Community Study of Matjhabeng and Masilonyana Municipalities

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Health & Development Africa

No 1 Milner Place, Sunnyside Ridge Park
32 Princess of Wales Terrace
Parktown, 2193
Johannesburg, South Africa
Tel: +27 11 484 8217
Fax: +27 11 484 8238
www.hda.co.za

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Health and Development Africa (Pty) Ltd Research Team

Dr Gill Schierhout
Dr Saul Johnson
Ms Sarah Laurence
Mr Lawrence Mashimbye
Ms Jennifer Baumann

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i. Acronyms

AIDS	Aquired Immune Deficiency Syndrome
FGD	Focus group discussion
HAART	Highly active antiretroviral therapy
HDA	Health and Development Africa
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
JHHESA	Johns Hopkins Health and Education in South Africa
MCP	Multiple and concurrent partners
OR	Odds ratio
PMTCT	Prevention of Mother-to-child transmisison of HIV
PPT	Periodic presumptive treatment
PEPFAR	President's Emergency Plan for AIDS Relief
STI	Sexually transmitted infection
STD	Sexually transmitted disease
TB	Tuberculosis
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing

ii. Executive Summary

Backgroud

Lesedi-Lechabile Primary Care is an NGO based in the Free State Province that focuses on preventing the spread of HIV in its target communities. The organisation is funded by the United States Agency for International Development and the President's Emergency Plan for AIDS Relief (PEPFAR) through Johns Hopkins Health and Education South Africa (JHHESA).

In 2008, JHHESA contracted Health and Development Africa (HDA) to conduct research among Lesedi-Lechabile Primary Care's target population (males and females at ages 16-40 years, particularly, in- and out- of school youth between the age of 16 to 25 years), in order to better understand the key factors promoting HIV transmission. This research was conducted in Matjhabeng and Masilonyana Local Municipalities, Free State Province, between October and November 2008.

Methods

The research included both quantitative and qualitative approaches. A random household survey was conducted with participants aged between 16 and 40 years old, and 767 individuals were interviewed. In addition to this, four focus groups were conducted among young people aged 16-24 years old, two with youth in-school and two with youth out-of-school.

Findings

Communication Channels

This area of the Free State Province has been affected by HIV, and this is reflected by people's own experiences. Around 46% of the people interviewed knew someone who had died of AIDS, and around 17% of people knew of a family member who had died of the disease. However, only 45% of the sample knew their own HIV status, which indicates some of the challenges with increasing HIV testing even in the face of this hyper-epidemic. This is however well above the national average of 24.7% of respondents who have had an HIV test in the last 12 months and know their results (HSRC 2008 National HIV Survey). Part of the explanation for this may be "fatalism", the feeling that a person has no control over whether they will be infected with HIV. Around 37% of people held these attitudes, which were more common among women (43% for women compared to 29% for men), and may reflect a generally disempowered feeling among women more broadly.

People in this community are well exposed to mass media, with about 89% of people saying they watched TV and listened to the radio. Lesedi FM was very popular (91% listened to it), as was 5FM with the youth. SABC 1 and 2 were the most popular TV channels (95% and 70% reported watching the channel respectively). While Sesotho sa borwa is the most common language spoken at home (95%), almost three quarters of the respondents could understand English on the radio (71%) and English was the most understood reading language (87%).

Structural Drivers of the HIV Epidemic

Given the history of this area of the Free State Province as a mining area, the researchers were interested in patterns of migrancy among the population. Although no hostels were included in

the sample, we found few people (5%) in these communities were born outside South Africa, and most of the South Africans were born in the Free State Province (80%). Despite this, about 20% of people said they received money from people living elsewhere. This could point to decreased mining activity in the Welkom area.

Among this sample (16-40 years old) marriage rates were low, with less than a quarter of men and half of women describing themselves as married. In fact, the number of people living with a married or steady partner was generally quite low (32% of females and 15% of males). This seems to have an impact on their sexual partnerships, which will be discussed below.

This area was characterised by high levels of unemployment (over 50%), despite the fact that education levels were quite high, with over 80% of the sample having finished high school. Possibly linked to lack of employment were high levels of alcohol use in this community. About half of the men visited shebeens, and about the same amount admitted to drinking heavily at least once in the past month. This is important, since alcohol abuse is linked to increased risk taking such as increases in casual sex and decreases in condom use[1].

Behavioural Drivers of the HIV Epidemic

The study was primarily interested in sexual behaviour and factors that could promote or mitigate the risks of HIV in infection. Delayed sexual debut was mentioned by about 42% of the respondents as an HIV prevention strategy, and attitudes were generally encouraging towards delaying sexual debut until after marriage or at least until after young people are 18 years old. Despite this, by the time young people reached 18 years old about 73% of them were already sexually active, and about 34% were sexually active by the time they were 16 years old. Similarly, the mean age of sexual debut was 18 years. This is the same for boys and girls. Given the low levels of marriage in this community messages about abstinence until marriage would seem unlikely to be successful, and other strategies need to be considered around delaying sexual debut.

Another key area of HIV prevention is condom use. Messages around condoms have been very successful, with over 90% of people mentioning condoms as an HIV prevention strategy. However, myths about condoms were still common, with 20% of people saying that condoms contain worms, and about 19% of women saying that condoms can be used more than once.

Most people had high levels of self-efficacy regarding condoms i.e. they felt they could use condoms and negotiate condom use with their partners. The exception to this was using condoms after drinking alcohol, where about a 33% of people felt this would affect their ability to use a condom.

Actual condom use to prevent HIV was quite high, with 60% of sexually active (those that had sex in the past year) people saying they used a condom to prevent HIV the last time they had sex. This was higher among young people (76% of those at the age of 16-19 years), but was lower among people who were unemployed at this time of the survey (54%).

One of the focus areas of this study was to explore patterns of sexual relationships and in particular multiple partnerships. To do this we asked respondents to describe in detail each of

their sexual relationships in the past 12 months, as well as a number of questions on norms and attitudes regarding numbers of partners. In the quantitative survey 92% of participants overwhelmingly felt that it was not acceptable for people to have multiple partners, and that having many partners increases a person's risk of HIV. This is despite the fact that only less than 20% mentioned reducing the number of sexual partners as an HIV prevention strategy.

We asked a number of questions regarding self-efficacy towards faithfulness or only having one partner. Although the majority of people had high levels of self-efficacy in this area, there was a consistent proportion (about 14%) of men who feel that they could not be faithful to their partners. This is interesting, since it corresponds to a similar proportion of men who do have multiple partners.

Around 30% of men reported having had more than one partner in the past 12 months. This was much lower for women (7%). Mineworkers had slightly higher levels of multiple partnerships (37%). Most people (17%) who said they had more than one sexual partner had two partners in the preceding year, but 12% of men had more than two partners.

We were interested in the pattern of sexual relationships, since this is critically important in the design of HIV prevention messages. Most (76%) of sexual relationships were with a main partner, i.e. a spouse, steady partner or "main" partner. However, this differed depending on whether a person had a single sexual partner or multiple sexual partners. For people with multiple sexual relationships, about 50% of these were described as casual. Almost all of the people living with their partners were monogamous, which may reflect the nature of these relationships, or that people in this situation may be less likely to report other partners. Interestingly, the casual relationships were not once off events, but rather 80% of these involved regular sexual relationships over a period of time. This points out that while people may describe relationship as casual these are in fact concurrent relationships given that they span a period of time[2].

As may be expected condom use was highest with casual partners (83%) and lowest with spouses (38%). However, even when people had a casual relationship there were still around 17% who did not use a condom.

In this study few people reported giving or receiving money or goods for sex (4.2% and 6.0% respectively). However, this is an area, which is difficult to document well in a quantitative survey like this, given the complexity of the concepts involved. In the qualitative study there were high levels of reporting in both male and female of transactional sex. Alcohol use was also reported, with about one in ten sexual encounters involving too much to drink by either partner.

Biomedical Drivers of the HIV Epidemic

The study looked at the issue of male circumcision, given its demonstrated protective effects on HIV transmission. In this community about 73% of the men were not circumcised. Despite this, there were encouraging attitudes towards the practice, with both men and women supporting the practice and believing that it has health benefits. However, there is a great awareness of the need for circumcised men to use condoms.

Treatment, Care and Support

In this area about 54% of all sexually active adults had been for an HIV test. For women this was 62% vs 42% for men. The difference can be explained by women being tested for antenatal services. However, when asked who had tested in the last year, men and women were more similar, with about 33% of men and 40% of women having tested.

Knowledge regarding treatment for HIV was certainly widespread, with 89% of people mentioning antiretroviral drugs as a treatment for AIDS. In addition the vast majority of people (82%) know that ARVs needed to be taken for life. While most people (74%) mentioned ARVs also as way to reduce mother to child transmission of HIV (MTCT), other ways of reducing this, including ways of safe infant feeding, were less well known (at 3% for exclusive breastfeeding and less than 40% for replacement formula feeding).

Conclusions

This study has provided an invaluable insight into community norms, attitudes and behaviours. It is clear that the community faces many challenges, especially high levels of unemployment despite many people completing their schooling.

For HIV prevention organisations working in these municipalities, this survey can assist to direct their programmes in a number of ways:

- Unemployed young people, especially those who visit shebeens, are an obvious and important target.
- Given low levels of marriage and high levels of sexual activity among youth, abstinence only messages are unlikely to be successful in this community.
- Fatalism is an important factor in this community, and messages and programmes that aim to combat this, especially among women, should be considered.
- Most believe that they can be faithful to their partners, and indeed most men and women are faithful to their partners. The programme can reinforce this as a normative behaviour.
- There are, however, a consistent and quite large minority of people who have multiple partners. This programme can seek to identify those men and women who may have multiple partners, and design programmes to address them.
- Rates of circumcision are low, but there seems high acceptance of the benefits of male circumcision in this community. There appears to be fertile ground for prioritisation of male circumcision in the future.

1 Background

1.1 Purpose of the Community Studies

In April 2008, Johns Hopkins Health and Education in South Africa (JHHESA) approached Health and Development Africa (HDA) to design and undertake community studies in the areas served by four of their partner organisations. These organisations are: The Valley Trust which serves parts of eThekwini metro Municipality, Lesedi-Lechabile Primary Care which serves Matjhabeng and Masilonyana Local Municipalities, Mothusimpilo which serves Merafong City Local Municipality and Lighthouse Foundation which serves Madibeng Local Municipality.

The surveys aim to explore community level factors relevant to the organisations and their work in HIV prevention. The findings from the studies will assist the development of targeted interventions for each of the partner organisations and to inform advocacy efforts aimed at mobilising these areas to strengthen their HIV prevention activities. Information from the surveys will also provide information to enable the organisations to set and measure strategic objectives, tailor the content of their programmes, set targets and will serve as a baseline against which community changes can be measured over time. This report outlines the findings relevant to Matjhabeng and Masilonyana Local Municipalities in Lejweleputswa District. A separate report detailing exposure to Lesedi-Lechabile Primary Care and perceptions of the organisation is available.

Members of HDA's research team conducted a site visit with Lesedi-Lechabile Primary Care in May 2008. The site visit included discussions with key informants about the organisation's information needs in relation to their HIV and AIDS activities.

Key issues of interest for Lesedi-Lechabile Primary Care included:

- Multiple and concurrent partners (MCP), especially among youth
- Relationship between risky sexual behaviour and alcohol
- Relationship between risky sexual behaviour and self-esteem.

HDA conducted a document and literature review of health-related studies in the target community to contextualise the present studies.

1.2 HIV in Lejweleputswa District Municipality

According to the District Health Barometer (2005/06), Lejweleputswa District Municipality has the 17th highest HIV prevalence in South Africa, with an HIV prevalence of 28.3% in women attending antenatal clinics in 2005/06. The proportion of antenatal clients tested for HIV was similar at 27.8%. However, Nevirapine uptake rates amongst newborn babies of HIV positive women were high at 91.1% but very low among pregnant HIV positive women at 14.7%[3].

2 Methods

Mixed methods, utilising both quantitative and qualitative components were utilised. Ethical clearance was obtained from the University of the Witwatersrand's Human Research Ethics Committee (Non-medical).

2.1 Quantitative Household Survey

A cross-sectional, multi-stage clustered household survey was conducted in the areas targeted by Lesedi-Lechabile Primary Care, within Matjhabeng and Masilonyana Local Municipalities. The survey was designed to be representative of 16-40 year olds residing in the area. The wards in which the organisation is active were identified through discussion with key staff members. Random sampling was conducted in all the wards served by the organisation.

Key Features of the Community Survey

- Interviewed 767 respondents in Matjhabeng Municipality and Masilonyana Municipality, Free State Province during October and November 2008.
- Included adults 16-40 years and across all race groups.
- A structured questionnaire was designed in a consultative manner with members of the project team, including external advisors. The questionnaire was translated into Sesotho sa borwa and isiXhosa.
- At each selected household, personal at-home interviews were conducted by trained interviewers using a structured pre-tested questionnaire. The questionnaire covered socio-demographic characteristics and various HIV and AIDS knowledge, attitude and behaviour indicators.
- Interviews were conducted in the home language of the respondent.
- The interview was about 1.5 hours in duration.
- A 10% validation check was done personally or telephonically on the work of each interviewer.

Further details of the sampling approach are available on request.

Questionnaire Development

A structured questionnaire was developed in consultation with JHHESA and each of the partner organisations participating in this research. The questions asked in each of the four communities were similar across most of the areas of enquiry, with one section that was unique to each organisation. The main areas covered were:

- Demographic information
- Media access, including television, radio and newspapers
- Knowledge of HIV transmission and ways of preventing HIV
- Misconceptions around HIV and other potential barriers to safer sexual behaviour
- Ideational factors and social norms related to HIV risk
- The nature and extent of MCP including duration of partnerships, use of condoms in various relationships and the role of alcohol in relation to sex and HIV

- Prevalence and attitudes to circumcision
- VCT
- Knowledge of AIDS treatment
- Knowledge of PMTCT
- Awareness and perceptions of Lesedi-Lechabile Primary Care's activities.

The questionnaire was piloted in September 2008 in order to ensure that the response categories were mutually exclusive, the questions were understood the way they were intended by the researchers and so that fieldwork errors could be addressed during training. Amendments suggested by the pilot were incorporated into the final instrument. The final post-piloted questionnaire was translated into IsiXhosa and Sesotho sa borwa. A copy of the questionnaire is available on request.

Methods of Analysis

The quantitative data were analysed using the statistical package STATA. Uni-variate and multivariate analyses were conducted.

2.2 Qualitative Study

An in-depth qualitative study was conducted with in-school and out-of-school youth aged 16-25 years. Four focus group discussions (FGDs) were conducted according to the following allocation: two focus groups were held with in-school participants and two focus groups with out-of-school participants. All groups were either boys or girls only owing to the potentially sensitive nature of the topic. In- and out-of-school youth were separated due to the different nature of each group's shared experiences.

Field Guide Development

A field guide was developed for the focus group research by HDA staff in conjunction with the qualitative research agency.

The main themes that were to be explored in the focus group discussions for all participants were:

- Sexual practices
- MCP
- Inter-generational sex
- Risk perception of HIV
- Role of alcohol and drugs.

The qualitative researchers were trained to explore how, where and by whom relationships were initiated and under what circumstances.

Fieldwork was conducted in Welkom. In-school participants were purposively selected from a number of schools in the area. Out-of-school youth from the communities served by Lesedi-Lechabile Primary Care were invited to participate in the FGDs by Youth Peer Educators from the organisation.

Methods of Analysis

All focus groups were recorded with the permission of all participants and were then transcribed and translated. All transcripts and field notes were imported into Atlas.ti qualitative analysis software and coded thematically. Themes were then grouped into broader code families as a means of condensing the data into sub-groups. Common themes were then drawn out for purposes of supplementing the quantitative data taken from the community survey. The qualitative data was analysed using Atlas.ti qualitative analysis software.

Key Features of the Qualitative Evaluation

- Fieldwork was conducted in Matjhabeng Local Municipality, Free State Province during September 2008.
- In-school participants were recruited from schools and out-of-school youth were recruited from the communities served by the organisation.
- Four FGDs were held with in- and out-of-school youth to understand attitudes and behaviours around sexual relationships, sexual practices and prevention of HIV and other STIs.
- Interviews and discussions were conducted in the language of the respondents.
- The group discussions were approximately 2 hours in duration.
- All FGDs were recorded, translated and transcribed
- Data were analysed thematically using Atlas.ti software.

2.3 Limitations of the Study

This study has a number of limitations related to the study design. It is difficult to draw causal associations using a cross sectional study. Secondly, in a household survey high-risk groups such as mine workers living in hostels may be missed. This study did not include hostels. In addition, as sexual behaviour data was self-reported it may be subject to bias.

3 Sample Description

3.1 Quantitative Sample Descriptors

Of the total sample of 767 respondents interviewed in Matjhabeng Municipality and Masilonyana Municipality, some 45% were male and 55% were female. The mean age was 26.2 years. A general description of the sample population is depicted in *Table 1* below.

