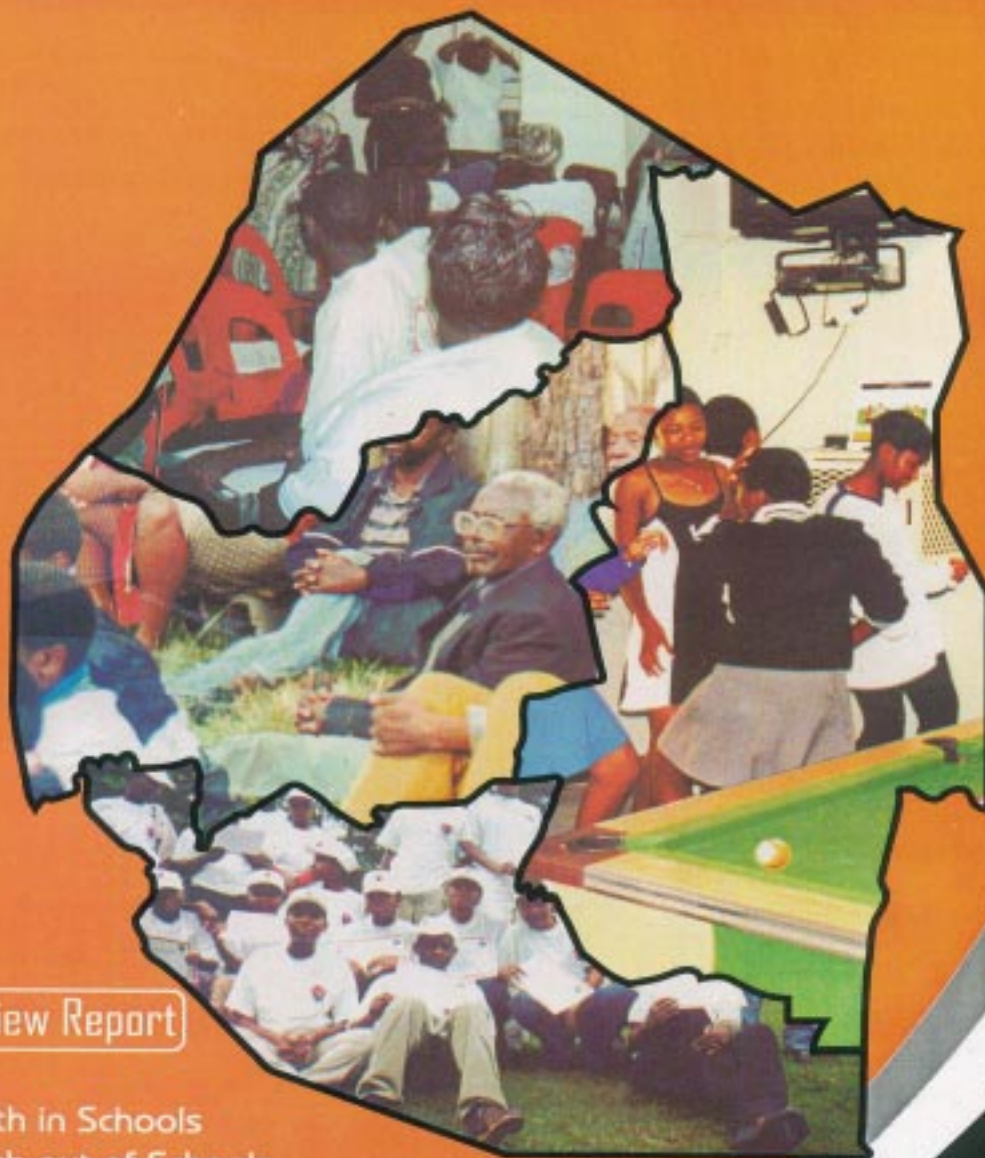


# SWAZILAND BEHAVIORAL SURVEILLANCE SURVEY (BSS)



## Overview Report

For:

- Youth in Schools
- Youth out of Schools
- Tertiary institution students
- Military
- Kombi Drivers and Assistants
- Long Distance Drivers (LDDs)
- Seasonal Workers
- Watchmen
- Police

- Female Sex Workers (FSWs)
- Women Factory Workers

2001/2002

# SWAZILAND BEHAVIORAL SURVEILLANCE SURVEY (BSS)



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## *List of Abbreviations*

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
BSS	Behavioral Surveillance Survey
E	Emalangen (Standard Monetary Unit Of Swaziland)
EA(s)	Enumeration Area(s)
FHI	Family Health International
FLAS	Family Life Association of Swaziland
FSWs	Female Sex Workers
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
LDDs	Long Distance Drivers
NERCHA	National Emergency Response Committee on HIV/AIDS
NGOs	Non-Governmental Organizations
SNAP	Swaziland National AIDS Program
SPSS	Statistical Package for Social Sciences
STI(s)	Sexually Transmitted Infection(s)
TB	Tuberculosis
TV	Television
VCT	Voluntary Counseling and Testing



## Preface

The Government of Swaziland (GOS), through the Ministry of Health and Social Welfare in collaboration with Family Life Association of Swaziland (FLAS) conducted the first round of the national Behavioural Surveillance Survey (BSS). This is the first round of the BSS and it shall be repeated after every two years. We regard the BSS as important for Swaziland as it will enable tracking of trends in HIV knowledge, attitudes and risk behaviors in selected groups in a population and will increase our understanding of the HIV prevalence trends over time. Populations selected to participate in this BSS were the military, police, seasonal workers, watchmen, factory workers, commercial sex workers, students from tertiary institutions, kombi drivers. Long Distance Drivers, in and out of school youth.

The BSS was conducted at a time when Swaziland is in need of data that can be used as baseline and as such the BSS will enable program managers to plan and implement prevention interventions that respond to trends in risk behaviors and to evaluate the intermediate outcomes of prevention interventions.

The results also serve to alert policymakers and program managers to emerging risks or changes in existing risk behaviors, reveal gaps in knowledge and understanding about HIV/AIDS that can be addressed by interventions, help identify populations whose behavior makes them particularly vulnerable to HIV and provide data on specific target groups that complements information from general population surveys.

