defecation	85%	75%	74%	87%
Before feeding children	69%	62%	57%	67%
After handling child`s stool/ changing a nappy/ cleaning a child`s bottom	57%	36%	40%	45%

4.5 Relevance of the HBCC project to the needs of the targeted communities

Relevance of the project was assessed based on some key indicators at household level. Households and key informants` contributions were used to assess relevance. Table 16 show that 85 %v of consulted people said the chosen communication channels were highly relevant. More than 68% across all districts said the hygiene promotional messages were relevant to their needs in responding to COVIID 19. Over 96% of the people reported that the timing of the intervention was highly relevant. This was supported by key informants. For example, District Environmental Health Officers said the project helped them a lot by filling gap that the government was failing because of capacity challenges. Furthermore, government officials said that the project aligned very well with government COVID 19 response strategy. The project complemented the national hygiene strategy and WHO International efforts to curb the spread of COVID 19.

Table 16: Relevance of HBCC project

Districts	Category	Communication channels	Hygiene Messages	Timing of intervention	Compliment national hygiene strategy	Align to government response plan to COVID 19
Norton	Highly relevant	90%	78%	95%	78%	90%
	Relevant	74%	20%	5%	30%	30%
	Not relevant	1%	2%	0%	2%	2%
Zvishavane	Highly relevant	88%	68%	91%	80%	85%
	Relevant	15%	30%	9%	19%	19%
	Not relevant	3%	2%	0%	1%	1%
Chivi	Highly relevant	85%	70%	100%	79%	80%
	Relevant	14%	25%	0%	20%	17%
	Not relevant	1%	5%	0%	1%	3%
Mutare	Highly relevant	91%	70%	100%	81%	90%
	Relevant	9%	26%	0%	19%	10%
	Not relevant	0	4%	0%	0%	0%

4.6 Sustainability of hygiene practices and COVID 19 prevention measures

People were asked if they are able to continue with improved hygiene behaviour beyond the HBCC project. Majority of participants in all the districts, 90% in Norton, 88% in Zvishavane, 85% in Chivi, 91% in Mutare said that they are able to continue washing hands regularly (Table 17). Community volunteers and EHTs supported this claim saying that majority households are now able to wash their hands regularly. They said in rural, communities have been able to replace broken down handmade handwashing facilities that they make from 5 litres recyclable containers. These facilities were observed during handwashing demonstrations. In addition, handwashing at market place is sustainable because vendors are already contributing money to buy sanitizers which they put in the hand washing tanks that HBCC project provided. A very small percentage reported that they will sometimes and at times unable to wash hands consistently because of lack of soap and water related challenges. Over 70% reported that they valued the importance of social distance to prevent themselves from infectious diseases. KII however commended that social distance is usually affected by shortage of resources/ goods and services. An example that was given is that there are currently long vaccination queues in all districts, a result of increased vaccine demand. The challenge that affects social distance is that services in some of the medical centres is slow and people run out of patience and at last fail to maintain social distances. At public transport stations like in Norton, when people wait in queues for too for ZUPCO[12] buses they end up breaking up the required social distance. Wearing of mask has been made a mandatory by law and over 65% of people are now used to that. Some KII reported that correct mask up will be a challenge in hot summer especially with handmade masks made of cotton clothes. The perception of people in low income areas is that hand sanitizers are usually used by people with income.

[12] Zimbabwe United Passengers Company (ZUPCO) is a government funded public buses and commuter mini-buses

Table 17: Sustainability of hygiene practices and COVID 19 prevention measures

Districts	Frequency	Regularly wash hands with soap/ash	Keep Social distance	Wearing of face masks in public	Hand sanitizing
Norton	Yes consistently	90%	73%	65%	40%
	Sometimes	10%	25%	34%	52%
	Unable	0%	2%	1%	8%
Zvishavane	Yes consistently	88%	68%	67%	10%
	Sometimes	15%	30%	32%	25%
	Unable	3%	2%	1%	65%
Chivi	Yes consistently	85%	70%	66%	15%
	Sometimes	14%	25%	30%	30%
	Unable	1%	5%	6%	55%
Mutare	Yes consistently	91%	70%	64%	45%
	Yes sometimes	9%	26%	33%	50%
	Unable	0	4%	3%	5%