Table 1: Description of the quantitative sample

Descriptor	Number (Percent)
Age Group	
16-19 years	180 (23.5%)
20-24 years	186 (24.3%)
25-29 years	142 (18.6%)
30-34 years	116 (15.2%)
35-40 years	141 (18.4%)
Gender	
Male	346 (45.0%)
Education	
Primary or less	100 (13.0%)
Secondary	423 (55.2%)
Matric	211 (28.5%)
Tertiary	23 (3.0%)

The most common language spoken by respondents at home was Sesotho sa borwa (82.0%), followed by isiXhosa (9.4%) and Afrikaans (3.5%). *Table 2* shows the languages respondents most often spoken at home.

Table 2: Percent respondents speaking various languages at home

Language	Percent
Sesotho sa borwa	82.0
isiXhosa	9.4
Afrikaans	3.5
Setswana	1.7
Xitsonga	1.7
isiZulu	1.0
English	0.3
Tshivenda	0.3
isiNdebele	0.1
isiSwati	0.1
Sepedi	0.1

Respondents were asked which languages they could understand on the radio. The majority of respondents (94.8%) reported that they were able to understand Sesotho sa borwa on the radio. The next most common languages that individuals could understand on the radio were English (71.7%), isiXhosa (44.6%) and Afrikaans (18.5%).

It is interesting to note that while Sesotho sa borwa was reported to be the language that the majority of the sample spoke at home and understood on the radio, it was not the language

that most respondents reported being able to read. English was the language that most of the respondents said that they could read at 87.1%, followed by Sesotho sa borwa (84.8%), Afrikaans (34.8%) and isiXhosa (25.2%).

3.2 Qualitative Sample Descriptors

A total of 36 youth aged between 16-25 years participated in the FGDs. The allocation per FGD was as follows: male in-school youth (11), female in-school youth (7); male out-of-school youth (9) and female out-of-school youth (9).

4 Communication Channels

4.1 Interpersonal Communication

Increasing numbers of people infected and ill with AIDS mean that many respondents' awareness of HIV and AIDS is heightened through personal contact with those affected. This direct contact with the impacts of HIV has the potential to profoundly influence the way people think about risk, life, and their behaviours.

Table 3 below shows that 353 (46%) individuals living in Matjhabeng and Masilonyana Municipalities personally know of someone who has died of an AIDS related condition. The 30-34 year old age group were most affected with 57% of respondents in this age group knowing of someone who has died of AIDS.

Some 43% of respondents said that they personally knew an individual who is HIV positive and 45% said that they knew their own HIV status. For all of the items, greater proportions of women knew of people infected and affected.

Table 3: Percent males and females with personal knowledge of HIV or AIDS

Statement	Males	Females	Total
Personally knows someone HIV+	33.5	50.1	42.6
Family member HIV+	9.3	24.0	17.3
Personally knew someone who died of AIDS	45.1	47.0	46.2
Family member died of AIDS	17.9	24.9	21.8
Know own HIV status *	37.0	52.0	45.2

* Around 10% of those who said they know their own status had never been tested for HIV irrespective of sexual activity.

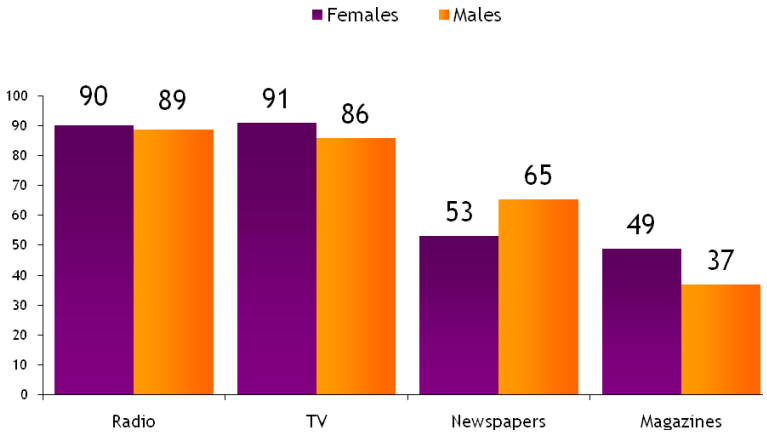
With almost one half (46%) of all respondents having personally known someone who died of AIDS, and over 40% personally knowing someone who is HIV infected, the epidemic in this area is highly visible. However, the data also indicate that fatalism may be a significant problem in this community – particularly for men. This can be supported remarkably by the fact that low percentages of people, particularly men (37.0%), know their own HIV status.

4.2 Media Consumption

There are a number of AIDS communication programmes in South Africa that utilise various domains of communication, for example, mass media (broadcast, print and outdoor), small media (posters, booklets, and utility items), and social mobilisation aimed at creating dialogue and action at local and community level. The survey measured access to various media channels in order to contextualise the environment in which Lesedi-Lechabile Primary Care operates and through which people receive AIDS related information.

Access to various media channels is shown in *Figure 1*. Radio was the most common media channel that respondents were exposed to, with 98% of the total sample saying that they listened to the radio. Television was the next most commonly utilised media channel with 89% of the sample reporting that they watched TV. Slightly lower proportions of respondents read newspapers and magazines (50% and 43.3% respectively). Males were more likely to read newspapers than females, whilst more females reported reading magazines than men did.

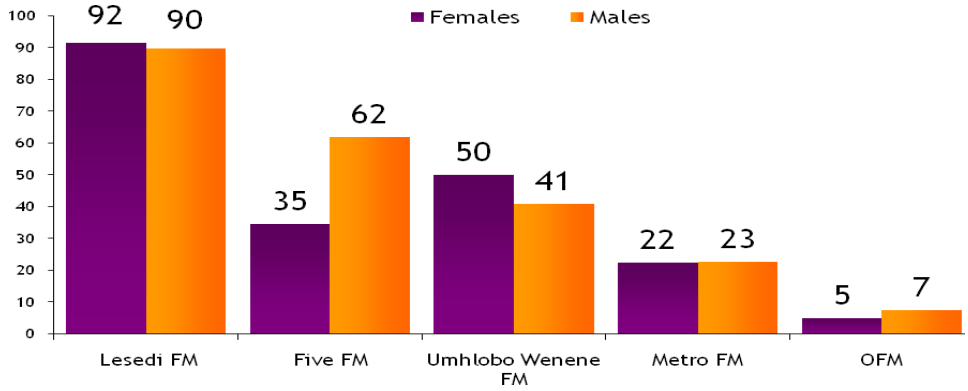
Figure 1: Percent males and females exposed to various media channels



Respondents were asked which radio stations they listened to. The five most listened-to radio stations were: Lesedi FM (90.8%), Five FM (46.8%), Umhlobo Wenene FM (46.1%), Metro FM (22.6%) and OFM (6.1%). Five FM appeared to be more popular with youth. Around 80% of 16-19 year olds listened to Five FM compared with only 20% of 35-40 year olds. Those aged 35-40 were also less likely to listen to OFM. Most of Metro FM listeners were between the ages of 20-34.

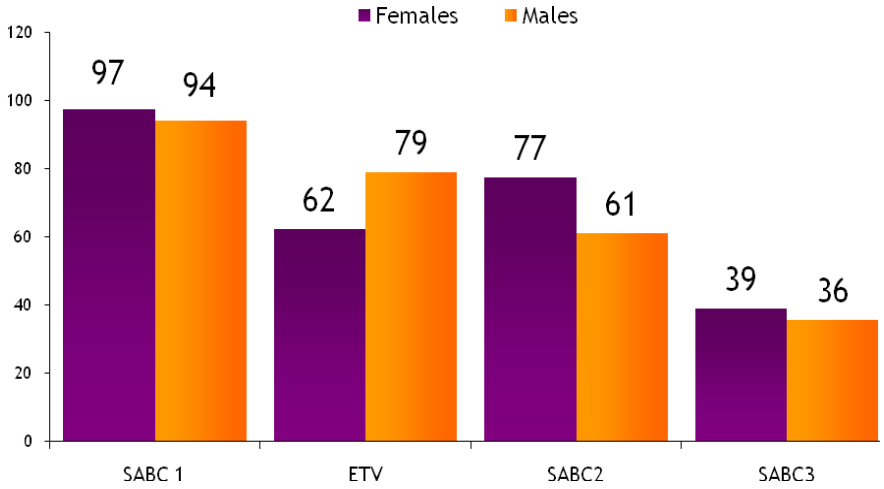
The proportion of females and males listening to each radio station was similar although males appeared more likely to listen to Five FM, where as females were more likely to listen to Lesedi FM and Umhlobo Wenene FM (*Figure 2*).

Figure 2: Percent males and females who listen to various radio stations



Around 96% respondents reported watching SABC 1. ETV was the next most commonly watched station (70%). Very few respondents reported watching MNET or DSTV (1.2% and 2.1% respectively). Females were more likely to report watching SABC 2 while males were more likely to report watching ETV (*Figure 3*).

Figure 3: Percent males and females who watch various TV stations



These data show that a large proportion of the community are accessing mass media, and hopefully also the AIDS programming that is channelled through mass media. Therefore it can be expected that some of the basic facts about HIV and AIDS, treatment literacy and other important health issues are likely to be reaching the community through these sources. Face to face interventions such as Lesedi-Lechabile Primary Care uses, have the potential to support and amplify the impact of mass media, particularly if the organisation is able to build synergies between local initiatives and mass media AIDS communication where this is appropriate.

High proportions of both men and women listen to Lesedi FM, indicating its potential as a channel for publicising the work of HIV prevention organisations in the area.

4.3 Summary and Conclusions

- The HIV pandemic is becoming part of everyday life for a large number of people in this community, indicated by high proportions of people personally knowing someone who has died of an AIDS related condition, or is HIV positive. Women were particularly likely to be affected in this way, more than men were. Lesedi-Lechabile Primary Care and other organisations need to help people make sense of the terrible tragedy of AIDS-related illness and death, and direct people towards appropriate responses. Women may need additional support to prevent despair and fatalism about the illness and men may need to be challenged with open dialogue about HIV since with the exception of AIDS-related deaths, fewer men know of people affected and infected than women do.

- A large proportion of the community are accessing mass media, and almost certainly some of the AIDS programming that is channelled through mass media. There may be potential to build synergies between mass media and the face-to-face interventions such as Lesedi-Lechabile Primary Care uses.

5 Structural Drivers of the HIV Epidemic

5.1 Migrancy

Migrancy has long been considered an important driver of the HIV epidemic in Southern Africa, and is particularly important in Matjhabeng and Masilonyana Local Municipalities. Various circumstances related to migrancy are thought to play a significant role in promoting sexual activity with non-regular partners and a high rate of partner change. In this survey, respondents were asked where they were born, whether or not they had a home elsewhere, what province they considered home to be, and about partnerships and remittances.

Around 5% of the respondents were born in other countries. Of these 5% born in other countries, 3% were born in Lesotho and the remainder were born in Mozambique, Angola and Zimbabwe. Of the 95% born in South Africa, 80% of the respondents had been born in the Free State and 10% had been born in the Eastern Cape. The younger age groups were more likely to have been born in this province than those over 35 years. Most men and women (96% and 92% respectively) regarded the Free State as their home. Of those who did not consider Free State to be home, around 19% had a partner living in a home somewhere else (7% of the total sample).

Approximately 20% of men and women in this area reported that they received money from family members living elsewhere. This varied by age of respondent, with 25% of those aged 16-19 years and 15% of 35-40 year olds saying they received money from elsewhere. Older respondents were slightly more likely than younger respondents to have a partner in a home somewhere else (8% for those aged 35-40 years and 5% for those aged 15-19 years).

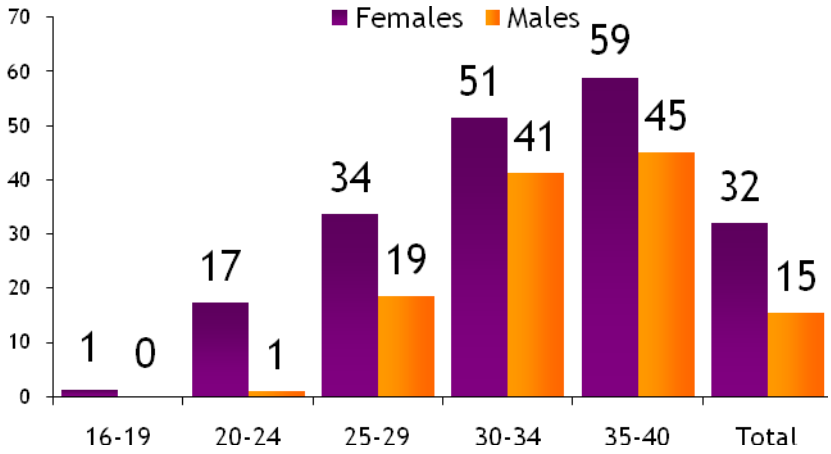
Levels of migrancy were lower than expected. This may be because of the young age of the sample – because of their age, a large proportion were students or unemployed (see page 21). Nonetheless, there were indications that many community members are connected strongly to other areas, as indicated by receipt of remittances (around 20%) and having a home elsewhere with a sexual partner or spouse in that home (7%).

There is clearly an urgent need for HIV prevention interventions to be proactive in addressing the needs of people with partners and connections outside of the area.

5.2 Marital Status

People's marital status is a determining factor in the design and delivery of HIV prevention programmes. Different types of relationships influence sexual behaviour that may increase their risk to HIV[4,5]. *Figure 4* shows the percentage of males and females by age group who were married of living together.

Figure 4: Percent married or living with sexual partner by age group



The data show low levels of marriage and cohabitating relationships particularly amongst those aged 20-30. A lower proportion of men were married or living with a partner than women.

5.3 Employment

Areas of high unemployment with pockets of income earning, such as mining communities, are often characterised by transactional sexual relationships. Further, feelings of nihilism or despair in such areas may undermine the efforts of HIV prevention programmes[8]. Just over one half (52.5%) of the sample in this area was unemployed, around 25% were students and just under 25% were employed. More males (31.1%) than females (16.3%) were employed and similarly more males (31.4%) than females (18.7%) were students. This is shown in *Table 4*.

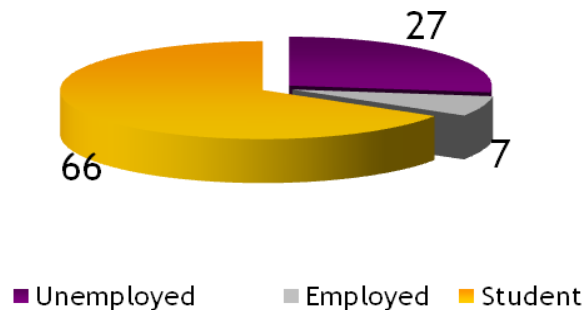
Table 4: Percent males and female by employment status

Employment Status	Males	Females	Total
Unemployed	37.2	65.0	52.5
Employed	31.1	16.3	23.0
Student	31.4	18.7	24.4
Grant	0.3	0.0	0.1

With almost 65% of women unemployed, there is an urgent need to ensure that HIV prevention interventions recognise the disempowered position of women in relation to income in this area, and address issues that may prevent them adopting safer sexual practices.

The National Strategic Plan for HIV and AIDS and STIs describe young people as a particular target group for HIV prevention interventions. *Figure 5* shows the percent of young men and women in the sample (16-24 years) by their employment status. The figure shows the majority of young people who are not students, are unemployed. Overall, 66% of those aged 16-24 years described themselves as students. When restricted to those aged 16-19 years, some 77% of respondents were students. There were no marked gender differences between being in- or out-of school in this age band.

Figure 5: Percent 16-24 year olds by employment status



Although the qualitative research did not explore the issue of employment amongst young people in detail, the quotation below hints at the complexity of unemployment amongst youth in this area, and the context of the quotation indicates the relationship between unemployment and the shebeen environment.

'We're not employed, we're doing nothing .., we're not stressed, it has not yet occurred to us to start looking for a job.' – Female, out-of-school

This comment was made in a broader discussion about the shebeen environment, indicating that unemployment is bound up with the use of alcohol, which provides a form of social sanction or solace for young people who are unemployed. This is discussed further in the section on alcohol (page 51).

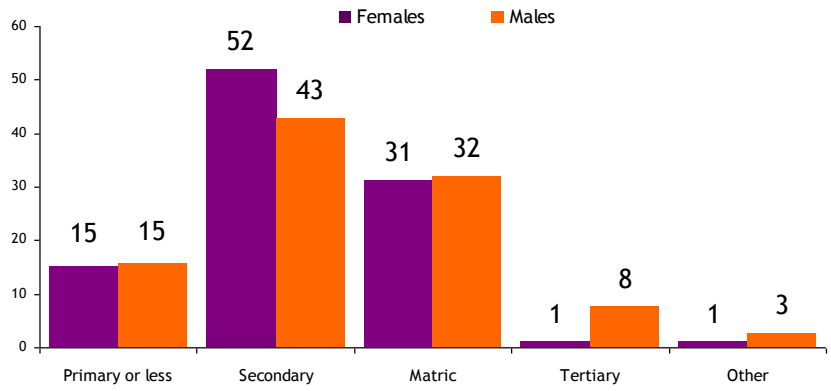
It would seem that both in-school and out-of-school HIV prevention programmes need to tackle head-on the transition from school into the wider community, preparing young people not only for the possibility of employment, but also for the possibility of unemployment.