The government in collaboration with other agencies involved in the fight against HIV/AIDS, will use the information gathered through the BSS to plan interventions that will bring meaningful changes in the rate at which HIV is spreading.

I congratulate Family Life Association of Swaziland (FLAS) and the partners involved in this study for the good and useful work done. It is our hope that it will enrich all people that are involved as we fight stigmatisation and discrimination of people living with the HIV virus and prevent new infection.

Dr. P.K Diamini



Minister for Health and Social Welfare  
Mbabane, November 2002



## *Acknowledgements*

The Family Life Association of Swaziland would like to express its profound gratitude to the Ministry of Health and Social Welfare for availing the opportunity for the organization to conduct such an important research undertaking. This exercise was made possible through funding from Family Health International (FHI) through United States Agency for International Development (USAID).

Heartfelt gratitude is also extended to the BSS project manager Ms Zodwa Diamini, her assistant Ms Sanelisiwe Tsela, programme assistant Mrs Bethusile Khumalo, the consultants Mr Walford Chukwu and Dr Godwin Okiror and the driver Mr Leo Masilela for their effort and dedication in this exercise.

We would like to appreciate the cooperation shown by school head teachers, community leaders, companies' management, the military, police and everyone who participated in the study. We would also like to thank the research assistants who worked very well with their supervisors in collecting the data.

Lastly we are grateful to FHI and the BSS technical working group for the technical guidance rendered during this exercise.

EXECUTIVE DIRECTOR



Khetsiwe Diamini



## *Executive Summary*

Behavioural Surveillance Survey (BSS) are repeated cross-sectional surveys in selected populations overtime and they are designed to tracks trends in HIV/AIDS - related knowledge, attitudes and behaviours. BSS make use of standardized protocol, which is crucial in achieving high quality data and results. Swaziland conducted the first round of BSS using Family Health International (FHI) protocol in 11 subpopulations namely: In School Youth, Out ofSchool Youth, Students attending Tertiary Institutions, Female Sex workers (FSWs), Long Distance Drivers (LDDs), Kombi drivers and assistants, Military, Police, Watchmen, Seasonal Workers and Factory workers between November 2001 and February 2002. It is envisaged that this BSS will be conducted every two years in the country. Modified versions of the FHI structured questionnaires were administered to the selected respondents by trained interviewers under close supervision of a team of supervisors. Data was entered and analysed using Social Package for Social Scientists (SPSS).

BSS results serve as an early warning system by alerting policymakers and program managers to emerging risks or changes in existing risk behaviours, reveal gaps in knowledge and understanding about HIVAIDS that can be addressed by interventions, help to identify populations whose behaviour makes them vulnerable to HIV infection or at high risk to HIV infection and generally provide information to guide program design, help evaluate programmes and explain changes in HIV prevalence.

To gain an insight into the sexual behaviour of the surveyed groups, qualitative studies using Focus Group discussions (FGDs) were conducted among some of the subpopulations that were included in the BSS round one in Swaziland. The salient findings from the BSS are presented below:



## Key Findings

- Approximately two-thirds of all respondents in each of the surveyed populations were able to cite three methods of protection against HIV transmission.
- Stigma and misconceptions about HIV/AIDS were observed across all surveyed populations despite high levels of knowledge about HIV preventive methods.
- Knowledge of someone who had died of or was infected with HIV/AIDS was also relatively high, ranging from 22.9% to 64.2%.
- Youth start engaging in sex at an early age. Mean ages are 16.3 years for in-school youth aged 15-19 years and 17.4 years for out-of-school youth in the same age group
- Out-of-school youth aged 15-19 years reported more sexual activity in the last 12 months than in-school youth of the same age (33.2% vs. 15.7%).
- Female youth both in and out of school tended to have sex with partners older than themselves. Males tended to have sexual partners of similar age.
- Significantly high proportions of the surveyed adult populations<sup>1</sup> had non-regular sexual relationships in the last 12 months, ranging from 28.5% to 57.7%.
- Multiple sexual relationships were common among both the adult and youth surveyed populations.
- Generally, condom use increased significantly as perceptions of sexual behavior risks rose. Condom use in non-regular sexual relationships was higher than in regular sexual relationships. Even among FSWs, condom use was higher with paying partners than with non-paying regular sexual partners.

<sup>1</sup> Adult populations refer to surveyed groups of factory workers, long-distance drivers, Kombi drivers/assistants, military, police, watchmen, seasonal workers and tertiary students.





## Key Findings, Continued

- Although condom use at last sex in non-regular sexual relationships was relatively high, ranging from 29.9% among seasonal workers to 82.9% among tertiary students, condoms were not used consistently.
- Condom use among in-school youth was higher than among out-of-school youth.
- The majority of female sex workers (FSWs) were young women under age 25 (63.9%).
- Sexual mixing with FSWs was observed across all surveyed populations.
- Reported STIs in the last 12 months was relatively high, rising to 16% in some of the surveyed populations.
- The proportion of the surveyed population ever tested for HIV was low, ranging from 6.3% to 28%. Knowledge about availability of VCT facilities was relatively low among youth in particular.



Voluntary counselling and testing is very important in the fight against HIV & AIDS

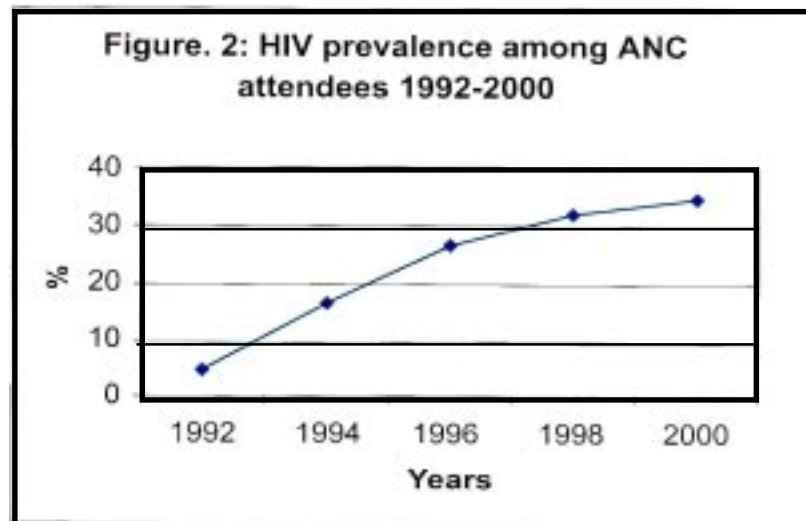




## 1.2 Overview of the HIV/AIDS Situation in Swaziland

Swaziland's first AIDS case was reported in 1987. In response, the Government established the Swaziland National AIDS Program (SNAP). One of SNAP'S major strategies is Information Education and Communication (IEC) campaigns, aimed at informing the public about modes of HIV transmission and ways of avoiding infection. HIV sentinel sero-surveillance began in 1992 among pregnant women, sexually transmitted infection (STI) patients and tuberculosis (TB) patients at selected health facilities. HIV prevalence data among these populations continue to show an upward trend.