4.7 COVID 19 Vaccination uptake

As of 3 August 2021, there have been 122,652 confirmed cases of COVID-19 with 4,249 deaths, reported to WHO. A total of 3,772,579 vaccine doses have been administered, with 1.48 million people fully vaccinated representing 10%[13]. According to Figure 18 and 19 daily vaccine doses and cumulative doses were very low. Acceptance of vaccines faced resistance in the first four months since its introduction that is March 2021 to June 2021. The country received its first 200 000 doses of Sinopharm in February 2021[14], but took more than 3 months to administer the vaccines. Discussions with key stakeholders including District Environmental Health Officers, community volunteers and journalists at Provincial revealed that most of them people in all districts were sceptical about vaccinations. Several false information and myths were circulating in the social media people away. For example, some said in 2 years all vaccinated people will die, there are serious side effects to the virus. In the social media there was also information that there is a memory chip in the vaccines and all the vaccinated will be monitored and controlled. Some felt they will not get COVID and so there was no need for them to be vaccinated. However, from June 2021 to August 2021 COVID 19 vaccine demand increased exponentially. Reasons put forward are that this

- There was COVID 19 spike in infection in June 2021 and number of deaths kept on increasing
- Government imposed nationwide lockdown and majority of people were vulnerable
- Vaccination campaigns by government and corporate
- Government encouraged all its civil servants to be vaccinated and the corporate world followed. In rural areas traditional leaders were encouraged to encourage people within their jurisdictions

As a result, there was a sharp rise in number of people getting vaccinated in July/ Agust 2021 (Figure 20 and 21).

[13] https://covid19.who.int/region/afro/country/zw
[14] https://www.enca.com/news/watch-zimbabweans-react-sinopharm-jab

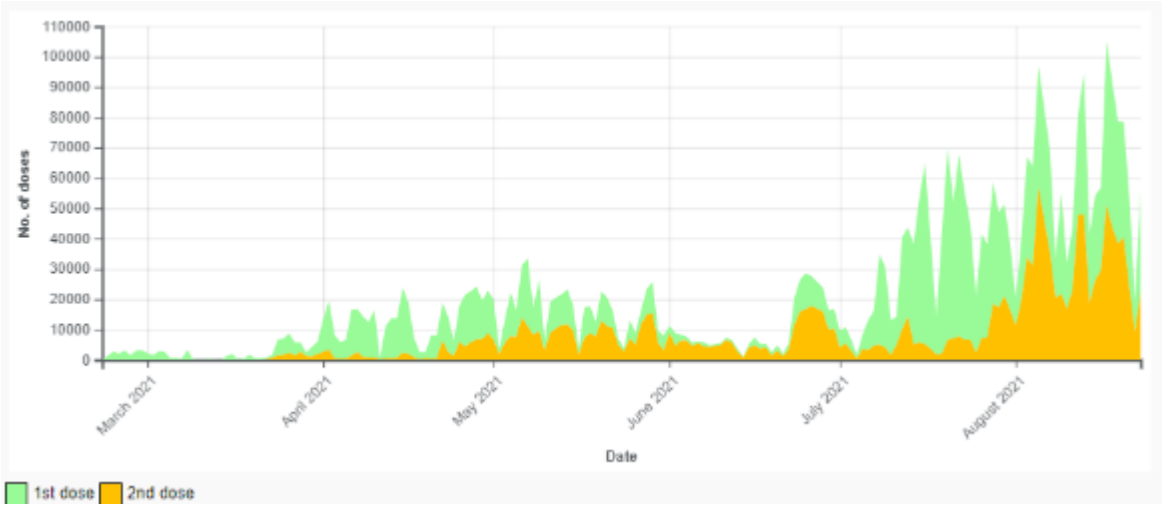

Figure 20: Daily COVID 19 vaccine doses administered in Zimbabwe[15]