As the areas sampled are mining communities, it is worthwhile to note that around 8% of males and 1% of women in the sample were currently employed on a mine. Hostels were specifically excluded from the survey, owing to complexities with access. Nonetheless, the proportion of miners interviewed in the household survey was lower than expected at 8%. This may be partly due to the age of the sample – which is skewed toward the younger age groups, whilst miners tend to be somewhat older. Secondly, whilst some miners would be expected to be living in the sampled households, they may also have been less likely than other people to be at home during the times that the interviews were conducted. If miners do have higher levels of risk behaviour than their non-mining counterparts, then the levels of risk behaviour captured in the survey may be an underestimate.

5.4 Education

Individuals with a particular level of education can access informational material about HIV[6]. Some 85% of women and 86% of men in the sample had attained secondary level education or higher (*Figure 6*).

Figure 6: Percent males and females by education level



*Excludes people who are currently students

5.5 Summary and Conclusions

- Migrancy is a key feature in Matjhabeng and Masilonyana Local Municipalities. However, the survey indicates that most respondents who were sampled in the household survey in this area are not migrants, in that most consider the Free State Province their home, were born there and/or did not have a home elsewhere. These data would have been different if hostels had been included in the sample. Nonetheless, there is also a substantial proportion of the community that have connections elsewhere, indicated through having a home elsewhere and/or sending

or receiving money to other homes. These connections outside of the community may be important to continue to consider in design of STI and HIV prevention interventions, particularly those that require partner notification or follow up.

- This study found low levels of marriage and cohabitating relationships in this area. This will make it less likely that young people will abstain from sex until cohabitation or marriage.

- Levels of unemployment were high, with particularly high unemployment amongst young people, many of whom were dependent on outside remittances. The qualitative research indicated that unemployment is one factor that contributes to young women visiting shebeens, which in turn may be related to high risk behaviour including high rates of sexual partner change and increased possibility for lack or incorrect condom usage while under the influence of alcohol.

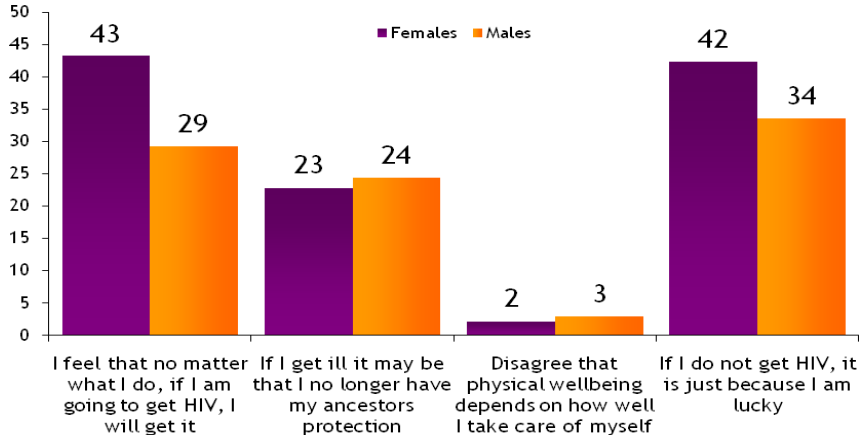
6 Behavioural Drivers of the HIV Epidemic

6.1 Fatalism

Fatalistic attitudes towards health in general and HIV in particular are likely to be a real barrier in adoption of healthy behaviours[7]. This is particularly likely to be an issue in communities that already have many social challenges.

Almost 30% of men and 43% of women felt that they would get HIV, no matter what they did. Similarly around 34% of men and 42% of women felt that if they did not get HIV it was a matter of luck. Around 24% of both men and women felt that getting ill was associated with losing the protection of ancestors *(Figure 7)*.

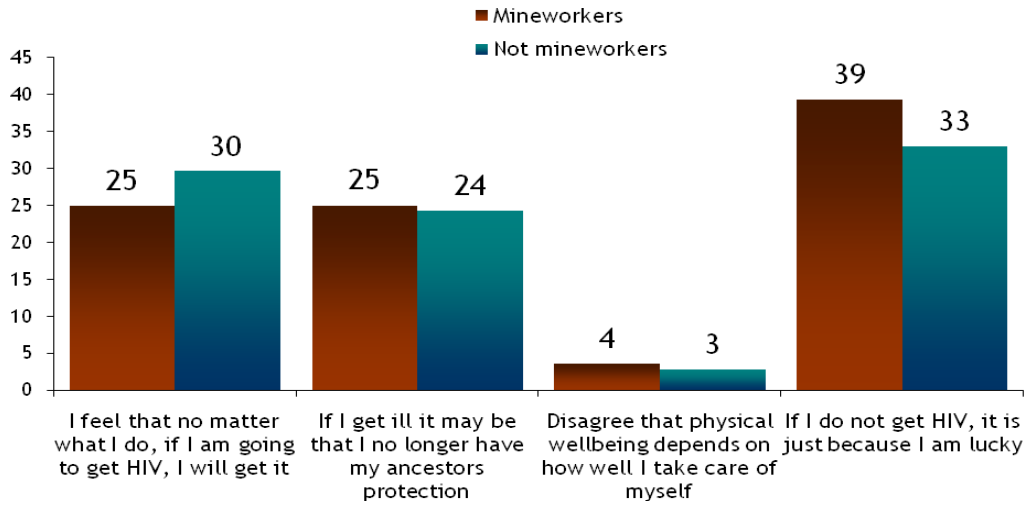
Figure 7: Percent holding fatalistic attitudes to health by gender



It is sometimes postulated that mineworkers may be more likely to adopt fatalistic attitudes to their health because of the mining hazards that they face on a daily basis[8]. There was no strong evidence for this being the case in these data. However, a slightly greater proportion of

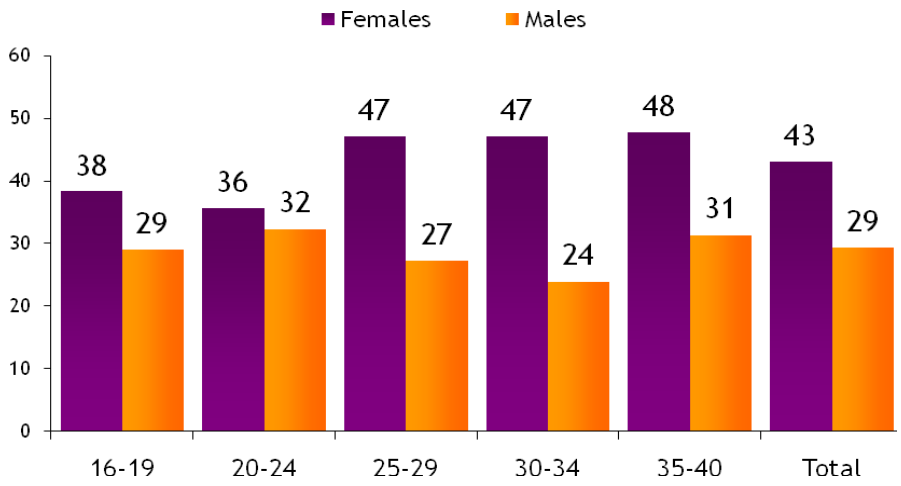
mineworkers when compared to non-mineworkers thought that not getting HIV was a matter of luck (39% compared to 33%) *(Figure 8)*.

Figure 8: Percent holding fatalistic attitudes to health by whether or not people are working in the mine (men only)



Fatalism amongst youth is a cause for concern, with more than 30% young people agreeing or strongly agreeing with the statement "no matter what I do, if I am going to get HIV, I will get it". However, fatalism around getting HIV is not just restricted to youth. *Figure 9* shows that certainly for women, those over 25 years were more likely than those under 25 years to be resigned about getting HIV. There was no clear age trend evident for men.

Figure 9: Percent agreeing that 'No matter what I do, if I am going to get HIV, I will get it'



It is interesting that higher proportions of women are fatalistic about getting HIV, and also higher proportions of women personally know of people who are HIV positive. It may be that

seeing HIV in their communities is one factor that makes women feel disempowered in relation to protecting themselves.

In the qualitative research, fatalism emerged as a theme in the sense that respondents suggested that the key to behaviour change is to learn healthy behaviours initially, rather than try to change after unhealthy patterns have been established – and that for this generation, it was 'too late.' This is illustrated in the following quotation:

'So I believe that we all know that HIV / AIDS is on the fire, we are continuously made aware of this, as from now on I believe the next generation after us will understand the dangers of sex, our parents did not talk to us about sex and that is why things are as they are. The next generation will understand better.'-Male, in-school

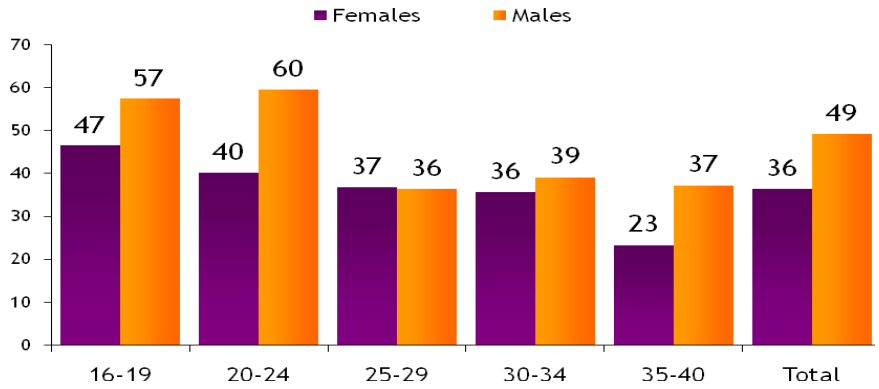
6.2 Delaying Sexual Debut

Delaying sexual debut is one of the cornerstones of HIV prevention responses. Delaying the age at which people start having sex, together with reducing the numbers of partners people have, are believed to have been critical in reducing the rate of spread of HIV[9]. This section integrates the quantitative and qualitative findings on abstinence and delayed sexual debut in this community.

Abstinence as an HIV Prevention Method

Around 50% of men and just over 30% of women in this community mentioned abstinence as a method of preventing HIV. *Figure 10* shows the percent of men and women who spontaneously mentioned abstinence as an HIV prevention method by age group. Young people, particularly young men, were most likely to know that abstinence is a way to prevent HIV.

Figure 10: Percent mentioning abstinence as HIV prevention method by age group and gender



The finding that over half of the respondents did not mention abstinence as a prevention method requires further exploration. It is not clear from the data whether this is due to a lack of information or education or whether underlying this, is that people just do not see abstinence as a sustainable option and therefore do not regard it as a serious HIV prevention method.

Indications from the qualitative research are that young people tend to associate morality and "doing the right thing" as reasons to abstain. Health-related reasons, such as to prevent HIV were not top of mind for most of the focus group participants. There was considerable discussion in the FGDs about the "wrongness" of having sex before marriage, and yet an acknowledgment that it does indeed happen.

The Right Time to Start Having Sex

Around two thirds of both men and women across all age categories strongly agreed that young people should not start having sex before the age of 18 years (*Table 5)*.

Table 5: Percent respondents who strongly agree that young people should not have sex before the age of 18 years

Gender	16-19	20-24	25-29	30-34	35-40	Total
Males	67.0	70.7	70.9	63.0	62.8	67.5
Females	67.4	64.4	64.4	70.0	66.7	66.4

In discussions about the "right time", the qualitative research highlighted abstaining from sex until marriage, rather than naming specific ages.

'Other young guys believe that sex before marriage is not a good thing, this is what they are taught from their homes, they decide that they will have sex after marriage'-Male, out-of-school

There was some discussion around delaying sexual debut until a later age or after one had met a specific personal goal; such as delaying sex until after one had graduated from university.

'Some guys take a resolution that they are going to wait until the right time comes, he will only start having sexual relations after completing his studies'-Male, out-of-school

Often the respondents contradicted themselves in the same sentence; stating that sexual activity should happen when one is ready, yet claiming that the "right time" was after marriage.

'[Having sex] has nothing to do with age, you can start as early as 14 or 15 [years old] you can have sex if you want to, it depends on how you feel, the sexual desire'-Female, in-school

'It really depends on what you're feeling at that particular time. You can tell yourself that you will only be ready at 18, by the time you reach 18 you would have long lost your virginity. I think the right time is when you're married'-Female, in-school

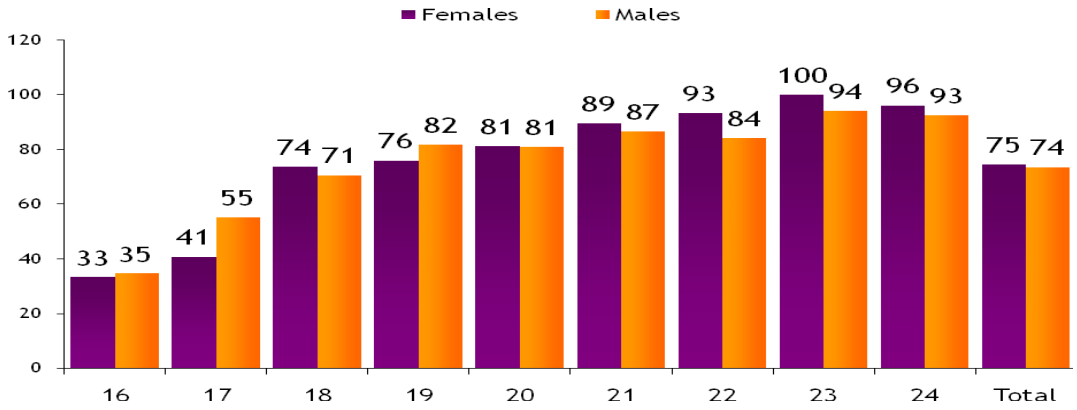
Some agreed that it would be wise to wait until marriage, because of religious beliefs or due to their upbringing. Some responses indicated that abstaining from sex for any period was an

individual choice and a measurement of self-respect. Other respondents noted that girls were engaging in sex as young as 9 or 11 years old. There was also recognition that sex is an individual choice and should be led by the feelings and readiness of the persons involved.

Age of sexual debut

Figure 11 below shows that by the age of 18 years, almost 74% of girls and 71% of boys had had sexual intercourse. The mean age of sexual debut was 18 years.

Figure 11: Percent young men and women who have ever had sex by age



In the light of low levels of marriage in this community, the data illustrate that despite people's beliefs about the right time to have sex; most young people are engaging in sex substantially before marriage or even cohabitation.

Barriers to Abstinence and Delayed Sexual Debut

In the qualitative research, lust/sex drive/hormones/lack of personal control was one set of reasons cited as the cause of sexual activity at a young age or prior to marriage. Some believed that sex was appropriate in one's youth as a way of 'getting it out of one's system' prior to settling down in marriage and the responsibility of caring for a family.

'Yes it is not natural for people to have sex after marriage, it does not happen anymore because we all have hormones, the hormones control us. When you speak [to] a girl you already know that you want sex, I am lusting for this girl, this is what controls us, so it is impossible to abstain until marriage'-Male, in-school

'Other guys believe that they want to experience everything including sex before marriage, do all the things he wants to do, when the time is right he will settle down and become a real man, he will have self control because he would have done almost everything that he wanted to do, no need to experiment or experience anymore. He will then be able to care for his family without looking for sex outside marriage'-Male, out-of-school

Peer pressure was mentioned quite frequently as a reason that one would engage in sex. Both girls and boys admitted to competing with each other in terms of having sex, with whom and the number of partners.

'You can decide not to have sex before marriage and try your best not to, but at the end of the day you end up having sex because of peer pressure, somebody is going to attract you'-Male, out-of-school

'Some guys compete and say I wonder how many girls am I going to be able to sleep with today'-Male, out-of-school

Sex was used by both boys and girls alike as a means of confirming one's love for the other. Boys may use it to openly coerce their partner into having sex, while girls tended to use it surreptitiously, as a means of elevating oneself into the status of primary girlfriend.

'The boy will tell you that if you love me prove to me, there is no other proof than sex, all he wants is sex, he will tell you that sex confirms the love'-Female, in-school

'Because we're naughty in bed the more we give them the more they want us, we give it to them, you do everything he asks of you the idea is to get him to come back so that you become his number one'-Female, out-of-school

The Role of Parents in Young People's Decisions

Some of the most powerful commentary emerging from the qualitative research on the topic of abstinence was in relation to parents as role models for their children. This included having open conversations about sexuality and taking the discussions further to include the consequences thereof. Merely stating that one must abstain from sex was not good enough; a parent was expected to practice what they preached to their children.