HIV prevalence among antenatal clinic (ANC) clients increased from 3.9% in 1992 to 31.6% in 1998 and to 34.2% in 2000. (See Figure 2). HIV prevalence among STI clients increased from 11.1% in 1992 to 47.6% in 1998 and to 50% in 2000.



The Government of Swaziland continues to show its commitment to the fight against HIV/AIDS. In 1999 the Government instituted a Cabinet Committee on HIV/AIDS, chaired by the Deputy Prime Minister. The same year it established the Crisis Management and Technical Committee, which developed the National HIV/AIDS Strategic Plan. This plan provides a guiding framework for a multi-sectoral national response to address three essential areas: risk reduction, response management and impact mitigation. The Government recently instituted the National Emergency Response Committee on HIV/AIDS (NERCHA) to coordinate and support efforts in fighting HIV/AIDS, using the Strategic Plan as a basis. Multi-sectoral HIV/AIDS councils have been established at the regional level. The Government policy on HIV/AIDS was adopted in 1998 with the primary goal of creating an environment conducive to the prevention and control of HIV/AIDS and other STIs. King Mswati III declared HIV/AIDS “a national disaster” when opening Parliament in February 2002.



### 1.3 Introduction to Behavioral Surveillance Surveys (BSS)

Behavioral Surveillance Surveys (BSS) provide valuable data about HIV/AIDS-related knowledge, attitudes and behaviors. The Family Health International (FHI) BSS methodology is a monitoring and evaluation tool designed to track trends in HIV/AIDS-related knowledge, attitudes and behaviors in sub-populations at particular risk of infection, such as female sex workers (FSWs), injection drug users, migrant men and youth. Based on classic HIV and STI sero-surveillance methods, BSS comprise repeated cross-sectional surveys conducted systematically to monitor trends (changes) in HIV/STI risk behaviors.

A key benefit of the methodology is its standardized approach to questionnaire development, sampling frame construction and survey implementation and analysis. BSS findings serve many purposes: they yield evidence of project impacts, provide indicators of project success and highlight persistent problem areas. They also give insight into HIV sentinel prevalence data, identify appropriate intervention priority populations, identify specific behaviors in need of change, function as a policy and advocacy tool and supply comparative data concerning behavioral risks.

National BSS have been conducted in more than 25 countries, and their use is growing. Used in Asia and Africa since 1999, they proved beneficial to understanding the pandemic from a regional and country-specific perspective. Multiple rounds of BSS have been conducted in several countries, with the trend data used to formulate new programs and adapt existing ones.

This report, extracted from a more detailed technical manuscript, presents an overview of the findings of the BSS conducted among II sub-populations in Swaziland from November 2001 to February 2002.



## 2.0 Objectives

**The objectives of the BSS Round One in Swaziland were to:**

- Help establish a monitoring system that will track behavioral trend data for high-risk and vulnerable target groups in Swaziland.
- Provide information on behavioral trends of key target groups in some catchment areas where HIV sentinel sero-surveillance is done.
- Provide information that will increase understanding of HIV prevalence trends over time.
- Provide information to guide the planning, design, implementation, monitoring and evaluation of HIV/AIDS/STI interventions.
- Provide evidence of the relative success of HIV prevention efforts taking place at selected sites.
- Obtain data in a standardized format, enabling comparison with other behavioral surveillance studies carried out in other countries.





## 3.0 Survey Methodology

### 3.1 Study Design and Sampling Procedures

Data for Round One of the Swaziland BSS were collected between November 2001 and February 2002. The BSS methodology employs a cross-sectional design that conforms to a standardized sampling process and collects information on standardized indicators. Because representative samples are obtained from defined geographic locations, the process can be repeated to monitor trends over time and to compare indicators between sites.

Table I shows the number of respondents from each target group at each site. Sample sizes for each of the 11 study populations included in this BSS were determined by behavioral parameters observed in selected studies conducted in the country, the expected behavior change, the degree of confidence in such a change, statistical power and design effects. Two-stage cluster designs were used with each group where appropriate. During the first stage, clusters were selected from a complete list of sites using Probability Proportional to Size (PPS). A sampling frame was prepared initially to provide the basis for selecting clusters. Information regarding regions, clusters, population groups and the number of individuals per cluster was recorded and used in the selection of clusters and respondents.

Bus ranks (terminus) were used to locate the Kombi (taxi) drivers and assistants while taxi routes were used as clusters for sampling them. Border posts were used to locate the long-distance drivers (LDDs). Military units were used to locate military men, factories for factory workers, security companies for watchmen, police stations for police officers and tertiary institutions for tertiary students. Mhume Sugar Company was used to locate seasonal workers and schools for in-school youth. Households were used to locate out-of-school youth. Bars, streets and discotheques/night clubs were used to locate sex workers. All the above areas/units/routes were used as clusters for sampling the different target populations. The questionnaires were developed in stages parallel to the field preparation. Separate questionnaires were developed for sex workers, adult respondents and youth based on international best practices.