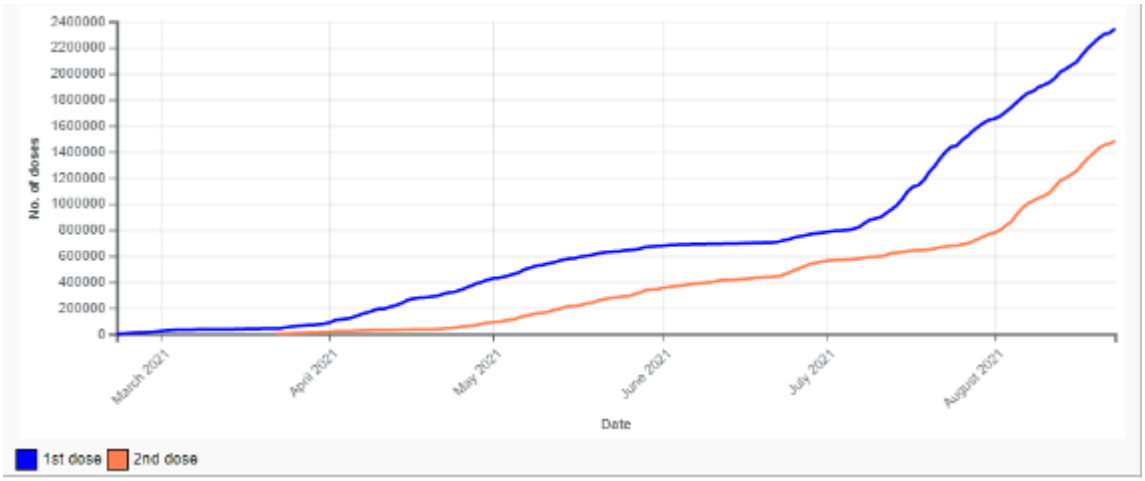

Figure 21: Cumulative COVID 19 vaccine doses administered in Zimbabwe[16]

4.8 Enabling factors to the success of the project

The project was successful because a number of enabling factors;

- Project got support from existing convenient WASH government structures. Working with the DEHOs, EHTs and Community volunteers helped in aligning the project to government response plans and activities. It also facilitated penetration of the project to local level. In addition, these structures existed in the project areas for many years, hence their experience helped in the project penetration.

[15] https://en.wikipedia.org/wiki/COVID-19_vaccination_in_Zimbabwe
[16] https://en.wikipedia.org/wiki/COVID-19_vaccination_in_Zimbabwe

- Use of Provincial radio stations- The Provincial radio stations were designed to be closer to the people in terms of geographical coverage and social life. So the use of provincial radio stations helped in reaching out to people because they related to local context culturally and socially. For example, Diamond FM relates well with the *Samanyika* people of Manicaland province
- Timing of the project was very convenient- The project came at a time when Zimbabwe was still coming to terms with COVID 19 pandemic outbreak and people had lot of unanswered questions about the virus, what it is, how it affects people, its cure and prevention. The project addressed topical issue COVID 19
- National Lock downs- National lockdowns helped by making people realise that COVID 19 was a serious disease and hence. This helped by making HBCC project to get the attention of people in the in the project area
- High level of mobile connectivity – The is high level of mobile phone connectivity in both urban and rural areas in Zimbabwe. This made it possible for SMS to reach out to as many people as possible

4.8. Challenges

The project experienced some challenges which can be used as lessons for future program

- Time allocated for the radio shows was very limited (15mins) per session. This did not give space for listeners to give feedback or ask questions during the sessions
- There was limited number of community volunteer volunteers in each district. For example, having one community volunteer per ward made was a huge task because they have to cover large population and geography
- People living with disabilities were not covered by some interventions. For example, deaf people missed on radio broadcasting programs and the blind people were not considered in the sms communication channel.
- National lockdown side effects- national lock downs affected school attendance. It was difficulty to full exhaust support for schools because they were closed in several months within the project

SECTION 5: CONCLUSION AND RECOMMENDATIONS

It can be concluded based on the findings from the four sampled districts that HBCC was a highly successful project. Majority people are now aware of COVID 19, and its effects. Majority of people now how the virus spreads and prevention measures to use. HBCC project positively influenced the behaviour of people towards COVID 19 prevention and health and hygiene as majority of people are

now able to wash their hands regularly with soap, mask up and properly wear their masks. However, the world, Zimbabwe included is still battling with COVID 19 pandemic, more awareness programs need to be carried out so that people do not relax and cause spike in infections again.