'Some parents/fathers who are real men lead by example, they want their children to behave the way they did during their time. They will then encourage their children and tell them what sleeping around will do for them. So your children are likely to follow in your footsteps if you lead by example'-Male, in-school

'Some parents do not speak to their children, they just say abstain from sex and not tell them about the consequences or the importance of safe sex using a condom, this causes a lot of problems because then the child does not know what the consequences are of having sex with no protection.'-Male

Culture was indicated as an impediment to open discussions in the home about sex and sexuality.

'To be quite honest, black people do not sit down with their children and talk to them about sex, white people discuss sex with our children, in our culture it is more like disrespect. My parents will never talk to me about sex even at my age, never, all they will say is "you're naughty" and not tell you anything anymore, or say things like "do you want to have a baby at your age", no explanation.'-Male

The research illustrates the importance of upbringing and relations in the home when it comes to sexual behaviour of youth. Parental control and open discussion about sex at home may

deter children from engaging in sexual activities, or this approach may backfire – some respondents noted that a strict upbringing could bring about rebellion rather than submission.

'[Abstinence] can happen but the reason could be that maybe her parents are strict with her, they do not let her go out as often as she wishes to… In most cases it is because of the parents not the girl herself'-Female

'Such girls, because they are continuously locked up, she gets a chance once in a while and uses it to her benefit and that is one she becomes pregnant - that is because she has no freedom'-Female

However, respondents did offer suggestions for parents in terms of how they want the issue of sexuality to be addressed in the home environment.

'I think another possible solution for all is that our parents must co-operate with us, they must not shout at us when we talk about sex, they must be open with us so that they can tell us when is the right time to have sex, and what to do and not what to do'-Male

6.3 Correct and Consistent Condom Use

Using condoms at every act of penetrative sexual intercourse is one of the most reliable and well known forms of preventing HIV transmission. Various factors are known to impede condom usage which includes: knowledge, misconceptions, duration of a relationship, self-efficacy, or perceived ability to use condoms in various circumstances. Findings on these factors for this community are presented below, together with findings on actual condom use.

Condoms as a Method of HIV Prevention

Over 90% of the sample spontaneously mentioned condoms as a way to prevent HIV. This attests to the success previous HIV prevention efforts that promoted condom usage in high risk sex. There were no gender differences.

The qualitative research showed that whilst respondents were knowledgeable about the protective benefits of condoms for HIV prevention this was often contradicted by their actual behaviours.

'I believe using a condom is the right thing even though we do not use it, it will prevent a lot of things like, pregnancy, HIV and STD's. It is up to a woman to tell herself that she is going to use a condom...'-Female, out-of-school

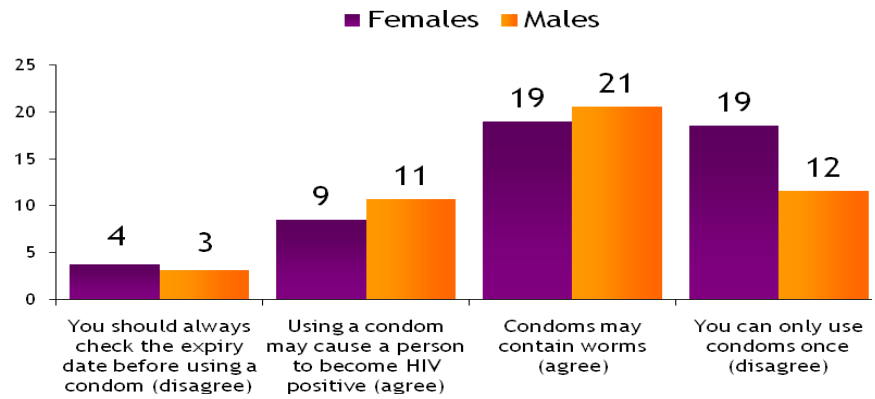
For example, participants would agree that they have knowledge about HIV and AIDS and that condom use is an effective prevention against HIV transmission, yet maintain their preference for sex without a condom, even when engaging in 'risky' sexual behaviours such as MCPs. Only a minority of this group stated behaviours that corresponded to their knowledge of HIV.

'Some parents do talk about HIV / AIDS, but then other youngsters want to experiment even though they know that AIDS kills, youngsters do not listen, there is enough awareness about HIV and AIDS, they want to prove it.'-Male, in-school

Misconceptions Around Condoms

Misconceptions around condoms were fairly common. For example, around 20% of men and women believed that condoms may contain worms. Around 19% of women did not know that condoms should only be used once. There were 9% of women and 11% of men who thought that condom usage may actually lead to HIV infection *(Figure 12)*.

Figure 12: Percent men and women holding various misconceptions about condoms



Condom Preference: choice$_{TM}$ and Female Condoms

There has been some concern in South Africa recently about the public perception of choice $_{TM}$ condoms, a government branded condom that is freely distributed in South Africa. Some 93% of the respondents in this community had heard of choice $_{TM}$ condoms. Of those who had heard of choice $_{TM}$, 74% said that they would use choice $_{TM}$ condoms. More women than men had heard of choice $_{TM}$ and would use them (76% compared to 70%).

Participants in the qualitative research voluntarily provided comment on branded vs. free condoms (choice$_{TM}$), with a preference of branded condoms. Reasons given were that they trusted the branded condoms in terms of product quality and safety.

'The free condoms are not safe as far as I am concerned, rather go and buy a good quality condom.'-Male, out-of-school

Some 61% of men and 82% of women in this community had heard of the female condom. Of those who had heard of the female condom, just under half (48%) said that they would be prepared to use one.

In the qualitative research, female condoms were discussed as an option to ensure self-protection, particularly when one's male sexual partner was against condom use. The downside to using a female condom, according to female respondents, was the notion that it needed to

be inserted into the vagina eight hours prior to having sex, which was felt to be inconvenient and that female condoms were said to make off-putting noises during intercourse[10].

Self-efficacy for Condom Use

Self-efficacy is one of the important ideational factors through which AIDS communication potentially influences behaviour.

In this survey, five items were used to measure different aspects of self-efficacy with regards to condom usage, for this reason we did not combine these items into a single scale (the scale reliability coefficient would have been 0.49). Responses to these items are shown for men and women in *Table 6*.

Most respondents (92%) agreed that they would be able to say no to sex if their partner refused a condom; 95% felt confident about their ability to discuss condom usage; 92% felt confident in putting condoms on; 90% were not afraid of rejection because of condom use.

A large number of people (around 33% of respondents) agreed that alcohol use would make them not worry about using a condom. This is of concern, particularly given that 28% of participants reported consuming 5 or more drinks in the preceding month in this community.

Table 6: Percent men and women who agree or disagree with statements about self-efficacy and condom usage

Statement	Male	Female	Total
I can say no to sex if my partner refuses to use a condom (disagree)	9.6	6.9	8.1
I feel confident in my ability to discuss condom usage with any partner I might have (disagree)	5.8	3.6	4.6
Drinking alcohol makes me not worry about using a condom (agree)	28.2	36.3	32.6
I feel confident in my ability to put a condom on myself or my partner (disagree)	5.8	8.6	7.3
If I were to suggest using a condom to my partner I would feel afraid that he or she would reject me	14.8	7.8	11.0

These data suggest that on the items measured, people are confident about their ability to use condoms. Whilst it is important to sustain these high levels of self-efficacy, it is unlikely that these levels are going to increase to much higher levels. The use of alcohol is a significant barrier to condom use in this community.

Condom Use Behaviour

Similar to other surveys, we asked people whether or not they had done anything to prevent HIV the last time they had sex and what that was. In this community, overall 60% of sexually active respondents said that they used a condom to prevent HIV the last time that they had

sex. Similarly, 60% had used a condom at last sex – almost all acts of condom use were to prevent HIV. The findings in this study shows a major generational shift in relation to condom use with young people aged 16–19 more likely to use condoms (76%) than those aged 35-40 years (44%). Males (64%) were more likely to use condoms as compared to females (56%).

Figure 13: Percent using condoms to prevent HIV at last sex by age group

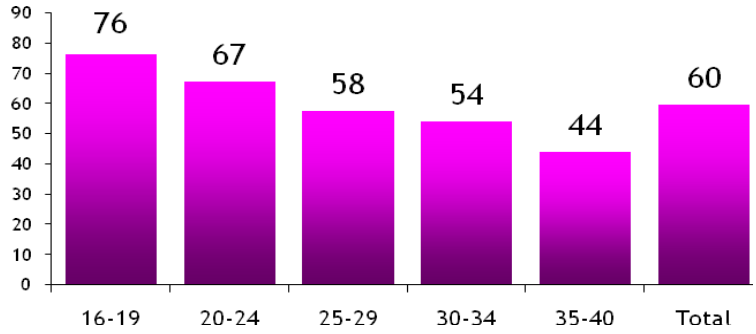
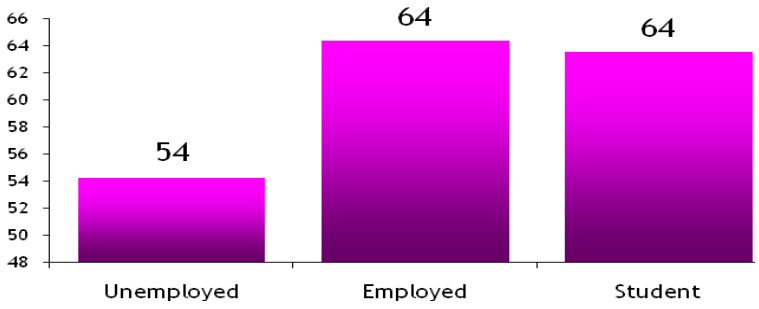


Figure 14 shows the percent of young people who used condoms to prevent HIV at last sex of young people by employment status. Some 54% of unemployed young people in this age group used condoms at last sex to prevent HIV, compared to almost 64% of students and similar proportions of those employed.

Figure 14: Percent youth (16-24 years) using condoms to prevent HIV at last sex by employment status



Out-of-school youth are less likely to use condoms than in-school or employed young people. This may be owing to less exposure to prevention programmes (that are usually offered through schools and workplaces), and other social and economic difficulties that such young people face. There needs to be more focus on out-of school youth to enable a continuum of interventions offered in-schools.

Participants in the qualitative research indicated that they did not systematically use a condom with every sexual encounter. Even with the knowledge of possible repercussions (i.e. pregnancy, HIV or other STIs), respondents remained adamant that they would not use a condom.

'There's a risk that I might become pregnant, but I will never use a condom.'-Female, in-school

'…[not using a condom is] like smoking, we all know smoking is bad for you but people do it.'-Male, in-school

'I will not become pregnant because I am using [other] contraceptives, I do think of STIs and other related diseases, but I just tell myself that I trust my partner.'-Female, in-school

Reasons Why People Do Not Use Condoms

In the qualitative research, the top reasons given for not using a condom were that condoms reduce sexual pleasure and/or cause discomfort during use. Some mentioned fear of contracting cancer or other illnesses, or of allergic reactions. Finally, others mentioned that at the time of sex, one was simply not going to use a condom, no reason given.

'If you want sex you do not think about using condoms, [sex] is all you are interested in, condom is the last thing on your mind, you realise afterwards that you have made a mistake.'-Male, out-of-school

The survey asked whether people felt that drinking alcohol affected condom use. Around 32% of respondents, and 35% of those who are sexually active, agreed or strongly agreed that drinking alcohol makes them not worry about using a condom. More women agreed or strongly agreed with this statement than men (42% of sexually active women compared to 28% of sexually active men). Almost 60% of females did not drink alcohol as compared to 26% of males who did not drink alcohol. This result correlates well with perceptions around condom and alcohol use. However when looking at actual condom use together with alcohol use around specific sex acts, there were no associations evident. There was also no mention of alcohol as a deterrent to using condoms in the qualitative research.

The following section expands on condom use in different types of relationships.

6.4 Multiple and Concurrent Partnerships

Reducing the numbers of sexual partners has been identified as a key area for future programming to reduce new HIV infections. It is not only the number of partners that people have over a lifetime that has been shown to be the strongest driver of the epidemic, but rather the extent to which people have more than one partner concurrently. A "Think Thank" meeting on HIV prevalence in southern Africa, convened in Lesotho in May 2006 by SADC and UNAIDS, concluded that "high levels of multiple and concurrent sexual partnerships by men and women with insufficient consistent, correct condom use, combined with low levels of male circumcision are the key drivers of the epidemic in the sub-region"[11].

Knowledge, Attitudes and Social Norms about Sexual Relationships

The survey asked people about the social acceptability of multiple partnerships in this community, and attempted to measure whether or not people knew that multiple partners increased a person's risk of getting HIV.

Approximately 32% of respondents said that having fewer sexual partners reduces the risk of HIV infection. This indicates that there is a considerable amount of knowledge about concurrent sexual relationships as a driver for HIV epidemic in this community. Over 90% said that the more sex partners you have, the higher your risk of getting HIV. There were no marked differences by age (*Table 7*) or by gender (not shown).

It would be expected that people who agreed that the more sex partners you have, the higher your risk of HIV, would also agree that if you have fewer sexual partners, you are less likely to get infected. However, this was not the case. These data indicate some confusion in the community over the concept of 'likelihood' and 'risk' and these somehow mean different things to people. There may be need for programmes to place greater emphasis on partner reduction messaging.

Table 7: Percent agreeing or disagreeing with statements related to knowledge and social norms in respect of MCP by age group

Statement	16-19	20-24	25-29	30-34	35-40	Total
If you have fewer sexual partners, you are less likely to get infected (agree)	38.8	33.5	26.1	30.2	27.9	31.8
The more sex partners you have the higher your risk of getting HIV (agree)	92.8	96.8	91.6	93.1	95.0	94.0
It is acceptable for a man to have more than one girlfriend at the same time (disagree or strongly disagree)	91.1	92.5	93.7	93.1	92.1	92.4
It is acceptable for a woman to have more than one girlfriend at the same time (disagree or strongly disagree)	93.8	96.2	95.1	95.6	97.1	95.5

Participants in the qualitative research expressed social disapproval for MCP, as illustrated by the following quotations:

'I believe that it is actually wrong to have sex with multiple partners at the same time or in the same week if you are a normal person… you should have one partner and have sex with one partner.'-Male, in-school

'No I think that [multiple partners] is dangerous considering diseases such as syphilis, sexually transmitted diseases etc…it is dangerous to have multiple sex partners in one day or in a week, how are you going to know where you got the disease from if you have multiple

partners? A condom is not 100% safe either, so you won't know who brought you the disease.'-Male, out-of school

'It's about you, how you respect yourself because sometimes I know that a certain girl is no good, but I go and have sex with her, I then go and look for another girl in that same week, then it carries on - this can only mean that you yourself have no respect for yourself, your body is a sex machine.'-Male, in-school

Despite the disapproval of MCP, as evidenced above, there was a strong sense in the qualitative research that faithfulness was not even to be expected in relationships – in other words, similar to sex before marriage – whilst it is not approved of and not "right", it continues to happen.

Expectations of Infidelity in Relationships

The qualitative data showed that neither males nor females believe in the possibility of satisfying, monogamous relationships, even before they begin dating. Both males and females mentioned that the other is certainly "cheating", or straying away from their primary partner to other relationships, be it for short- or long-term alliances.

'Guys find it difficult to trust ladies because we know ourselves, we know what we are doing with other girls outside, so how can we trust our partners because we are not honest ourselves.'-Male, out-of-school

'No, all the guys are cheating, where are you going to get a guy who doesn't cheat, they all cheat.'-Female, out-of-school

Some girls insisted that dating in the conventional form (i.e., dating as a precursor to establishing a long-term relationship that can potentially lead to marriage and/or a family) simply does not exist anymore.

'I believe there is no dating nowadays, it does not exist, that is my opinion, you're just a dustbin.'-Female, out-of-school

There was also a sense that cheating was a part of the national identity – part of being South African.

'South Africans generally are not loyal to our partners, there is no trust…I think the reason is because we can all see, we are exposed to what is going on around us...'-Male, out-of-school

Both parties seem to enter into relationships with the presumption that men and women alike are untrustworthy and harbour ulterior motives to their relationships. These motives may include an interest in material things, be it gifts or money, or having the partner as a status symbol.

' "Conditional love" - a girl falls in love with me because she wants something from me, so I can buy her things, take her out and things like that'-Male, in-school

'Girls have a thing for guys who wears designer labels…you will find girls saying things like "I date a guys who wears Carvela shoes".'-Female, in-school

'Other guys use money as power to attract girls'-Male, out-of-school

The already existing distrust between the sexes contributes to a dooming of the relationship from the start. This may contribute to the attitude of acceptance of MCPs by these respondents. Some participants implied that sleeping around was something new – this is how things were done now.