**Table I: Study populations, study areas and sample size**

Category	Description	Location and study sites	Study Populations and ample size
In school youth	Youth in secondary/ high schools	Mainly in formal schools in the Manzini, Hhohho and Lubombo regions	A total of 968 youth: 482 males and 486 females
Out of school youth	Single out-of-school youth	Households in the Manzini, Hhohho and Lubombo regions	A total of 1,776 youth: 867 males and 909 females
Students from tertiary institutions	Students in tertiary institutions	Colleges, vocational institutions and the University of Swaziland	A total of 1,332 students: 757 males and 575 females
Kombi drivers and assistants	Local Kombi drivers and assistants: highly mobile men who spend most of their time on the road	The Manzini and Mbambane bus ranks (terminals)	345 males
Long distance Drivers	Long Distance drivers who spend days away from their families	Transport companies premises, Ngwenya and Lavumisa border gates	123 males
Military	Men in the army	Units in the Manzini, Hhohho, Lubombo and Shiselweni regions	387 males
Police	Men in the police force	Police stations in the Manzini, Hhohho, Lubombo and Shiselweni	185 males
Watchmen	Men working as security guards	Security companies in the cities of Manzini, Matsapha and Mbambane	167 males
Seasonal workers	Males employed as cane cutters	Mhlume Sugar Company	251 males
Factory workers	Female factory workers	Companies at the Matsapha industrial site	231 females
Female sex workers	Women selling sex for money	Bar, hotels, restaurants, night clubs and streets in the Manzini and Mbambane corridor	137 females
Total no. of surveyed respondents			5,902



### 3.2 Study Populations

The FHI BSS protocol seeks to include populations that are at particularly high risk or increased vulnerability to HIV infection, and that play a significant role in influencing the direction and dynamics of the HIV/AIDS epidemic. At a workshop organized by the Ministry of Health, all partners working on HIV/AIDs in Swaziland met to select 11 sub-populations deemed vulnerable and at high risk of HIV infection for the first round of BSS.

Although it is important in a generalized epidemic to expand prevention efforts to those with lower risk of transmitting the virus, researchers must not lose sight of the groups in the general population that are influencing the epidemic. Population groups practicing high levels of risk behavior have a great impact on the spread of HIV infection in generalized epidemics, so it is important to maintain, improve and expand targeted interventions for these groups while also scaling up interventions in the general population and logically monitoring behavioral trends. In this context, it is appropriate that surveys concentrate on subsets of the general population that may interact with sex workers or have multiple partners.

**Female sex workers (FSWs)** influence the dynamics of the HIV epidemic because their work involves multiple sexual relationships that expose them and their clients to HIV infection. The survey among sex workers was conducted at night with help from their peers.

**Military men** are mobile due to nature of their jobs, and usually work away from their families. These factors make military personnel vulnerable to HIV infection, as they are exposed to risky sexual behaviors such as engaging in non-regular sexual relationships. Men of all military ranks at nine units were randomly selected and interviewed.

**Police officers** are deployed in different areas of the country and frequently work away from their families, predisposing them to risky sexual behaviors. Policemen from 25 police stations were randomly selected and interviewed.

**Watchmen** stay away from their families for long hours, with a significant proportion working throughout the night factors that may predispose them to risky sexual behaviors. Watchmen were randomly selected and interviewed on company premises at 3 p.m., the time they assemble before being deployed to their respective workplaces.

**LDDs, Kombi drivers/assistants** are also vulnerable to HIV. These very mobile populations spend most of their time on the road, factors that subject them to engaging in risky behaviors. Routes were used as a cluster



for sampling Kombi drivers/assistants and fixed-time intervals were used to select respondents. LDD respondents were picked randomly from transport companies and border posts.

**Seasonal workers** are housed in hostels for the period they are engaged. Such accommodation arrangements do not allow the workers to stay with their families, thus predisposing them to risky behaviors. Seasonal sugar workers at Mhume Sugar Company were randomly selected and interviewed.

**Female factory workers** were considered a low-income sub-population for this BSS. Manufacturing is an important sector of the country's economy, so many rural women migrate to urban areas, leaving their families to find employment in the factories. The meager wages they earn are often not enough to support themselves and their distant families, so some resort to other livelihood strategies that may expose them to HIV infection. Women from nine factories in the Matsapha industrial site were randomly selected and interviewed.

**Youth** are particularly vulnerable to HIV infection. Worldwide, most new HIV infections occur among youth under age 25. In Swaziland, the majority of HIV-positive pregnant women attending ANC's in 2000 were young women under 25. Youth are an essential focus for HIV prevention in every sexual health program. Peer pressure plays an important role in youth conduct, so behavior change is strongly believed to have a significant impact on the epidemic's progress. For this BSS, **in-school youth** aged 15-19 from 30 schools around the country were systematically sampled and interviewed. **BSS, in-school youth** aged 15-19 from 30 schools around the country were systematically sampled and interviewed.

**Out-of-school youth** are characteristically hard to reach with HIV interventions. Many are unemployed and idle, factors that may lead youth to engage in high-risk sexual behaviors. Using the PPS sampling technique, out-of-school youth aged 15-24 who were unmarried and not cohabiting were selected from 90 Enumeration Areas (EAs) 30 from each of the three regions covered. Shiselweni region was not included in this BSS because a similar survey had recently been carried out there by UNAIDS using the same protocol. In each selected EA, respondents were selected using the "random walking" method. Eligible respondents in selected households were also contacted and interviewed.

**Students from tertiary institutions** were also included in this survey. Swazi youth who meet the requirements of tertiary institutions are usually enrolled. Most come from environments like boarding schools, where they have been confined under the stringent guidance of teachers. Tertiary students are usually independent with limited parental supervision. These factors are thought to predispose tertiary students to engaging in risky behavior, making them vulnerable to HIV infection. Students in seven tertiary institutions were randomly selected and interviewed.



### 3.3 Data Management

This BSS used standard FHI questionnaires, with modifications for country-specific issues, administered by trained interviewers under close supervision by a team of supervisors. Data were entered and analyzed using Statistical Package for Social Sciences (SPSS).