Recommendations

- The project came is coming to an end when the country has begun the critical vaccination program which has been also facing resistance. Mobilise resources to support behaviour change towards vaccination and to discredit myths circulating on the social media
- Increase airtime for radio shows from 15minutes to at least 30minutes to allow time for listeners to ask questions and presenters to respond
- Take radio journalists in some of the field work so that they can as well get to know of some COVID related issues on the ground and build topical issues to discuss during broadcasting
- In future increase the number of community volunteers to improve their coverage
- Expand the road shows to rural districts to improve their coverage
- Allocate budget for resources that should be used in supporting capacity development. For example, CARE should bring masks and sanitizers that they should give people during demonstrations and
- Increase components in the project design that cater for the needs of people living with disabilities. For example, some are blind and some are deaf so information and awareness raising should be able to reach out to them
- Support Community Volunteers with resources for example bicycles, that enable them to continue supporting and empowering their communities

APPENDICES

Appendix 1: WASH'Em data collection tools

a) Hand washing demonstration guide and data collection tools https://washem.info/rapids-assessments
b) Touch points guides and data collection tools https://washem.info/rapids-assessments
c) Disease perception guide and data collection tools https://washem.info/rapids-assessments

Appendix 2: Household Questionnaire

Individual Survey – Endline Review Assessment Tool for the Hygiene Behaviours Change Coalition-HBCC Project

Information sheet and Consent guide

I <name of interviewer> am from the CARE International Zimbabwe. We are conducting End Line Review to assess the overall behaviour change outcomes of the COVID-19 Hygiene Behaviour Change Campaign. The review will measure the behavioural outcomes, and determine how the project has contributed to these changes; with a special focus on how the project has generated positive changes in the lives of targeted women, girls, boys, and men; including vulnerable groups such as those living in remote locations as well as the elderly and people with disabilities. The assessment will identify unintended consequences of the project, both positive and negative; for target groups and others impacted.

You have been selected by a random lottery to participate in this interview. In this survey, we will collect information on your knowledge and understanding of the COVID19 disease its causes and the effect, how you are preventing yourself from contracting the disease including hand washing. In order to get true perceptions of you, we would like to do the interview without others influencing the responses. If you accept to complete this survey, your answers will be used to get a better understanding of the community hygiene behaviour change in preventing and mitigating COVID 19 illness.

The survey will take about 30 minutes to complete. You will neither benefit nor lose anything personally, but the information you provide will be very valuable to future programing. All information you provide will be used only for research purposes. It will remain confidential and known to those dealing with the survey only.

I would like to notify you that some of the questions are quite personal. Your participation is voluntary, and you can stop giving information at any time or choose not to answer a particular question.

If you have questions, we will be happy to answer them now or at any point in the survey. If you have questions about the study or participation after we have completed today's session, please contact [Emergency accountability officer, at XXXX or XXXX].