'We the new generation, when you meet a girl you tell her that you already have a girlfriend, even if you do not have one at that time, just so that it allows you to have other girls'-Male, out-of-school

'How can we say we're dating when he still dates other girls in my presence, what kind of dating is that? I am also seeing other guys at the same time'-Female, out-of-school

'If you are a thief and you meet a person you've never met before, you are simply going to assume that the person is also a thief, that is why we do not trust our girls because we assume that they are also fooling around with other guys like we are fooling around with other girls.'-Male, out-of-school

Regardless of whether or not people felt that faithfulness was possible broadly in society, we asked them to what extent they personally felt capable of sticking to one partner. The findings are presented in the following section.

Self-efficacy for Faithfulness to One Partner

Self-efficacy for a desired behaviour is regarded as a first step in achieving that behaviour, in a number of models of behaviour change. This concept is fairly new to the area of MCP and many of the items described below have been measured for the first time in this survey.

Overall, high proportions of men held desirable attitudes to faithfulness, that is, most felt that they could be faithful, be satisfied, commit to one person and control their sexual urges. *Table 8* shows the items that were measured for men only, by age group. *Table 10* shows the same information for women. Across all of the items, there were around 14% to 12% men who did not feel able to be faithful. In this study, older men are less likely to feel they could be faithful to one partner than younger men. Although no clear trend is evident across all of the measures, men in the older age group seem to feel themselves less capable of faithfulness than those in the younger age group - for example, 24% of men 35-40 years felt that they could not commit to only one partner, compared to 19% of those aged 16-19 years.

Table 8: Percent men agreeing with statements related to self-efficacy for faithfulness

Statement	16-19	20-24	25-29	30-34	35-40	Total
I am capable of being faithful to my main partner (agree)	88.2	82.8	85.5	87.0	88.0	86.0
Will not be sexually satisfied with only one partner (agree)	16.1	13.1	18.2	17.4	18.0	16.0
I cannot commit to having only one sexual partner (agree)	19.4	24.2	18.2	32.6	24.0	23.0
I cannot control my sexual urges (agree)	17.2	13.1	20.0	19.6	22.0	17.5

Mineworkers are often regarded as evidencing higher risk behaviour than non-mineworkers. In this community, there was no evidence that the 8% of men who worked on the mine were any more or less likely to feel they could be faithful, than other men in the sample. However, this should be interpreted with caution due to the fact that the sampled mineworkers may not be representation of the general population of mineworkers since hostel dwellers were not included in the sample.

Table 9: Percent mineworkers agreeing with statements related to self-efficacy for faithfulness

Statement	Total	Mineworkers*
I am capable of being faithful to my main partner (disagree)	14.0	10.7
Will not be sexually satisfied with only one partner (agree)	16.0	14.3
I cannot commit to having only one sexual partner (agree)	23.4	17.9
I cannot control my sexual urges (agree)	17.5	17.9

* Small numbers - indicative only.

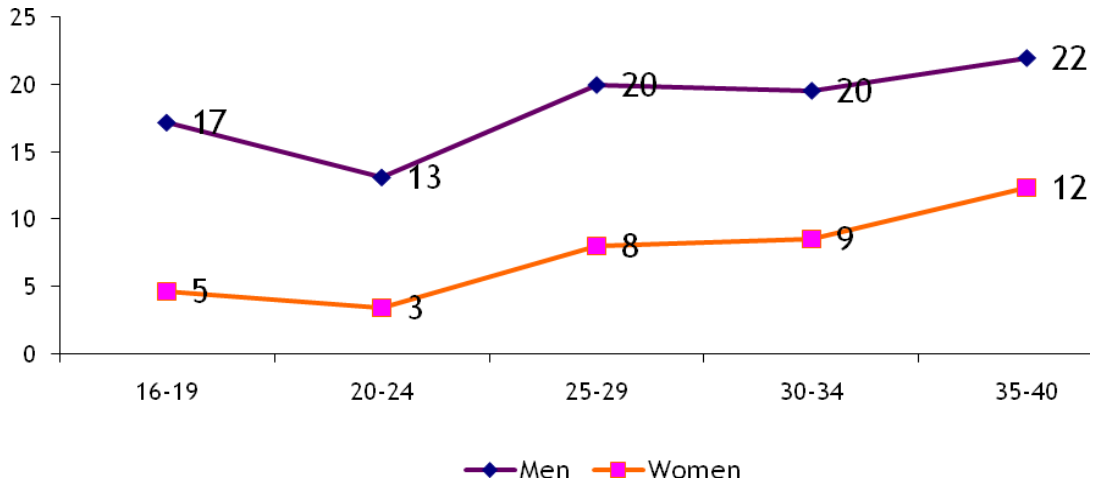
Over 95% of women across all age groups believed that they could be faithful to their main partner. Women in the 20-24 year age group were more likely than younger and older women to feel that they would not be sexually satisfied with only one partner.

Table 10: Percent women agreeing with statements related to self-efficacy for faithfulness by age group

Statement	16-19	20-24	25-29	30-34	35-40	Total
I am capable of being faithful to my main partner (agree)	95.3	98.8	95.4	97.1	96.7	96.7
Will not be sexually satisfied with only one partner (agree)	1.2	5.8	3.5	1.4	3.3	3.1
I cannot commit to having only one sexual partner (agree)	4.7	5.8	6.9	4.3	7.8	6.0
I cannot control my sexual urges (agree)	4.7	3.5	8.1	8.6	12.4	7.4

For both men and women, self-efficacy for faithfulness on some of the measures seems to decline in older age groups. This is illustrated in *Figure 15* which shows the percent of men and women by age group who say they cannot control their sexual urges.

Figure 15: Percent men and women who say they cannot control their sexual urges



The qualitative research raised the point that "faithfulness" can also be a relative term; variations on the theme can include those who are "faithful" to their one partner while they are together (in the same town, etc). If one partner is also having other partners this may be reason enough for the other partner to engage in sex with others, while still considering themselves "faithful".

'I'm not faithful but I am trying to be faithful although I am cheating, I have a reason why I'm cheating - most of the time [my boyfriend] is not with me, I know very well where he is and what he is doing.'-Male, in-school

'I do not know what [my boyfriend] is doing when I'm not next to him, it is okay to cheat on him as long as I'm playing it safe [having safe sex]'-Female, out-of-school

Reasons Why People Have More than One Partner

In the community survey, both men and women were asked what they believed to be the most common reason why men (and women) would have more than one partner. The most commonly mentioned reason by men and women on why men in this area would have more than one sexual partner was for 'curiosity, fun or variety' in sex (29%). The second most commonly mentioned reason was the view that men cannot control their sexual urges (25%). By contrast, 41% of respondents believed that the main reason why women would have more than one partner was for money or goods that her partner would provide. A further 20% mentioned survival goods, such as food or clothes for herself or her children. Physical distance from main partner was mentioned as a reason for both men and women but was perceived more often to be a reason for men (12%) than women (6%).

Figure 16: Percent respondents mentioning main reason why men in this community would have more than one sexual partner

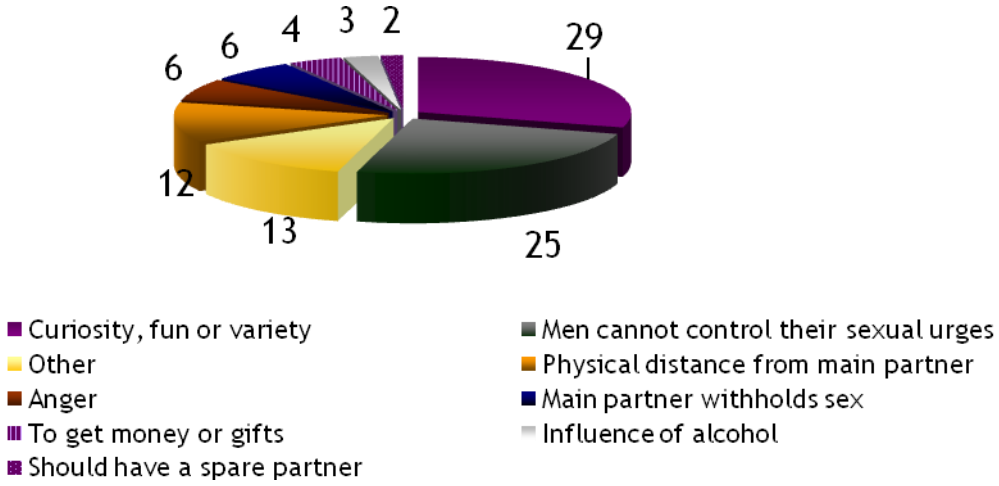
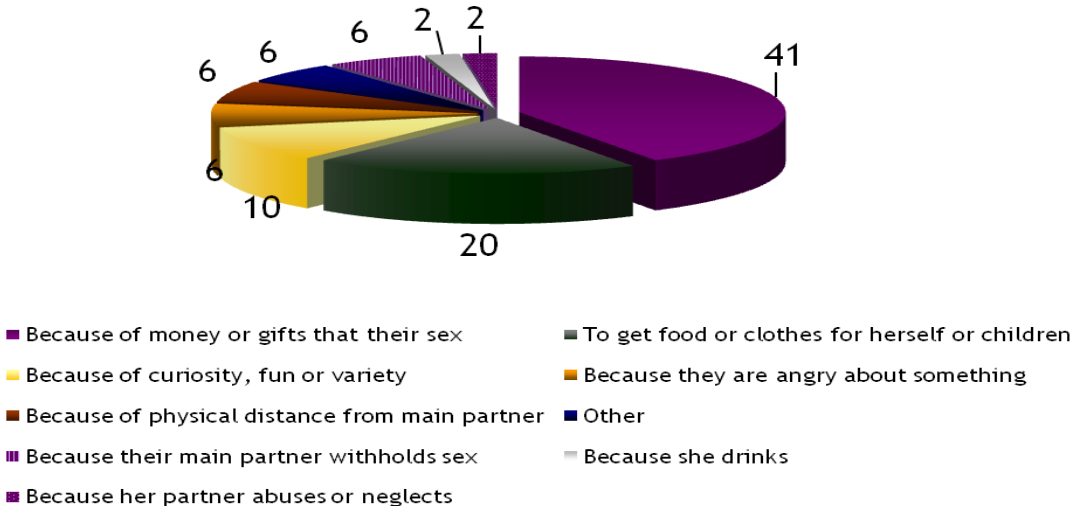


Figure 17: Percent respondents mentioning main reason why women around here would have more than one sexual partner



While people prefer to have a main partner, some engage in sexual relationships with other partners for curiosity, fun or variety of sex. Despite their involvement in other sexual relationships, they try and keep these relationships secretive secret from their main partner...

'It sometimes happens that I have my own boyfriend and have feelings for my friend's guy, I plan with him secretly and we leave both our partners and go do our thing [have sex] and we pretend as if nothing happened.'-Female, out-of-school

Sometimes having more than one partner sometimes served as a means of selective dating with the ultimate goal of finding one's long-term partner.

'If you have multiple partners, one of them you really love. But you will find that the one that you love is actually not in love with you. I think it is acceptable because if you have three partners, the one that you love does not love you, you have the other two who will give you the attention. At the end of the day you will choose one from the three, the one you will spend the rest of your life with.'-Female, in-school

Some participants in the qualitative research felt that the HIV epidemic was at least partially to blame for MCP behaviour. There was a sense amongst participants that HIV and other STIs had contributed to the destruction of the concept of love, and that without love, it was more acceptable to have multiple partners, thus forming a negative cycle of despair, mistrust, high risk behaviour, HIV, and further despair and high risk behaviour.

'I think it is okay to have two partners because nowadays there is no guarantee with love, no more love, you can tell yourself that you trust this person and love him, on the other hand he could be fooling around and bring you AIDS, STDs or STIs.'-Female, in-school

Other participants expressed different views – that, rather than being a feature of today, and tied up with the loss of love and the despair brought by HIV, people have always had multiple partners – the pattern is set by the previous generations.

'According to me there's no straight [committed relationships] or whatever, this has been happening for generations, our mothers/fathers have been having relationships outside their marriages, if my father can have a child with the neighbour's wife, this must have been happening for a long time, it is the same thing. There's no way things are going to change now, cheating will never stop, in my opinion there's no straight guy or whatever, you are just somebody's dustbin, that's all.'-Female, out-of-school

The issue of gap length – the extent to which different relationships overlap – is thought to be a critical issue in the rapid spread of HIV. Some youth in the qualitative research noted that multiple partnerships can easily lead to multiple sex partners in the same week or same day.

' …during the day I go and have sex with a sugar daddy, he gives me money, later on you meet your boyfriend, you're also going to have sex with him.'-Female, out-of-school

'Sometimes I have sex with my secret person and on my way home I meet [my boyfriend], he takes me I just go and have sex with him after having sex with the other guy; that has happened to me before. How am I going to say no to [my boyfriend]?'-Female, out-of-school

Numbers of Different Sexual Partners

Of those 16-40 year old men who have had sex in the past year, approximately 30% in this community reported more than one partner in the preceding 12 months. The proportion of women reporting more than one partner in the past year was considerably lower than for men, at around 7%.

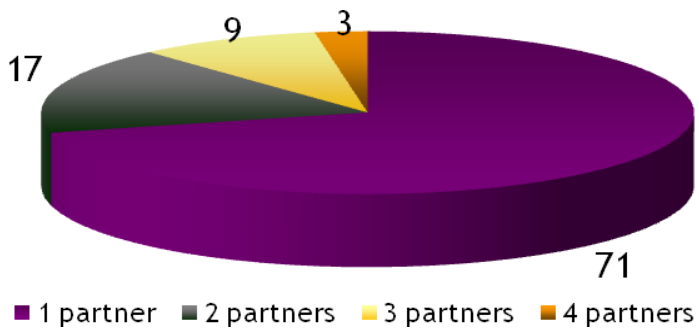
Amongst men, no clear trend was evident by age group; 39% of 15-19 year old men reported more than one partner and a similar proportion of 30-34 year olds reported more than one partner (38.9%). The lowest rate of multiple partners was amongst 35-40 year olds (18%). There were indications of a trend by age for women, with the highest rates amongst the 15-19 year olds, at 10%, and the lowest in the oldest age group at 5%.

Table 11: Percent males and females reporting more than one partner in the past twelve months

Sex	16-19	20-24	25-29	30-34	35-40	Total
Males	39.0	31.1	20.9	38.9	18.4	29.7
Females	10.3	5.7	8.0	6.5	5.5	6.9

The majority of men in this area (71%) had one partner in the preceding year while 17% had two partners and 9% had three partners. A higher percentage (30%) of males reported having more than one partner in the past twelve months than females (7%). However, this can be influenced by gender norms where men would over-report to come across as sturdy and women would under report to seem respectable.

Figure 18: Percent sexually active men with one or more partners in past year



For women, most (94%) had only one partner in the preceding 12 months and 6% had had two partners.

We examined partnerships by whether or not people were working in the mines. In this community, mineworkers did seem to have slightly higher rates of multiple partners than those not working on the mine; some 37% of sexually active men working on the mine had more than one partner in the preceding year, compared to 29% of those not employed on the mine. However this finding should be interpreted with caution owing to small numbers.

Some 1% of sexually active men (those that had sex in the past year) and 1% of sexually active women (those that had sex in the past year) had more than one sexual partner in the preceding month.

Table 12 below shows an analysis of possible predictors of having multiple sexual partners. The univariate analysis consisted of modelling each of the risk factors independently. Age, gender, employment status, education, age at first sex, alcohol use and belief about the ability to control sexual urges were significant predictors of having multiple sexual partners in the univariate analysis. Education, alcohol use and the belief that one cannot control one's sexual urges were not significant when entered in the multivariate model with the other variables. However, age, sex, employment status and age at first sex remained significant in the multivariate model. There was borderline significance on age; for every year increase in age, there was a 5% reduction in the number of sexual partners (OR: 0.95, P=0.06). Men were four times more likely to have more than one sexual partner as compared with women (OR: 3.89, P<0.001). Students seemed to be 71% less likely to have multiple partners compared with people who were unemployed (OR: 0.29, P=0.01). Respondents who engaged in sex early (10 – 15 years) were more than twice likely to have multiple partners as compared to those who started having sex at 20 – 35 years (OR: 2.80, P=0.02).