### 4.0 Survey Results

Key results are presented in the following order:

- Adult male populations: military, police, watchmen, LDDs, Kombi drivers/assistants and seasonal workers (Table 2)
- In-school youth (Table 3)
- Out-of-school youth (Table 4)
- Tertiary students (Table 5)
- Female factory workers (Table 6)
- Female sex workers (Table 7)

Knowledge indicators comprised several parts. For example, respondents who passed “Knowledge of HIV Prevention Methods” were expected to cite correctly the three most common HIV prevention methods: abstinence, faithfulness to one uninfected partner and condom use. “No Incorrect Beliefs about AIDS” tests correct understanding regarding the most common misconceptions about HIV. To pass this indicator, respondents had to answer “Yes” to the question of whether “A healthy looking person can be HIV infected,” “No” to “Sharing meals can spread HIV” and “No” to “A person can get HIV from mosquitos.” A “non-regular sexual partner” was defined as a non-spousal and non-cohabiting partner, excluding commercial sex workers. The term “commercial sex” refers to sexual encounters where money is exchanged for sex. Full definitions of the indicators are listed in Appendix 1.



*Interviews in progress*





## 4.1 Adult Male Populations

### 4.1.1 Military, Police, Watchmen and Seasonal Workers

The survey included 387 military officers, 185 police officers, 251 seasonal workers and 167 watchmen. Military and the police respondents were older, with mean ages of 38 years for military and 33.2 years for police. Mean ages for seasonal workers and watchmen were 29.8 and 28.6 years, respectively. The majority of military officers, 73.4%, were married, as were 70.5% of seasonal workers, 66.5% of police and 39.5% of watchmen.

Significantly high proportions of both military and police populations reported being mobile, with 71.6% of military men and 60% of police having recently been away from home for more than one month. A significant proportion of seasonal workers and watchmen also reported living away from their families. Nearly one-half of seasonal workers (49.8%) and 34.3% of watchmen reported visiting home at least once a month. About 28.7% of the military, 15.7% of the police, 19.1% of seasonal workers and 12.7% of the watchmen reported that they had consumed alcohol at least once a week in the last four weeks. A small proportion of police (2.2%), military (1.3%), watchmen (1.2%) and seasonal workers (0.8%) had used injectable drugs.

Around two-thirds of the adult male surveyed populations can correctly cite the three HIV/AIDS prevention methods (Table 2), the largest groups being military. Only 48% of seasonal workers have “No Incorrect Beliefs about AIDS,” compared to 71 % of police (Table 2).



**TABLE 2 ADULT MALE POPULATIONS**

<b>BSS Indicators</b>	<b>Military</b>	<b>Police</b>	<b>Seasonal workers</b>	<b>Watchmen</b>	<b>KOMBI DRIVERS &amp; ASSISTANTS</b>	<b>LONG DISTANCE DRIVERS</b>
Knowledge of HIV prevention Method	72.4% 280/387	69.7% 129/185	60.2% 151/251	69.5% 116/167	63.5% 219/345	67.5% 83/123
NO incorrect beliefs about AIDS	58.9% 228/387	71.4% 132/185	48.6% 122/251	55.1% 92/167	51.0% 176/345	54.5% 67/123
Sex with non-regular sexual partner(s) in the last 12 months	57.7% 212/387	38.4% 71/185	30.7% 77/251	49.1% 82/167	57.7% 199/345	28.5% 35/123
condom use at last sex with a non-regular partner	59.4% 126/212	73.2% 52/71	29.9% 23/77	59.8% 49/82	59.8% 119/199	57.1% 20/35
Sex with commercial sex worker(s) in the last 12 months	0.8% 3/387	-	0.4% 1/251	0.6% 1/167	2.3% 8/345	4.8% 6/123
*condom use at last sex with a commercial partner	- 0/3	- 0/0	-	- 1/1	- 6/8	- 4/6
Reported episode of STIs in the last 12 months	12/1% 47/387	6.5% 12/185	10.0% 32/251	4.8% 23/167	4.3% 15/345	5.7% 33/123
Ever tested for HIV	25.0% 96/387	19.5% 36/185	12.7% 32/251	13.8% 23/167	11.6% 40/345	26.8% 33/123
Accepting attitude towards people living with HIV/AIDS**	34.0% 128/376	36.6% 67/183	23.9% 59/246	41.5% 68/164	29.7% 102/345	26.8% 33/123

*\*Sample sizes too small for any meaningful inferences to be made*

*\*\*Please check Appendix 1 for definition (no stigmatizing attitude).*



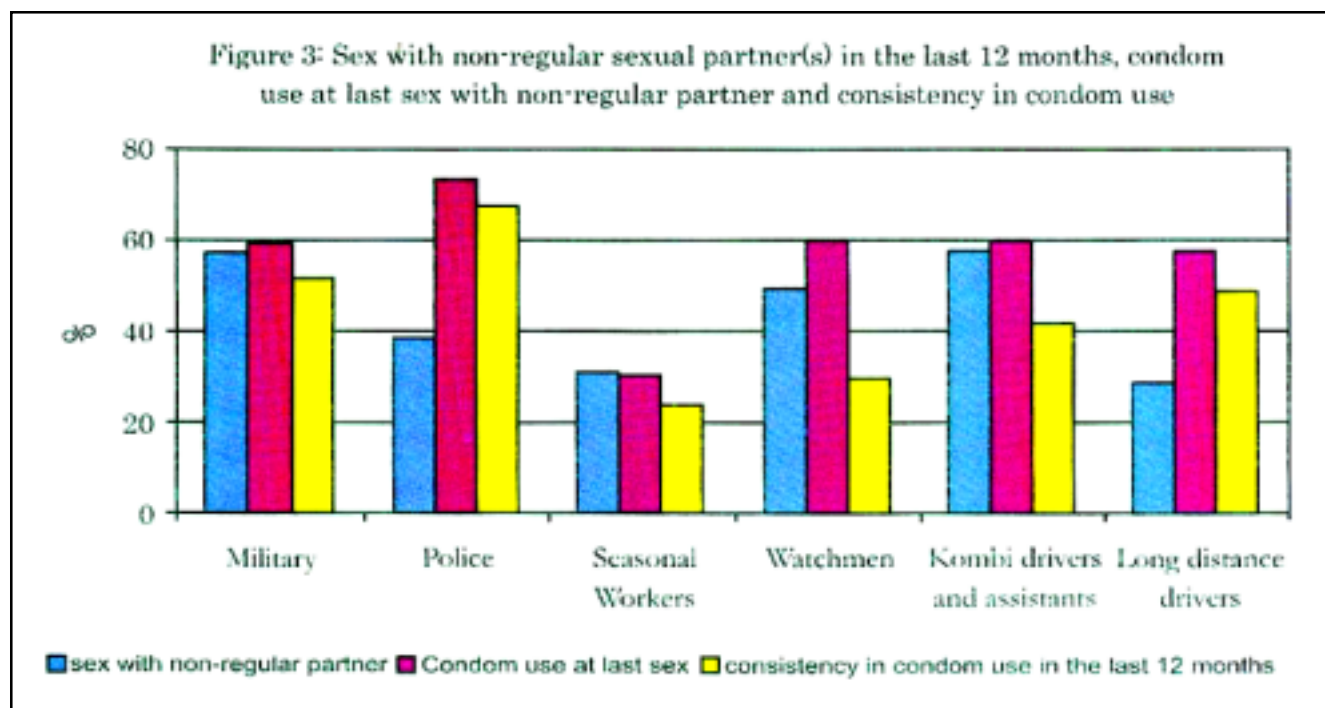
This high level of knowledge did not match the desired sexual behavior. Significantly large proportions of the surveyed adult populations engaged in non-regular sexual relationships in the last 12 months, as shown in Table 2. More than half (54.8%) of the military, 49.1% of watchmen, 38.4% of police and 30.7% of seasonal workers reported having sex with a non-regular sexual partner during that period. Multiple sexual relationships were common across all groups. The majority of police (59.7%), watchmen (61.4%) and seasonal workers (65.8%) who reported having sex with non-regular sexual partners in the last 12 months had one such partner in that period, with the remainder having two or more partners. One-half of the military reported one non-regular sexual partner, with the other half having two or more such partners. Married men reporting non-regular sexual relationships were common across all surveyed adult male populations. Among married seasonal workers and watchmen, the proportions reporting sex with non-regular sexual partners in the last 12 months were 14.7% and 16.9%, respectively.