Do you agree to participate in this survey? 1=Yes 0=No

1. General				
Date of interview:	Name of interviewer:	Region:	District:	Village:

Sn	Questions	Response
2. Demography		
1.	Village/ Residential Area	[Text]
2.	District	[Text]
3.	Age of the Respondent	[Number]
4.	Sex of the respondent	1=Male 2=Female
4.	Educational status of the Respondent	1= Illiterate/No schooling 2=Informal School 3=Lower Primary 4=Upper Primary 5=Secondary 6=Tertiary
5.	Household size	[Number]
3. Knowledge and Understanding of hygiene related diseases and the COVID19		
1.	How did you hear about the new coronavirus disease 2(COVID 19)? (Multi select) (Facilitator should ask for all different sources from which the interviewee heard about coronavirus disease.)	1=Family member 2=Health staff including CHW 3=Mass media (Radio, TV) 4=Community member 5= Social media Others:_____ specify
2.	What do you know about the new coronavirus disease COVID-19? (multiple choice) (Facilitator prompts interviewee's responses related to what they know about protection steps, symptoms, transmission, self-care, risks/complications, government action, etc. Facilitator should prompt the interviewee until he/she says "that is all the information I have heard about coronavirus.")	1=Protection steps 2=Symptoms 3=Transmission 4=Self-care 5=Risks/complications 6=Government action
3.	What are the main symptoms of the coronavirus/COVID-19? (multiple) (Facilitator should first let the interviewee respond freely, and then probe for each of the following symptoms: Fever/Cough/shortness of breath & breathing difficulties/ muscle pain/ headache/ diarrhoea.)	1=Fever 2=Cough 3=Shortness of breath 4=Breathing difficulties 5=Muscle pain 6=Headache 7=Diarrhoea 8=Others Specify……
4.	What ways do COVID 19 virus spread?	1=close contact with infected person 2=through contaminated object or surface 3= Contacting infected droplets from cough or

		sneeze
5.	What ways do you prevent from contracting COVID19 disease	1= don't know 2= Stay at least 1 metre away from others 3= Clean hands frequently 4= Cover the mouth with a tissue or bent elbow when sneezing or coughing 5= Wearing of mask
6.	Has your level of understanding and hygiene practices related to COVID 19 improved compared to same time last year?	1= Yes 2= No
7.	What factors have helped to improve your level of understanding and hygiene practices related to COVID 19? ……..	
8.	If yes, what in particular facilitated the improvement in understanding hygiene practices related to COVID-19?	1= Radio messages on C19 2= availability of HWFs 3= availability of soap/water
4.Access to information and communication		
9.	Are there any COVID 19 or hygiene promotion activities that you received through the following communication channels? Tick the ones you know.	1= Television 2= Social Media 3= Radio 4= Newspapers 5= Community Leaders 6= Bill boards/ Posters 7= Religious Leaders 8= Other Specify……
10.	Can you give examples of COVID 19 or health and hygiene messages that you viewed or saw on communication channels you mentioned? …….. ……	
11.	Which communication channel do you trust most?	1= Television 2= Social Media 3= Radio 4= Newspapers 5= Community Leaders 6= Bill boards/ Posters 7= Religious Leaders 8= Other Specify……
12.	Do you understand the message that you received?	1=Yes 2= No
13.	If yes which communication channels did you receive COVID 19 or health and hygiene related messages that you can recall? (Tick the ones you received from)	1= Television 2= Social Media 3= Radio 4= Newspapers 5= Community Leaders 6= Bill boards/ Posters 7= Religious Leaders 8= Other Specify……