Table 12: Predictors of multiple partnerships

Characteristic		Total (N)	One partner (%)	Multiple partners (%)	Crude OR (95% CI)	P- value	Adjusted OR (95% CI)	P- value
Age	Continuous	-	-	-	0.95 (0.91, 0.98)	**0.003**	0.95 (0.90, 1.00)	**0.06**
	16-19	80	75.0	25.0	2.97 (1.33, 6.63)	**0.008**	-	-
	20-24	143	81.1	18.9	2.07 (0.98, 4.39)	**0.06**	-	-
	25-29	118	87.3	12.7	1.30 (0.57, 2.96)	0.54	-	-
	30-34	98	81.6	18.4	2.00 (0.89, 4.49)	0.09	-	-
	35-40	109	89.9	10.1	1	-	-	-
Sex	Male	229	69.9	30.1	5.82 (3.47, 9.76)	**<0.001**	3.89 (1.92, 7.90)	**<0.001**
	Female	319	93.1	6.9	1	-	-	-

Characteristic		Total (N)	One partner (%)	Multiple partners (%)	Crude OR (95% CI)	P- value	Adjusted OR (95% CI)	P- value
Marital Status	Not married /divorced	334	76.6	23.3	1	-	-	-
	Not married but in a steady relationship lasting >3 months	41	95.1	4.9	0.17 (0.40, 0.71)	**0.02**	-	-
	Not married but living with partner	33	84.8	15.2	0.59 (0.22, 1.57)	0.29	-	-
	Married	138	96.4	3.6	0.12 (0.05, 0.31)	**<0.001**	-	-
Employment Status	Unemployed	315	84.4	15.6	1	**-**	-	-
	Employed	147	81.6	18.4	1.22 (0.73, 2.05)	0.45	0.71 (0.36, 1.38)	0.31
	Student	78	82.1	17.9	1.19 (0.62, 2.28)	0.61	0.29 (0.11, 0.76)	**0.01**
Education	Secondary or less	353	84.4	15.6	1	-	1	**-**
	Matric or above	188	80.8	19.2	1.28 (0.81, 2.04)	0.29	1.19 (0.66, 2.14)	0.56
Age at First Sex	Continuous	-	-	-	0.78 (0.70, 0.86)	**<0.001**	-	**-**
	10-15	95	62.1	37.9	5.30 (2.61, 10.77)	**<0.001**	2.80 (1.15, 6.87)	**0.02**
	16-17	160	84.4	15.6	1.61 (0.79, 3.29)	0.19	0.87 (0.35, 2.16)	0.77
	18-19	166	89.8	10.2	0.99 (0.46, 2.12)	0.99	0.97 (0.39, 2.40)	0.95
	20 -35	126	89.7	10.3	1	-	-	-
Alcohol Use	Never	139	82.7	17.3	1	-	-	-
	Several times a week/ Daily	67	64.2	35.8	2.67 (1.37, 5.20)	**0.004**	1.10 (0.49, 2.45)	0.81
	Once a week	92	80.4	19.6	1.16 (0.59, 2.29)	0.66	0.60 (0.28, 1.31)	0.20
	Once a month	60	75.0	25.0	1.60 (0.77, 3.32)	0.21	0.94 (0.40, 2.23)	0.89
Cannot control my sexual urges	Agree	78	75.6	24.4	1.78 (0.99, 3.15)	**0.05**	1.31 (0.63, 2.73)	0.48
	Disagree	469	84.6	15.4	1	-	-	-

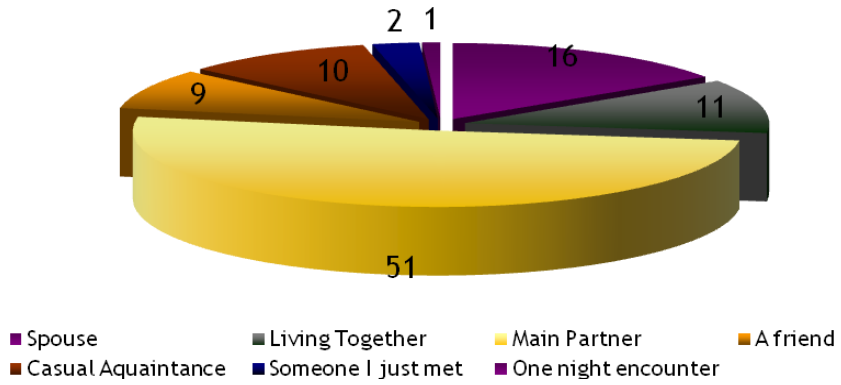
Types of Sexual Partnerships

Of all the sexual partnerships that were described by these residents in this community, some 16.5% (n=121), were non-monogamous - that is, other partners were reported by the same respondent in the same year.

Who People Were Having Sex With

Over three quarters of all sex partnerships that the respondents report can be described as 'steady', or life-time partners, rather than casual partners. Of all the sex relationships described in this area around half were with a main partner, 11% were with a live-in partner and a further 16% were with a spouse. More than one half of non-monogamous relationships were with casual acquaintances, or someone recently met. However, this should be interpreted with caution considering that some relationships described as 'casual' were engaging in repeated sex.

Figure 19: Type of partnerships



Since we had information at each of the relationships that respondents had been involved in, we were able to categorise each sex relationship as respondent-monogamous (no other relationships were described by that particular respondent) and respondent-non-monogamous (at least one other relationship was described by that respondent).[1] Given that over 50% of all relationships in this area are with 'long-term' partners (main partner or spouse), it is useful for HIV messages to know the extent to which these, and other partnerships are monogamous.

Table 13 below shows the distribution of types of partnerships. Of all sexual partnerships that were reported in the preceding year, around 50% were with people that the respondent described as a 'main partner', 16% were with a spouse. Some 10% of relationships were with a casual acquaintance.

[1] Since sex partners were not interviewed, we don't know whether the monogamous relationships were truly monogamous, since the sex partner may have had other relationships, hence the term respondent-monogamous.

Table 13: Types of partnerships by respondent-monogamous and respondent-non-monogamous

Partner Type	Respondent-Monogamous	Respondent- Non-Monogamous	Total
Spouse	18.2	2.5	15.6
Living together	13.7	0.0	11.5
Main partner	56.0	25.0	50.8
A friend	7.5	14.2	8.6
Casual acquaintances	2.8	46.7	10.1
Someone I just met	1.2	9.2	2.5
One night encounter	0.7	2.5	1.0

The table below shows that of all partner types, casual partnerships are most likely to be non-monogamous (77% of all casual partnerships were respondent non-monogamous, that is the respondent reported other partners in the same year). Some 8% of relationships with main partners were not respondent-monogamous.

Table 14: Percent relationships that were non-monogamous by type of relationship

Relationship Type	Percent
Living together	0
Spouse	3
Main partner	8
A friend	27
One night encounter	43
Someone I just met	61
Casual Acquaintance	77

The proportion of spousal and live-in relationships that were non-monogamous was lower (3%). It may be that live-in and spousal sexual relationships offer greater intimacy and satisfaction than other non-cohabitating relationships, and therefore are more likely to be monogamous than other types of partnerships. On the other hand, additional partners may have been under reported by respondents with live-in partners or spouses– bearing in mind that respondents were interviewed in their own homes, and the respondent may have felt insufficient privacy to report accurately.

The qualitative research identified different ways of describing partners. Most notably, there was the “weekend special” which is a relationship specific to a tavern environment, usually occurring only on weekends and not considered to be primary or serious relationships. Often “weekend specials” involve multiple and concurrent partners for at least one of the persons involved.

'Sometimes you meet a person at a tavern… you meet over the weekend, he shows everybody that he is with you, Monday he is not there, he goes to [his girlfriend], he is always with [her], weekends [she] is at home and he comes to you, that is the "weekend special".'-Female, out-of-school

A category of men was also described, the "night men". These relationships seemed to be characterised by greater secrecy.

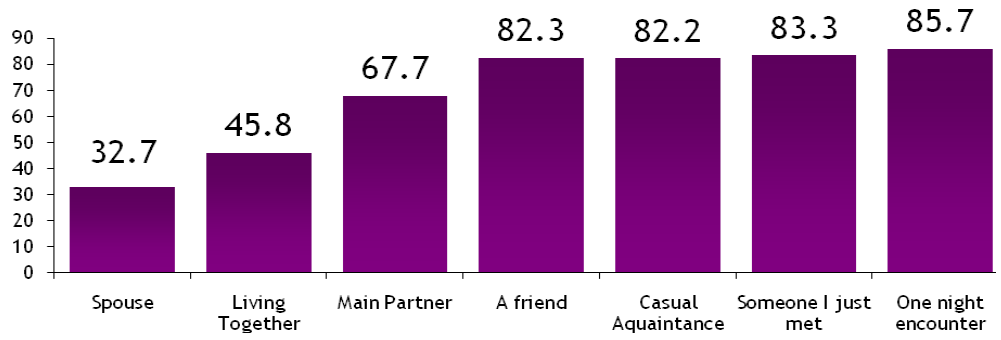
'The guys who use girls are "night men" they will propose to you at night, they will not approach you during the day, he does not love you because you will not see him during the day.'-Female, in-school

Who People Used Condoms With

Condom use is most critical in relationships where both partners are not faithful to one another. In this community62% of respondents reported using condoms to prevent HIV.

Condom use to prevent HIV was lowest in spousal and live-in relationships (38% of last sex with a spouse/live-in); higher with main partners (68%) and highest for casual encounters (83%).

Figure 20: Percent sex acts where condoms were used to prevent HIV by relationship to respondent



The qualitative study supported the above data in that most respondents claimed it was less likely that they would use condoms with their main partner or the one they "love". There was also evidence that supported the use of condoms with casual partners, or partners that one "did not care about". There also were respondents who claimed they or their sexual partners did not want to use a condom, even when engaging in casual sex or with someone they didn't know very well.

'[With] the one I love I do not use a condom.'-Female, out-of-school

'[With] the one that I do not love I have to use a condom because my sexual desire/feeling for him is completely different to [the feeling I have with] my boyfriend.'-Female, out-of-school

While consistent condom use is important in all relationships, it is particularly important in relationships which are known to be non-monogamous. It is of concern that there were still 20% of known non-monogamous sexual relationships in this area where condoms were not used to prevent HIV. *Table 15* below shows the distribution of these unprotected non-monogamous relationships, by partner type. Although the table should be interpreted with caution owing to small numbers, the table indicates that most of these unprotected non-monogamous encounters in this area are casual encounters.

Table 15: Percent of respondent non-monogamous sexual encounters where a condom was not used to prevent HIV

Partner Type	Frequency	Percentage
Spouse, live-in partner	3	12.5
Main partner / friend	6	25.0
Casual encounters	15	62.5
Total	24	100

Inconsistent condom use in steady relationships is a cause for concern; in the qualitative research, respondents claimed that it would be difficult to use a condom consistently with a steady partner. Some respondents felt that use of the condom in their steady relationship was unnecessary, and that establishing knowledge of each other's HIV status was enough protection.

'You can have sex without using a condom as long as you trust each other.'-Female, in-school

'My partner and I used to use a condom…we later went to the clinic to check our [HIV] status, so from then onwards we do not use the condom'-Female, in-school

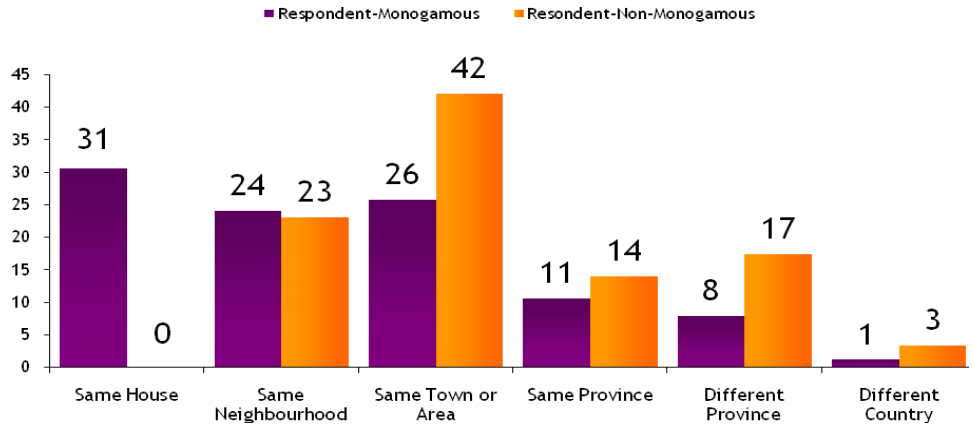
The data indicate that there is still considerable scope to increase condom use in this community. There are still casual encounters where condoms are not used to prevent HIV and condom use amongst those who are having sex with main partners, needs to be increased. The results clearly show that there is a need to emphasise continued condom use even after testing for HIV.

Where sexual partners lived

The *Figure* below shows where sexual partners of the respondents lived. Overall, around one quarter of all sexual partners lived in the same house as the respondent; almost 30% of partners lived in the same town or area, but not as proximate as the same neighbourhood.

Figure 21 also shows the data separately for relationships that were respondent-monogamous (no other sex partners reported by the respondent) and for respondent non-monogamous relationships (other sex partners reported by the respondent). Around 17% of all non-monogamous partnerships were with partners in a different province, compared to 8% of monogamous partnerships.

Figure 21: Where sex partners live by percent respondent-monogamous and respondent non-monogamous relationships

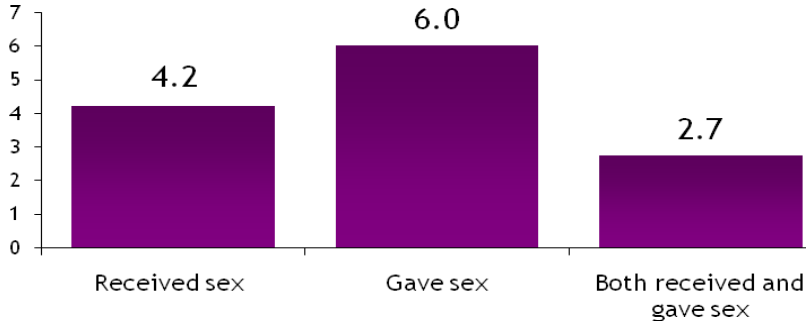


Interestingly, there were no non-monogamous relationships reported where the primary sexual partner was living with the respondent in the same house; it is possible that additional partnerships may be differentially (in terms of gender) under-reported by people who have sexual partners living with them - either because of guilt, or fear of repercussions if found out.

Transactional Sex

Around 6% of relationships, included provision of sex in return for money or goods, and 4% included receiving sex in exchange for money or goods.

Figure 22: Proportion of sexual partnerships that included receiving or giving sex in exchange for money or goods



Closer examination of the data shows that these transactional relationships do not appear to be mutually exclusive, for example, 64% of those relationships which included paying for sex with money or goods, also involved receiving money or goods in exchange for sex. In other words, some respondents reported giving money in exchange for sex *as well as* receiving money in exchange for sex – often in the same relationship. Thus, what is being reported here is clearly not very close to commercial sex work, and does not have the same power imbalances that would be typically associated with transactional sex.

The qualitative research nonetheless identified transactional sex as being a feature of life amongst females in this community. As stated by one participant:

'Yes the very same money we got from the sugar daddies [we will spend with our boyfriends], my boyfriend is also involved with an older lady, and he is also going to give me her money; that is what we all do.'-Female, out-of-school

'Our boyfriends also love older women because they give them money and sometimes they let them drive their cars. The older women tell us that they are busy with young guys.'-Female, out-of-school

Notably, both boys and girls were party to such relationships and transactional relationships were noted as a contributor to people having more than one partner, particularly more than one regular partner.

'We get involved with older men because they give us money. Guys our age do not have money so they cannot give us money. I know that if I sleep with an older guy he will give me R200 in the morning which I will use to buy myself a jean.'-Female, out-of-school

Acceptance of transactional sex as normative was tied in with cynicism about relationships generally, which has been discussed earlier.

'I think we as boys have the tendency of saying to ourselves, if I spend for a woman I must also get something back because I've spent for this woman.'Male, in-school

'…guys will buy you gifts and take you on expensive dates, but you have to pay for the gifts and the outing.'-Male, in-school

Overall, transactional sexual encounters were not all that common in this community, at 6% of all relationships. However, the qualitative research seemed to indicate that this phenomenon may be more widespread than this, and did not seem to be associated with stigma or disapproval amongst the focus group participants. Transactional sex is difficult to measure and it is almost impossible in a quantitative questionnaire to distinguish the normal exchange of material resources between spouses for example, and relationships that are built around such exchanges and involve exploitation of the economic situation of another person. Further work is needed to understand how to measure this issue and its contribution to partner concurrency and other issues such as condom use.

Frequency of Sex with Different Sexual Partners

Frequency of intercourse is an often overlooked factor in HIV prevention. The risk of contracting HIV in a one night stand is clearly far lower than if that one night stand becomes an affair with frequently occurring sex over months or years.

The table overleaf shows how often people reported having sex with each type of partner. *Table 16* shows that spousal relationships were characterised by more frequent sex than were casual relationships. Some 47% of spousal relationships included sex 2-3 times a week or more

often, compared to 22% of relationships with main partners or friends and 20% of casual encounters. However it is notable that around 80% of casual relationships included sex beyond just this once – these were relationships that the respondents returned to.