Condom use with non-regular sexual partner(s) was relatively high. Among the surveyed adult population reporting having sex with a non-regular sexual partner(s), 73.2% of the police, 59.8% of the watchmen, 59.4% of the military and 29.9% of the seasonal workers reported using a condom at last sex with a non-regular sexual partner. Consistent use of condoms using a condom in every sexual encounter with a non-regular sexual partner in the last 12 months was 67.6% for police, 51.7% for military, 29.6% for watchmen and 23.6% for seasonal workers. These findings indicate that condoms are still not used consistently in all groups as shown in figure 3.



*Adult males are also concerned about the Spread of HIV*





Very few members of the surveyed adult populations reported having sex with a commercial sex worker(s) in this survey. A small proportion (0.8%) of the military, 0.6% of watchmen and 0.4% of seasonal workers reported having sex with commercial sexual partner(s) in the last 12 months. None of the policemen reported having sex with a commercial sex worker. Sample sizes for the military, watchmen and seasonal workers reporting sex with commercial sex worker(s) were too small to make meaningful inferences about condom use in these types of sexual relationships.

More than 97% of the surveyed adult populations had heard about STIs. knowledge of STI symptoms was relatively high, with a majority spontaneously identifying genital ulcers/sores and genital discharge as symptoms of male STIs. Reported incidence of STIs in the last 12 months was rather high in all surveyed adult populations. About 12.1% of the military men, 10% of seasonal workers, 6.5% of police and 4.8% of watchmen reported at least one episode of urethral discharge and/or a genital ulcer in that period.

The proportion of surveyed adult populations who said they had ever had an HIV test was 25% for military, 19.5% for police, 13.8% for watchmen and 12.7% for seasonal workers. Few respondents reported having an HIV test in the last 12 months.



When respondents were asked if they would be willing to care for a family member sick with HIV/AIDS, the majority (more than 90%) said they would be willing to do so for both male and female relatives. However, seasonal workers reported slightly more willingness to care for a male relative than a female relative with HIV/AIDS (91.6% vs. 88.8%). When asked if they would keep secret the fact that a family member became ill with HIV/AIDS, 28.1% of watchmen, 34.3% of seasonal workers, 37.3% of police and 37.7% of military said they would keep it secret. Except for watchmen (41%), only around one-third of the target populations demonstrated “Accepting Attitudes toward People Living with HIV/AIDS.” Most of the adult groups expressed at least one stigmatizing attitude.

Among the surveyed population, television and print media were the most commonly cited sources of information on HIV/AIDS, with 80-90% reported having heard HIV/AIDS messages over the radio.

The proportion of respondents who had watched TV programs/adverts on HIV/AIDS/STIs in the last four weeks ranged from 50-87%, and those who had read/seen information on HIV/AIDS in the print media ranged from 33.3% among seasonal workers to 89.7% for police. The most commonly cited sources of print media information were leaflets, newspapers and posters.

#### **4.1.2 Transport Workers: LDDs and Kombi Drivers/Assistants**

The survey included 123 LDDs and 345 Kombi drivers/assistants. The surveyed LDDs were older than the Kombi drivers/assistants, with mean ages of 35.3 and 26.9 years respectively. The majority (82.1%) of LDDs reported being married, compared to just 25.2% of Kombi drivers/assistants.

Both LDDs and Kombi drivers/assistants reported significant mobility, with 43.9% of LDDs and 36.7% of Kombi drivers/assistants reporting recently being away from home for more than one month. About 27.6% of LDDs and 22.1 % of Kombi drivers/assistants reported consuming alcohol at least once a week in the last four weeks, and a small percentage (0.6%) of Kombi drivers/assistants had also used injectable drugs. All (100%) of LDDs and Kombi drivers/assistants had heard about HIV/AIDS. Both groups displayed high levels of knowledge of all three appropriate ways of preventing HIV/AIDS 67.5% and 63.5%, respectively. There was little difference between the two groups regarding “No Incorrect Beliefs about AIDS,” with 51 % of Kombi drivers/assistants and 55% of LDDs passing this indicator.

More than half (57.7%) of Kombi drivers/assistants and 28.5% of LDDs reported having sex with a non-regular partner in the past 12 months. Of Kombi drivers/assistants who reported having sex with a non-regular sexual partner, around half (50.2%) had one sexual partner with the remainder having two or more partners in that period.