14.	Was your access to information on COVID 19 and hygiene practices improve as a result of CARE HBCC project?	1=Strongly agree 2= Agree 3= Neither agree or disagree 4= Disagree 5= Strongly Agree
15.	How easy or difficult would you say it is to…? 15.1. Find the information you need related to COVID-19? 15.2. Understand information about what to do if you think you have COVID-19? 15.3. Judge if the information about COVID-19 in the media is reliable? 15.4. Follow the recommendations on how to protect yourself from COVID-19? 15.5. Understand recommendations about when to stay at home from work/school, and when not to? 15.6. Follow recommendations about when to stay at home from work/school, and when not to? Understand recommendations about when to engage in social activities, and when not to? Follow recommendations about when to engage in social activities, and when not to?	1=Very easy 2=Easy 3=Difficult 4=Very difficult 5=Impossible
16.	Do you think HBCC- CARE programmes influenced you to adopt COVID-19 preventive measures, such as wearing face masks, physically distancing and cleaning surfaces?	1=Strongly agree 2=Agree 3=Not Sure 4= Disagree
17.	Do you wear face mask to prevent against COVID 19 in public places?	1= Yes always 2 =Yes sometimes 3= Yes but not correctly 4=No
18.	Do you practice physical distance to prevent COVID 19 in public places?	1=Yes always 2= Yes Sometimes 3=Yes but less frequent 4= No
19.	Do you clean surfaces and or sanitize to prevent from COVID 19.	1=Yes more frequently 2=Yes less frequently 3= No
20.	Did the HBCC- CARE project influenced your to increase handwashing frequency?	1=Yes 2=No
21.	If someone in your family did get COVID-19, do you think you are now better equipped with information or means on how to deal with the situation?	1= Yes 2= No 3= Not sure
22.	If you compare your family with other families who live near you, who is more exposed to COVID 19 in the next 6 months?	1=Other families 2= We are all at risk 3= My family
23.	What would you do if you or someone from your family gets sick? (Facilitator should first let interviewee respond freely, and then probe on each of the following)	1=I will look for a more experienced relative to advise me on what to do 2=I would go to the hospital / health unit 3=I would go to the neighbourhood nurse 4=I would go to buy

		medicines at the market 5=I'm going to look for the traditional healer 6=I would stay in quarantine 7=Other(specify)
24.	During the last 7 days, which of the following measures have you taken to prevent infection from COVID-19?	1=Wash hands regularly using hand rub or soap and water for at least 20 seconds. 2=Avoid touching eyes, nose, and mouth with your hand/fingers. 3=Covering mouth and nose when coughing or sneezing, and washing hands after. 4=Avoid close contact with anyone who is sick, especially those with flu or cold symptoms such as fever, cough, or sneezing. 5=Clean and disinfect frequently touched objects and surfaces. 6=Stay at home if I am sick, except to get medical care. 7=Avoid shaking hands with others. 8=Avoid large gatherings. 9=Other measures:
25.	Did HBCC programme help you to overcome stigma, rumours and or misinformation?	1=Yes 2= No
26.	If yes can you explain ……. …….	
27.	What can families like yours do to prevent spread of COVID 19? ……. ……. …….....	
	6. WASH Behaviours	
1.	Did the HBCC- CARE project influenced your to increase handwashing frequency?	1=Yes 2=No
2.	Are you satisfied by quality and quantity of hygiene materials/products received?	1= Yes 2= No
3.	In a typical day, how often do you wash your hands	[Number of times]
4.	Why is it important to wash hands? **(tick all that applies, do not prompt)**	1=Get rid of dirt 2=Kill bacteria 3=Prevent disease 4=Smell nice
5.	Thinking about yesterday, at what moments did you wash your hands? ***(Check all that apply)***	1=Before eating 2=Before cooking/meal preparation

		3=After defecation 4=Before feeding children 5=After handling a child's stool/changing a nappy/cleaning a child's bottom 6= Did not clean hands 7= Other (specify)
6.	What do you use to wash your hands? **(choose only one, do not prompt)**	1=Water only 2=Soap and water 3=Water and ash 4=Sand and water 5=Does not wash hands
7.	Is there a specific place for hand washing?	1=Yes - there are hand washing facilities near the toilet and the kitchen 2=Yes - there is a multifunctional hand washing facility (a basin or tap that is used for hand washing, and is used for other things like laundry, too) 3=No - there are no hand washing facilities available near the kitchen or toilet 4=No - there are hand washing facilities at the toilet, but not at the kitchen 5=No - there are hand washing facilities at the kitchen, but not at the toilet.
8.	If there is a hand washing place, is it in a location where other people can easily see it? (If someone doesn't wash their hands will people notice?)	1=Yes - others can see 2=No - others can't see
9.	If there are hand washing facilities, are they shared by more than one family or more than 10 people?	1=Yes - the facilities are shared 2=No - The facilities are used only by one family or less than 10 people.
10.	Is there soap or ash in the home? If so how regularly is it available?	1= Yes- daily 2= Yes-sometimes 3= No soap of any kind or ash is available
11.	If soap or ash is in the home, where is it kept?	1=Yes - Near the toilet or in the kitchen 2=Yes - Elsewhere in the house
12.	If soap is available, what type is it?	1=Liquid soap or foaming soap 2=Bar soap that is designed for hand washing/bathing and