Table 16: Frequency of having sex with this sex partner by type of partnership

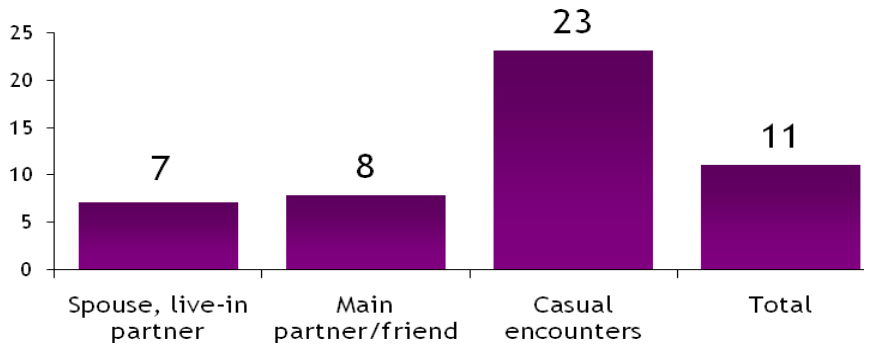
Frequency	Spouse, live-in partner	Main partner or friend	Casual Encounter	Total
Just this once	3	6	20	8
Once in a while	15	27	37	26
2-3 times per month	35	45	23	37
2-3 times a week or more often	47	22	20	29

Involvement of Alcohol in Sexual Partnerships

Alcohol is well known to lessen people's perception of risk, and in the case of risky sex, may act through increasing likelihood of sex happening, and/or decreasing likelihood of use of condoms.

Figure 23 shows that in 11% of all sex acts reported, one of the partners had had too much to drink (respondents judged how much too much was) and in 5% of all sex acts reported, both partners had had too much to drink. Having had too much to drink at the last sex act was more common in casual relationships - just over 20% of sexual experiences with casual partners were conducted when one or both partners had had too much to drink.

Figure 23: Percent sex acts where one or both partners had too much to drink by type of relationship



Respondents in the qualitative research indicated that alcohol impairs one's judgement. Many admitted to using alcohol only to discover that they had "made mistakes" the next day (i.e., had sex with someone, or had unprotected sex). Some admitted to using alcohol as a precursor to their activities, not necessarily labelling the drinking as the cause of their behaviour, but rather just a part of it.

'When one has had an alcoholic drink, it removes the shyness; you just become bold, irrespective of the fact that you're male or female.'-Female, out-of-school

'Sometimes I sit there and get drunk, I'm stressed and the guy is suddenly appealing to me, so I go for it and sleep with him.'-Female, out-of-school

Thus, it would seem that alcohol is a feature of a substantial proportion of casual encounters in this community, and excess alcohol use may predispose people to these high-risk encounters.

6.5 Alcohol

Excess alcohol consumption is increasingly recognised as a potentially important contributor to high-risk sexual behaviour. It is thought to lower people's discernment in choice of sexual partner, and reduce the likelihood of condom use[12].

Some 47% of men and 13% of women had been to a shebeen, tavern or nightclub in the past month. Amongst those who had been to a shebeen, tavern or nightclub, at the most recent visit, around 6% had ended up having sex with someone they had first met there.

The qualitative research showed that the shebeen or tavern is commonly the social gathering place to have fun and meet people. It is here that the community, young and old alike can gather to relax and initiate relationships. Even if two people are already acquainted, the tavern is an opportune place to get to know one another better in a setting outside of the norm (i.e., school, etc). Other than a tavern, no other alternatives for socialising and meeting people are specified in the research, except for mention of weddings or other family events.

'[Going to the tavern] is how we entertain yourself; if you do not go there it's not normal.'-Female, out-of-school

'We're not employed, we're doing nothing .., we're not stressed, it has not yet occurred to us to start looking for a job.'-Female, out-of-school

Drinking alcohol in excess was common amongst respondents in this area, with around 46% of men and 13% of women reporting that they had had five or more drinks in one sitting on at least one occasion in the preceding month. For men, having too much to drink was most common in the 25-29 year age group, with 60% of men in this age band reporting having had five or more drinks at one sitting. A lower proportion of women reported having consumed five or more drinks at one sitting (13%), and there were no marked differences by age amongst women. *Table 17* below shows high alcohol consumption among males aged 20 – 34 years. The same trend was observed in HIV prevalence (HSRC Survey, 2008), which also peaks around 30-34 years amongst males. For females, there is no close association observed in alcohol consumption and HIV prevalence. Interventions particularly around responsible alcohol consumptions should target taverns and shebeens.

Table 17: Percent males and females who reported having five or more drinks at one sitting on at least one occasion in the preceding month

Sex	16-19	20-24	25-29	30-34	35-40	Total
Males	19.2	54.6	60.0	58.7	49.0	45.5
Females	9.3	13.8	13.8	12.9	14.6	12.9

Respondents in the qualitative study supported the use of alcohol as a means for relieving stress, and as a form of entertainment.

'Some people take alcohol because they're stressed, they're trying to forget something, you then go with any boy to get you drunk hoping to release the stress.'-Female, out-of-school

According to the qualitative research, the tavern is also associated with initiating and/or pursuing casual relationships, where one can meet a person for sex with no expectation for a future. The tavern is also a venue where intergenerational sex is initiated and where men and women cheat on their main partners.

'Boys are different, some are honest and are committed to a relationship and they do not take you to a tavern. A boy who takes you to a tavern is not in love with you … all he wants is to propose to girls at the tavern, he does not love you.'-Female, in-school

'I think [sexual relationships] begin at the taverns, sugar daddies buy liquor for them, they meet at the tavern, then they sleep with the girls.'-Female, in-school

'You do not expect to meet a person at a tavern and expect to build a life with that person. What are you going to learn from that person? How do you fall in love with a person who is drunk half the time?'-Female, in-school

6.6 Summary and Conclusions

Fatalism

- A large proportion of the community hold attitudes that are consistent with fatalism towards getting HIV. This is true for both genders and all ages, but for women there is an increase in fatalism after age 25. This is a potential barrier to the adoption of safer sexual practices, and uptake of VCT and may go some way toward explaining why people do not always act on their knowledge. There is also a sense amongst young people, that once unhealthy behaviours are established, there is little chance of changing them and therefore infection becomes inevitable. It may be important to find ways to counter this assumption, showing young people that they can lower their risk behaviour. Interventions that reinforce that the majority of young people are HIV negative and can remain this way will continue to be important.

Abstinence

- Less than 50% of respondents could name abstinence as a way to prevent HIV. This may be because of lack of education or because abstinence is not considered a sustainable behaviour, and therefore not a viable way to prevent spread of the virus.

- Qualitative research indicated that abstinence is associated with morality and 'doing the right thing", rather than primarily seen as "health-related" behaviour.

Delaying Sexual Debut

- The majority of young people in this community are engaging in sex before the age of 18; most people do not think that young people should do this – even young people themselves predominantly believe that they should not do this.

- Most young people are engaging in sex before marriage or even cohabitation. This is unsurprising given the low levels of cohabitating partnerships in this community.

- Contradictory views were held regarding when young people should start having sex; these included issues of personal readiness, relationship status as well as the sanction provided by marriage.

- Young people in this community identified sexual activity as a way to get status and control in relationships, and some felt that it was almost impossible not to engage in sex, given hormonal drives.

- Some believed that sex was appropriate in one's youth and would assist people to be faithful once married.

- Young people seemed to want the guidance and support of their parents through greater openness in discussion regarding sex, including abstinence and its alternatives. They wanted parents to be realistic and informed role models.

Condom Use

- In this community, over 90% of people could spontaneously mention condoms as a means to prevent HIV. However both the quantitative and qualitative research indicated that for a number of reasons, people were not using condoms consistently, despite being fully aware of the risk of this behaviour. Some of the reasons mentioned included being in a relationship for a long time and knowledge of one's partner's status.

- Surprisingly high numbers of people held misconceptions around condoms; for example, around 20% of men and women believed that condoms may contain worms. Around 20% women did not know that condoms should only be used once. Only 9% of women and 11% of men thought that condom usage may actually lead to HIV infection. There is therefore a need to address the actual use of condoms and myths and misconceptions surrounding their use.

- People seemed to be confident about their ability to use condoms. It is important to continue to sustain these high levels of self-efficacy. On the other hand, there was high correlation between alcohol consumption and low condom usage.

- This study confirms previous studies' findings that condom use is lower amongst older people. HIV prevention programmes may need to focus on condom use in older people, particularly in high risk relationships.

- The higher levels of condom use amongst young people masks differences in condom use by employment status – significantly lower proportion of young people who are unemployed are using condoms than those who are employed or are students. Condom use amongst the unemployed youth urgently requires further investigation and intervention.

- Though there were high levels of acceptability towards use of choice ™ condoms (74%) although some 26% of respondents did not trust/would not use choice ™ condoms. The qualitative research seemed to indicate that free or government issued condoms would be suspected – and people felt more confident of brands that they purchased themselves. Measures to counteract these misconceptions need to be developed and implemented.

Sexual Relationships

- Qualitative research revealed a level of cynicism amongst young people about relationships. Neither males nor females seemed to believe in the possibility of satisfying, monogamous relationships.

- In this community, the perceived inevitability of unfaithfulness between partners was linked to 'being South African'; to self knowledge – we can't trust our partners, they must be doing what we are doing; to the nature of men and women, expressed through notions such as 'this has been happening for generations' and to instrumental views of relationships – where relationships were seen primarily to get participants money or status.

- Despite the above, this community evidences high levels of social disapproval of multiple partnerships, for both women and men. There are also high levels of knowledge about the HIV risk that multiple partners present. This was evident in both the quantitative and qualitative data.

- Levels of self efficacy for faithfulness were generally high; over 95% of women and most men felt themselves able to be faithful in relationships. Nonetheless there were still around 3% to 14% men who did not feel able to be faithful. There were indications that older men seem to feel less capable of being faithful (24% said they could not commit to one partner) than those in the younger age group (19% said they could not commit to one partner). There were indications that older women felt themselves less capable of controlling their sexual urges than younger women did.

- On one level, people believed that men primarily took additional partners for reasons of 'curiosity, fun or variety' in sex and women took additional partners for the money or goods that that extra partner would provide.

- The majority of men in this area (71%) had one partner in the preceding year. 17% had 2 partners and 9% had three partners. Some 37% of sexually active men working on the mine had more than 1 partner in the preceding year, compared to 29% of those not employed on the mine.

- Looking at all of the relationships that were reported by respondents in the past year, three quarters of all sex partners that the respondents report, can be described as 'steady', or life-style partners, rather than casual partners. Of all the sex relationships described in this area around half were with a main partner, 11% were with a live-in partner and a further 16% were with a spouse; some 8% of main partner relationships were not monogamous.

- There is a need for greater communication around risks of having multiple and concurrent partnerships. Harm reduction messages should also be communicated among people who are removed from their main partners.

- Around 20% of casual encounters did not use condoms at last sex. There were still almost 1 in 3 encounters with main partners where condoms were not used – and a substantial proportion (8%) of these main partnerships were respondent non-monogamous.

- Overall, transactional sexual encounters were not all that common in this community, at 6% of all relationships. However, the qualitative research seemed to indicate that the phenomena were more widespread than this. Transactional sex is difficult to measure and it is almost impossible in a quantitative questionnaire to distinguish the normal exchange of material resources between spouses for example, and relationships that are built around such exchanges and involve exploitation of the economic situation of another. Further work is needed to understand how to measure this issue and its contribution to high risk behaviour such as MCP and inconsistent condom use.

- Spousal and cohabitating relationships were more likely to involve frequent sex than were casual partnerships or partnerships between friends. However there is still a large proportion of casual partnerships which involved frequent sex – only 20% of casual encounters were once-off encounters. This implies an increased risk of HIV transmission between these partners.

- MCP behaviour was seen both to have its origins in the past – our mothers and fathers did it – and also to be related to the present, tied in with the decline of love ("love just does not exist nowadays"), which in turn was at least partially attributed to HIV – someone you love may bring you this illness, therefore there is no love. All

of these factors led, not to a moral acceptance of MCP, but to people being resigned to their own relationships at some stage being non-monogamous.

- On the one hand, it would seem desirable to raise the bar and increase people's expectations of their lives and relationships, and thereby to break the negative cycle of MCP. On the other, to the extent that MCP is happening, it is better that people do not blindly trust their partners if there is a likelihood that by doing so they may contract HIV through that person's sexual network outside the relationship.

Alcohol Use

- Alcohol was a feature of a substantial proportion of casual encounters, and measures to address alcohol use, particularly amongst young women, may reduce the occurrence of casual sex. Alcohol use may also impair judgement in terms of condom use.

- The proportion of respondents visiting shebeens was higher among men (40%) as compared to women and girls (13%). In contrast, the qualitative research suggested that social norms that judge people as misfits or abnormal if they do not visit shebeens, may be a strong feature of this community, particularly amongst the unemployed. Thus it would seem that while frequenting of shebeens may not be widespread it is nonetheless important to consider in aspects of HIV prevention programming in this area for key target groups, notably unemployed young women.

7 Biomedical Drivers of the HIV Epidemic

7.1 Circumcision

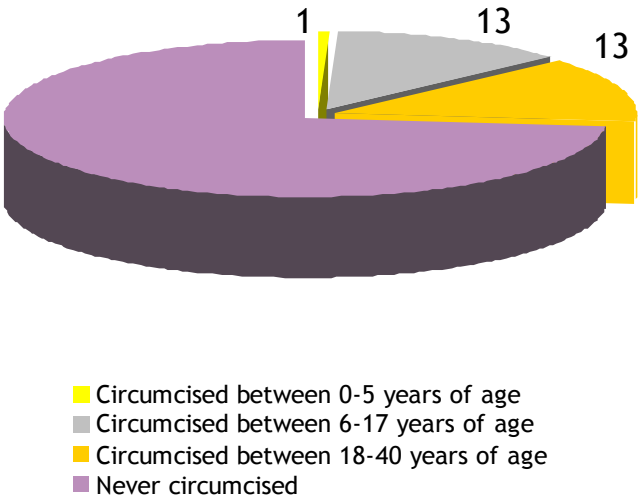
Male circumcision has been shown in some studies to have a partial protective effect in HIV transmission. Based on the existing evidence, in some countries, male circumcision has been recognised as an additional intervention to reduce the risk of heterosexually acquired HIV infection in men[13]. However, we know very little about what people know and assume about circumcision. It is critical that circumcised men do not develop a false sense of security and assume that circumcision is fully protective. In addition to this, there are many cultural, religious, social and medical practices associated with circumcision around the world; circumcision is conducted in many different ways for many different reasons on males of different ages- this makes it harder to properly implement, monitor and evaluate circumcision interventions as part of comprehensive HIV prevention services. Because this intervention is potentially important in the future, this survey asked people about their attitudes and practices around circumcision, particularly as it relates to perception of HIV risk.

Prevalence of Circumcision

In this community, 20% of men aged 16-40 years had been circumcised. It is important that circumcision occurs before men start having sexual intercourse if the risk reduction benefits are to accrue. Of those men who had been circumcised, around half (50%) had been

circumcised before the age of 18 years. *Figure 24* below shows the percent of men in the community by whether or not they were circumcised and the age at circumcision amongst those circumcised.

Figure 24: Prevalence of circumcision amongst men and age at circumcision



This shows that in this community, there are many men who most likely were sexually active for some time before being circumcised.

Attitudes to Circumcision

There were high levels of acceptability towards circumcision among both males and females, with 65% of men and 59% of women either agreeing or strongly agreeing with the statement that men should be encouraged to be circumcised (*Table 18*). Although there were some differences by age group, there was no clear trend observed by age in the percent of people holding this view.

Table 18: Percent men and women who believe that men should be encouraged to be circumcised

Sex	16-19	20-24	25-29	30-34	35-40	Total
Males	59.6	67.7	74.6	58.7	64.7	64.9
Females	60.5	56.3	69.0	55.7	54.4	59.3

Almost64% of men and 62% of women believed that circumcision had some health benefits for men (*Table 19*). Younger women were more likely to believe this than older women (67% of 15-19 year olds compared to 57% of 35-40 year olds). For men, the age group most likely to believe this were those aged 20-25 years.

Table 19: Percent men and women who believe that circumcision has health benefits for men

Sex	16-19	20-24	25-29	30-34	35-40	Total
Males	55.3	72.7	74.6	50.0	60.8	63.5
Females	67.4	59.8	64.4	64.3	56.7	62.4

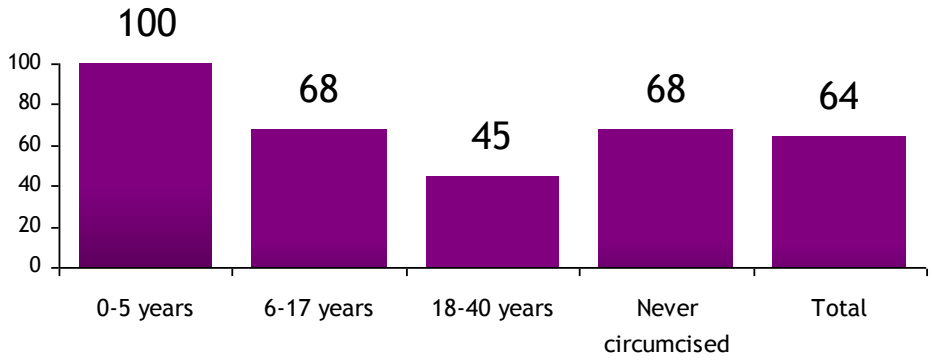
Circumcision and Condom Use

There are concerns that some circumcised men may stop using condoms, in the mistaken belief that circumcision alone will offer protection against HIV.