Among LDDs who reported having sex with a non-regular partner in the last 12 months, 43.8% had one partner and the remainder had two or more. Condom use with non-regular sexual partners during the last sexual encounter was 57.1% for LDDs and 59.8% for Kombi drivers/assistants. A small proportion of LDDs (4.8%) and Kombi drivers/assistants (2.3%) reported having sex with commercial sex worker(s) in the past months. The sample sizes were too small to make any meaningful inferences on condom use in these types sexual encounters.

STI awareness was generally very high, with 100% of LDDs and 95.4% of Kombi drivers/assistants having heard of STIs and able to identify genital ulcers/sores and genital discharge as male symptoms. The report incidence of STIs (urethral discharge and/or genital ulcer) was 5.7% among LDDs and 4.3% among Kombi drivers/assistants in the last 12 months.

Respondents were asked if they had ever had an HIV test and the period in which the test was done. Among LDDs, only slightly more than one-quarter (26.8%) had ever been tested for HIV, with the majority having the test within the last 12 months. Only a few (11.6%) Kombi drivers/assistants had ever had an HIV test.

## 4.2 Youth Populations

### 4.2.1 Male and Female In-school Youth (Aged 15-19 Years)

A total of 968 young people aged 15-19 years still attending school were included in the BSS. Overall mean age of this group was 17.2 years (17.5 for males and 17 for females).

Few of these youth (10.8%) reported consuming alcohol in the last four weeks, with males more likely than females to consume (17.9% vs. 5.8%). Of more concern was that 0.1% of the youth had used heroin and about 1.9% reported ever using dagga.

An overwhelming majority of in-school youth (99.9%) had heard about HIV/AIDS. Approximately 60% were able to cite the three most common HIV protection methods, with no significant differences between the sexes. Only around one in five in-school youth had “No Incorrect Beliefs about AIDS,” with no statistically significant differences between boys and girls.

More than 70% of in-school youth reported never having sexual intercourse; 28.3% reporting ever have sex. Respondents in the Lubombo region had a slightly higher proportion of youth reporting ever having sex compared to youth in the other two regions, but regional variations were not statistically significant. Of 274 in-school youth who reported ever having sex, 60.4% were males and 39.6% were females. The overall mean age at first sex was 16.3 years (16.4 for males and 16.1 years for females). Mean age of sexual partner first sexual contact was 15.1 for males and 20 for females. This indicates that females tend to have sex with older sexual partners, while males tend to have sexual partners of similar age.



About 15.7% of in-school youth reported having sex with non-commercial sexual partner(s) in the last 12 months. Of those who reported ever having sex, more than half (55.5%) were sexually active in the last 12 months. The majority of these youth (67.5%) had one sexual partner and the rest had two or more partners during that period. Regional variations in proportions of youth reporting engaging in non-commercial sex were not statistically significant. (See Table 3.)

Condom use at first sexual encounter was relatively high (74.5%). Youth in the Hhohho region reported the highest condom use (89.5%) at first sex, while those in the Lubombo region reported the lowest rate (59.5%), as shown in Table 3. This difference was statistically significant.

Condom use with non-commercial sexual partner(s) at last sex was also high across all surveyed youth (84.8%). Regional variations in condom use were not statistically significant. Youth who did not use a condom most often cited non-availability (22.7%) and trusting a partner (22.7%) as reasons. A small proportion of youth (0.1%) reported having sex with a commercial sex worker in the last 12 months, with none reporting condom use. Awareness of condoms was high among youth, with 97% reporting they knew places where condoms could be obtained.

A high proportion of youth (98.1%) had heard about STIs, but knowledge of symptoms was relatively low. The most commonly cited symptoms in females were genital sores/ulcers and genital discharge, and for males, genital sores/ulcers and burning pain during Urination. Very few (0.5%) reported ever having at least one episode of STI in the last 12 months. Slightly more than half of in-school youth expressed at least one stigmatizing attitude about HIV/AIDS.

A majority of in-school youth reported willingness to use VCT services if the services were available. Slightly more than half of those surveyed (52.7%) knew where to go for an HIV test. Only 6.3% of youth had ever had an HIV test, of which 83.6% reported having it done voluntarily and 16.4% saying it was required. Not all youth having an HIV test received pre- or post-test counseling: 78.7% received pre-test counseling and 55.7% received post-test counseling. Only about 66% ever received their HIV test results.



**TABLE 3: MALE AND FEMALE IN SCHOOL YOUTH BY REGION**

<b>BSS indicators</b>	<b>Hhohho</b>	<b>Lubombo</b>	<b>Manzini</b>	<b>National</b>
Knowledge of HIV Prevention method	58.6% 188/321	62.2% 74/119	60.6% 319/526	60.0% 581/968
No incorrect Beliefs About AIDS	21.8% 70/321	17.6% 21/119	19.9% 105/526	20.4% 197/968
Ever had Sex	26.8% 86/321	31.1% 37/119	28.6% 151/525	28.3% 274/967
Condom use at first sex	89.5% 77/86*	59.5% 23/37*	69.5% 105/151	74.0% 204/274
Sex with non Commercial sexual Partners in the last 12 months	13.7% 44/321	20.2% 24/119	15.9% 84/528	15.7% 152/968
Condom use at last non Commercial sex	94.4% 38/44*	83.3% 20/24*	83.3% 71/84*	84.8% 129/152
Commercial sex among Youth in the last 12 months	- 0	- 0	0.2% 1/528	0.1% 1/968
Condom use at last Commercial sex among youth	- -	- -	- 0/1*	- 0/1*
Reported episode of STIs in the last 12 months	0 0/321	0.8% 1/119	0.8% 4/528	0.5% 5/968
Ever tested for HIV	5.3% 17/321	4.2% 5/119	7.4% 39/528	6.3% 61/968
Accepting Attitudes Towards people living with HIV/AIDS**	39.8% 128/321	48.7% 58/119	42.9% 224/521	42.7% 410/961

*\*Sample sizes too small; data should be interpreted with extra caution*

*\*\*Please check appendix 1 for definition (no stigmatizing attitude)*



#### 4.2.2 Male and Female Out-of-school Youth (Aged 15-24 Years)

A total of 1,776 unmarried male and female out-of-school youth were included in the BSS. The overall mean age of out-of-school youth was 19.7 years (20.1 for males and 19.4 for females). Of the group, 90.5% had ever attended school. Slightly more females (91.6%) than males (89.3%) reported having attended school, but the difference was not statistically significant. A significantly higher proportion of females than males reported having completed primary and secondary schooling.