		is scented 3=Laundry powder, laundry bar soap, dishwashing liquid or ash
13.	Are you able to afford handwashing soap without support of donors?	1=Yes – always 2=Yes- regularly 3=Yes- but less often 4=No
14.	Is there always water available at the hand washing place?	1=Yes 2=No - the person had to go elsewhere to get water before hand washing (for example, into the home to access stored water).
15.	Did your hygiene and behaviour positively improved as a result of Hygiene and behaviour promotions you received?	1= Strongly improved 2=Improved 3= No improved
16.	Is there any traditional, social or religious practices in your area that does not allow you to practices certain hygiene practices (i.e. hand washing, social distance, and wearing masks)?	1= Yes 2= No
17.	If 12 is yes can you explain? a) Religious practices ……. b) Traditional/ Cultural practices……... c) Social practices……...	
	Touch points	
18.	What mode of transport do you use for travelling?	1=Bus/ Mini buses 2=Private 3=Bicycle 4=Train
19.	Do you sanitize your hands before using public transport?	1=Yes 2=No
20.	Is there enforcement of handwashing before people enter public transport (e.g. bus)?	1=Yes 2=No
21.	If you use public transport, are there markings for social distancing at bus/ taxi terminus?	1=Yes 2=No
22.	Do you always wear face mask in public places	1= Yes 2=No
23.	From you view do people wear face masks properly in public places?	1= Yes everyone wears properly 2= Yes majority wear properly 3= No- majority do not wear face masks properly
24.	From your views do people practice social distance at public places such as bus terminus, clinics, shops	1=Yes- majority 2= Yes- minority 3 =No
25.	If the answer to 20 is no or minority can you explain why? ……	

	……	
26.	Do you attend community/ village gatherings? (i.e. church, village leadership meetings, political meetings)	1= Yes 2=No
27.	If yes, is there provision for hand washing or sanitizers at such meetings	1=Yes 2=No
General		
28.	How relevant was the hygiene and behaviour change support provided by Care Zimbabwe	1= Very relevant 2=Relevant 3=Not relevant
29.	Did the programme come at the right time?	1=Yes 2=No

Appendix 3: Key informant guide-mass media (Radio Station)

1 What is the name of Radio station?

2 What is your average listenership? (On average how many people do you reach out per year?)

3 Who mainly tune in to your station?

a) Young people (children/ youths)
b) Women
c) Old people
d) Men

5 What is your target audience?

a) Rural/communal people?
b) Urban people?

6 What programs do you put during your prime time?

7 Are there any radio stations in the targeted locations currently promoting COVID 19 awareness and hygiene behaviour? Can you state them?

8 Do you have programs/ sessions where you promote COVID 19 awareness and hygiene behaviour as a radio station according to WHO standards?

5 b) If yes what kind of hygiene/ health COVID 19 packages/ messages you are conveying to the public? Can you share with us examples (talk shows, drama, jingles, interviews, teachings call in etc.?)

5 c) What time of the day do you carry hygiene/ COVID 19 awareness/ good hygiene promotions?

5 d) How often do carry out hygiene/ COVID 19 awareness/ hygiene promotion?

5 e) Are there any among the programs specifically targeted at women and children? Explain……

5 d) How are the people responding to your messages? What is the general behaviour of local people towards the messages? Can you provide any feedback?

5 e) Do you have programs for children were you promote hygiene and COVID 19 awareness?

If yes/no explain why?

6 Do you think mass media can influence hygiene behaviour change and COVID 19 awareness and preparedness?

7 If yes how do you think the mass media can positively influence the hygiene behaviour? What kind of packages can capture different age groups (children, youths, women, adults)?

8 How do you measure the impacts of your programs?

9 In your opinion what is the most effective way of reaching out and influencing behaviour change towards good hygiene and preventing COVID 19