In this survey, most people (95%) disagreed or strongly disagreed with the statement that a man who is circumcised does not need to use condoms to prevent HIV. Although a slightly higher proportion of men than women believed this, the difference was not significant. There were no marked differences by age category in the proportion of people believing this. Those with lower education levels were more likely to think that circumcised men did not need to use condoms (9% of those with primary education or less, compared to 5% overall).

Figure 25 below shows the percent of sexually active men who used a condom at last sex by whether or not they were circumcised. Some 45% of those circumcised between the ages of 18 and 40 years used a condom at last sex, compared to 68% for those circumcised in early adolescence or not circumcised. In this community, there were very few people circumcised at ages younger than 5 years, therefore the estimate for condom use in this group should be interpreted with caution.

Figure 25: Percent sexually active men using condoms at last sex by circumcision status and age at circumcision



It would seem that most men are aware that circumcision does not offer full protection against HIV. However there is still room to communicate this message, particularly for men who have lower education levels. The finding that men circumcised later in life were less likely to use condoms than those circumcised at younger ages and the uncircumcised, is a cause for concern.

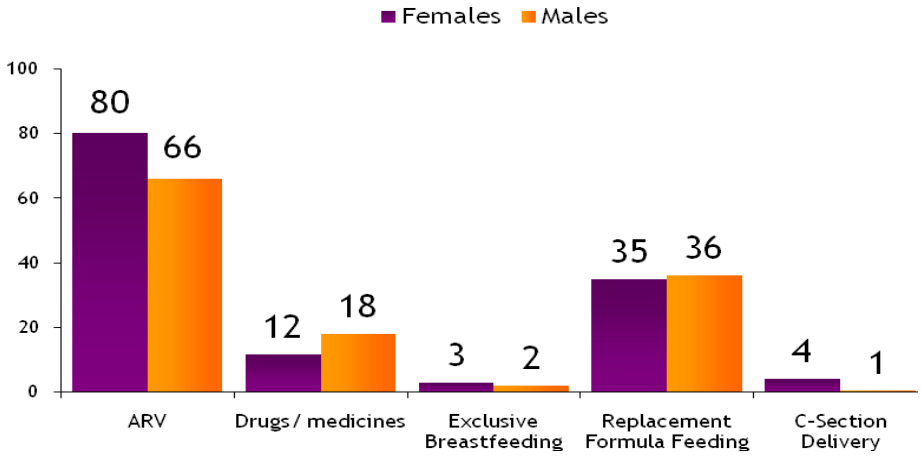
7.2 Prevention of Mother to Child Transmission of HIV

Services to prevent babies and young children from getting HIV from their mothers are not accessed by all who need them. Some of this has to do with service delivery, but it is also important to be sure that community members know about these services, and that they either ask for the services or agree to them if offered.

Respondents were asked if they knew of ways to prevent an HIV positive mother or mother-to-be from passing the virus on to her child. The percent correctly mentioning various forms of intervention is shown in *Figure 26* below.

Around 80% of women and 66% of men mentioned ARVs and 12% of women and 18% of men mentioned drugs or medicines. Very low proportions of men and women knew that exclusive breastfeeding, formula feeding or caesarean section were means of preventing mother-to-child transmission of HIV.

Figure 26: Percent spontaneously mentioning various forms of PMTCT by gender



There is clearly considerable room to improve knowledge of PMTCT in this community, particularly knowledge of interventions around feeding recommendations. This is a critical area as new infections amongst babies are almost entirely preventable.

7.3 Summary and Conclusions

- Male circumcision and its relationship to risk and risk behaviour present a real challenge to communicators and programme implementers. In this community it is critical that this issue is addressed as men choosing to be circumcised in adulthood seem to be using condoms less than uncircumcised men and also less than those circumcised earlier in life. Further work is needed to identify appropriate interventions and messages in this area.

- Knowledge of PMTCT, particularly with respect to infant feeding options urgently needs strengthening in this community and should be considered as an important component of HIV and AIDS information and communication strategies.

8 Treatment, Care and Support

8.1 VCT

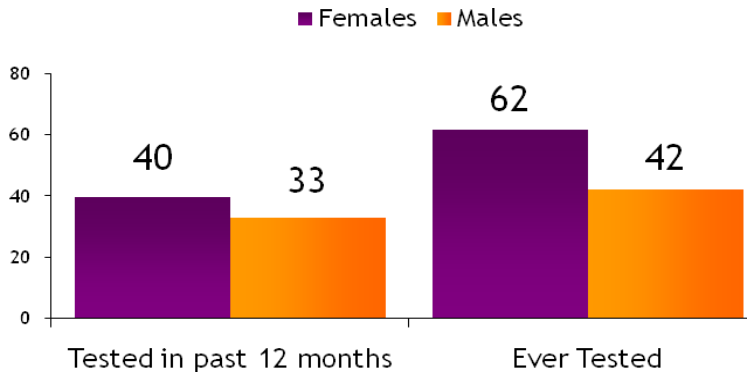
Through knowing their HIV status, people can be motivated to remain HIV negative, or to care for themselves and access appropriate treatment and other services if HIV positive. VCT services have long been regarded as a critical bridge between HIV prevention and care and support services. In this survey, we asked community members if they had been tested for HIV, and if so, how long ago. We also explored a few misconceptions around VCT.

Tested for HIV

In this community, 51% of people who had ever had sex, and 54% of people who were sexually active at the time of the survey, had ever had an HIV test. Sexually active women were more likely than sexually active men to have ever had an HIV test, with 62% compared to 42%.

Around 33% of the sample who are sexually active had undergone an HIV test in the preceding 12 months. Sexually active women were also more likely to have had had an HIV test in the last year with 40% compared with 33% of sexually active men having been tested in the past 12 months (*Figure 27)*.

Figure 27: Percent sexually active respondents ever tested and tested in the past 12 months



Repeat Testing

It is important that individuals with many partners, or high rates of sexual partner change, undergo HIV testing more than once – at least each time they start a new sexual relationship. Individuals who had ever had an HIV test were asked how many times they had been tested. The majority of respondents (58%) had been tested between two and four times while 39% had been tested only once.

Some 8% of males and 6% of females wrongly believed that if a person tests negative for HIV they never have to go back for testing again. This misconception was higher amongst the older age group, with around 10% of those 35-40 years believing this.

Half of the sexually active respondents in this community said that they knew their HIV status. However, of those people who said they knew their status, some 31% had never been tested for HIV. This is difficult to understand as these individuals are sexually active, and this finding may therefore indicate some misconceptions around testing in this area.

Further, around 10% of respondents who had been tested in the past twelve months said that they did not know their status. It is possible that these people had had new sexual partners, and this is the reason, or that they did not receive the result of their test.

An additional concern was raised in data from the qualitative research which indicated that some people believed that an HIV test with one's partner guaranteed protection against HIV without the use of any barriers for transmission.

In summary, there seems to be some confusion over VCT in this community, with some sexually active people never tested thinking they know their status, and others, despite having tested recently saying they did not know their status. Testing with partners also seems to be an area that needs focus and clarification, particularly where partners may not be faithful to one another.

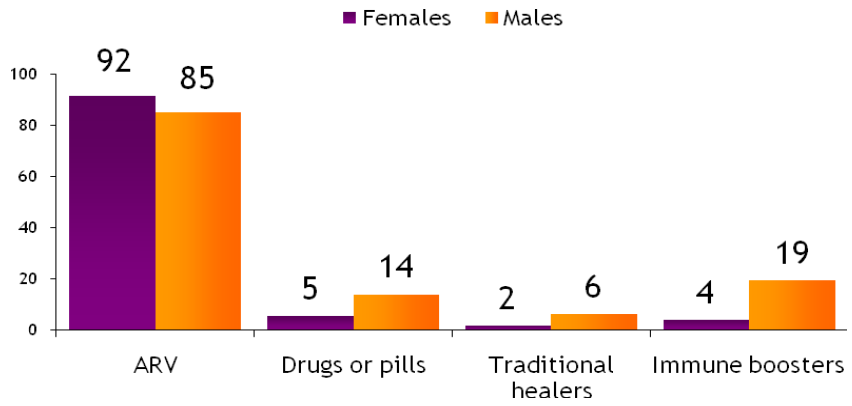
8.2 Treatment Literacy

It is important that people know that there is a treatment for AIDS, as understanding this and seeing community members accessing care and support services, makes it more likely that people will come forward for testing and access needed services before illness is too far advanced for treatments to be effective.

Most people (93%) correctly believed that there was a treatment for AIDS – that is, treatment being something to keep you healthy and not a cure for the disease. The remaining 7% either did not know if there was or not, or said there was no treatment.

Those who believed that there was a treatment, were asked what that treatment was. The question was unprompted and people were encouraged to name as many treatments as they knew of. Most people were able to name anti-retrovirals (ARVs) (92% of women and 85% of men). Other forms of treatment were mentioned far less often. Immune boosters were mentioned by 4% of women and 19% of men.

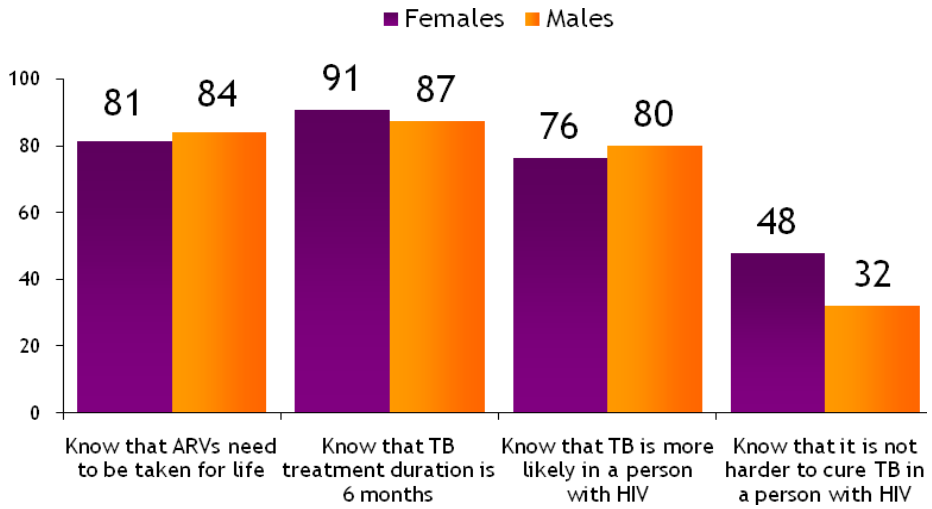
Figure 28: Percent spontaneously mentioning various treatments for AIDS



Most people knew that ARVs should be taken for life.

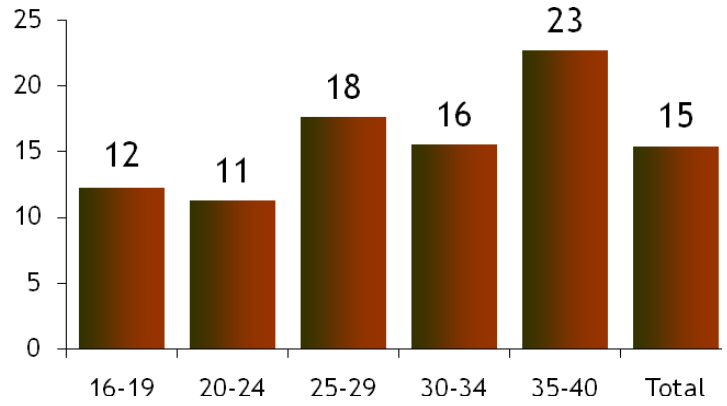
Knowledge of Tuberculosis (TB) treatment duration was also high. Fewer people were aware of the linkages between TB and HIV, with less than half of people knowing that it is not harder to cure TB in people with HIV.

Figure 29: Percent knowing correct facts about treatment



Some 15% of respondents agreed with the statement that traditional healers can cure AIDS. However, when asked to spontaneously mention treatment for AIDS, less than 7% of people mentioned traditional healers. More older people than younger people agreed with the statement that traditional healers can cure AIDS, with almost 1 in 4 aged 35-40 years believing this (*Figure 30)*.

Figure 30: Percent who believe that traditional healers can cure AIDS by age group



Overall, members of this community tended to know about medical treatment of AIDS and TB. There was less knowledge about the link between TB and HIV, but this is to be expected as it has not been a major focus of communication or programming. There is therefore need to strengthen communication about TB and its link to HIV. There are substantial numbers of people, particularly older people who believe that traditional healers can cure AIDS. We cannot be sure whether or not this belief would prevent people from accessing other treatments, or whether people with a strong people in traditional healers curative powers would nonetheless use and benefit from ARVs and other care and support

8.3 Summary and Conclusions

- People in this community need help understanding the importance of VCT and accessing services. Testing rates can be improved, particularly amongst men. People need to know that after testing HIV negative, they are at risk of becoming HIV positive with each new partner, or if they have a partner who is having sex with others. Testing with partners seems to be an area that needs focus and clarification, given that some people seemed to think that going for a test with a partner would confer protection, without an appreciation of the need for both partners to not have sex with others.

- Most people in this community knew about ARVs, knew that they should be taken for life and could correctly say that the duration of TB treatment was for 6 months. There are substantial numbers of people, particularly older people who believe that traditional healers can cure AIDS. This is not necessarily a cause for concern, as long as people holding this belief are still able to support themselves and others to use and benefit from ARV's and other care and support interventions.

9 Overall Conclusions

1. Setting targets and benchmarks in a community that is characterised by migrancy needs to be done with caution because people may more easily move in and out of the area – this can make some trend data hard to interpret if for example, the population profile or risk characteristics change substantially over time. Encouragingly, amongst the people surveyed, most people regarded the Free State Province as home, and many people had been born there, indicating that this community may be more stable than some other mining areas.

2. The connections that community members have with households in other areas, including regular sexual partners living elsewhere should be borne in mind in the design and implementation of interventions which require partner or family involvement, such as in STI treatment. Such interventions are harder to deliver successfully in this kind of context, yet remain critically important.

3. A notable feature of this community was the high level of unemployment amongst youth, coupled with low condom use and high alcohol intake amongst those who are unemployed. Building the resilience of in-school youth to face possible unemployment once they leave school and for both in and out of school youth assisting them to resist peer pressure and community norms related to alcohol abuse and unsafe sex is critical. Linkages with organisations providing income-generating projects could be initiated among out-of school youths to combat effects of unemployment and mitigate the effects of HIV and AIDS.

4. The fatalism and cynicism that young people have about sexual relationships in this area was also striking. Interventions with youth in this community need to reinforce to young people that it is possible to change patterns of sexual behaviour; even if they have made unsafe choices in the past, they don't need to continue to do so. Many young people have already engaged in sexual intercourse and interventions to delay sexual onset, reduce the number of partners and advocate for correct and consistent condom use continue to be important. Capacitating parents to raise issues of sexual behaviour with young people appropriately and non-judgementally may be useful in some contexts.

5. In order to address MCP organisations needs to focus on those at greatest risk. Our analysis indicated that these groups include young men, students and those who start having sex at a young age.

6. The qualitative research showed that underlying young peoples' views and expectations of sexual relationships, including expectations of infidelity, lie set ideas about men and women, with boys and girls having fixed ideas about what the other sex thinks and wants. These need to be challenged if these young people are to be open to developing trusting mutually satisfying relationships that form a foundation for faithfulness.

Interventions need to find ways to challenge boys and girls to respect and listen to one another.

7. Given the high proportion of people accessing television and radio, it can be assumed that a large proportion of the target audience are already accessing AIDS programming and edutainment that is channelled through mass media, such as Scrutinize, Tsha-Tsha, Soul City and other programming. Local HIV prevention organisations could consider noting areas of focus and content of this AIDS programming and building synergies between the programming and some of its own activities. In this way the mass media and local organisations can amplify the impact of one another.

8. Many people listen to Lesedi FM, and over 80% understand Sesotho sa borwa, suggesting that radio coverage of HIV prevention organisations' activities on this station would be potentially valuable in increasing community awareness of the organisation. Public Relations possibilities could be integrated making them part of the communication network.

9. The data highlight the relevance of interventions such as Lesedi-Lechabile Primary Care's *Men Engage*. Particularly critical areas of intervention for males that are suggested by these data are:
   - Increasing openness and dialogue about the epidemic amongst men - men were far less likely than women to say they knew someone HIV positive.
   - Increasing VCT amongst men - far fewer men then women knew their HIV status.
   - Ensuring that men are informed that circumcision does not fully protect them against getting HIV - many men in this community who were circumcised as adults were not using condoms.
   - There is also need to strengthen the marketing of men's programmes in various communication channels

10. The community study presented in this report has provided both quantitative and qualitative data on a number of key drivers of the HIV epidemic in this community. Some of the indicators presented here can be measured in follow up surveys and used to asses change over time. Additional recommendations for programme refinement that are suggested by the data are presented at the end of each of the chapters of the report.

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