About 12.6% of these youth indicated they had consumed alcohol in the last four weeks, and 5.8% reported using drugs such as mandrax, cocaine and dagga. A small percentage (0.9%) reported sniffing glue.

A significantly high proportion (98.7%) of out-of-school youth had ever heard of HIV/AIDS. Knowledge of three preventive methods was similar to other surveyed groups, with no significant gender difference. Fewer out-of-school youth than in-school youth had “No Incorrect Beliefs about AIDS.”

The overall mean age at first sex for out-of-school youth was 19 years (19.8. for males and 18.3 for females). Among those aged 15-19, mean age at first sex was 17.4 years, and among those aged 20-24, mean age at first sex was 19.9 years. Mean age of sexual partner at first sex was 28.7 for females and 22.4 years for males. Females tended to have sex with much older sexual partners.



*Peer educators also need to be provided with accurate information to pass on to their peers*



A significantly high proportion of out-of-school youth reported ever having sex (69.3%), with youth in the Manzini region reporting the lowest (64.6%) and Hhohho region the highest (73.3%). This difference was statistically significant. Nearly half of those who reported ever having sex (49%) were sexually active in the last 12 months.

Further analysis showed that 64% of out-of-school youth aged 20-24 were sexually active in the last 12 months. A significantly high proportion of the youth aged 15-19 (33.2%) were also sexually active in the same period.

Of out-of-school youth who reported ever having sex, condom use at first sex was 37.3%. Youth in Lubombo reported the lowest condom use at first sex (33.3%) compared to youth in the other two regions, as indicated in Table 4. Regional variations in condom use were not statistically significant.

The overall proportion of youth having sex with a non-commercial sexual partner in the last 12 months was 49.2%, ranging from 47.8% in the Lubombo region to 52.7% in the Hhohho region. Condom use at last sex with a non-commercial sexual partner was 49.9%, with youth in the Manzini region reporting the highest rate (57%) and youth in Lubombo reporting the lowest (41.6%). Among those who did not use a condom, trust of the partner was the most commonly cited reason (34.3%), followed by partner objecting (12.5%).

Further analysis of data on sexual behaviour by gender among out-of-school youth across the three regions showed that male youth in the Manzini region reported being less sexually active than both males and females in all three regions. These youth also reported the highest condom use with non-commercial sexual partners. They also reported lowest rates of STIs in the last 12 months. A small proportion of out-of-school youth across all regions (0.5%) reported sex with commercial sex workers in the last 12 months.

A high proportion of respondents were aware of places to obtain male condoms, but very few reported ever hearing of a female condom. Sexually active out-of-school youth were more aware of where to obtain a male condom (90.9%) than non-sexually active (79%).

About 90% of out-of-school youth had heard about STIs, but their knowledge of STI symptoms was relatively low. Those aged 20-24 had higher knowledge (55.5%) than those aged 15-19 (44.5%). Most commonly cited STI symptoms were genital ulcers/sores. Reported incidence of STI episodes in the last 12 months among these youth was 5.8%, ranging from 4.7% in the Hhohho region to 7.4% in Lubombo region. Regional differences were not statistically significant.





Youth were also asked if they had ever had an HIV test. A small minority had ever been tested (9.7%); of these, 60.9% had been tested in the last 12 months. About 50.7% of youth knew of a place they could go for HIV testing. Not all who had an HIV test were counseled: 68.4% received pre-test counseling and 76.4% received post-test counseling; 80% received their test results.

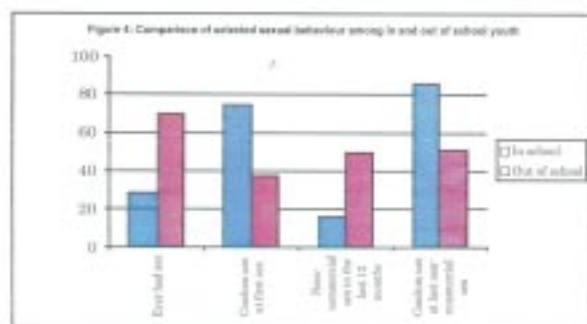


*Youth at FLAS recreational centre*



*Youth meetings also empower them with information*





**TABLE 4: MALE & FEMALE OUT OF SCHOOL YOUTH BY REGION**

BSS indicators	Hhohho	Lubombo	Manzini	National
Knowledge of HIV Prevention method	64.7% 290/448	64.2% 442/689	64.9% 415/639	64.6% 1147/1776
No incorrect Beliefs About AIDS	9.8% 44/448	11.5% 79/689	12.7% 81/639	11.5% 204/1776
Ever had Sexual intercourse	73.3% 328/448	71.0% 489/689	64.6% 413/639	69.3% 1230/1776
Condom use at first sex	38.6% 126/328	33.3% 163/489	41.2% 170/413	37.3% 459/1230
Sex with non Commercial sexual Partners in the last 12 months	52.7% 236/448	47.8% 329/689	48.4% 309/639	49.3% 874/1776
Condom use at last non Commercial sex	52.1% 123/236	41.6% 137/329	57.0% 176/309	49.9% 436/874
Commercial sex among Youth in the last 12 months	0.9% 4/448	0.3% 2/689	0.3% 2/639	0.5% 8/1776
Condom use at last Commercial sex among youth	- 4/4	- 0.5	- 2/2	- 5/8
Reported episode of STIs in the last 12 months	4.7% 21/448	7.4% 51/689	4.9% 31/639	5.8% 103/1776
Ever tested for HIV	11.4% 51/448	10.7% 74/689	7.5% 48/639	9.7% 173/1776
Accepting Attitudes Towards people living with HIV/AIDS**	34.7% 153/441	34.7% 235/678	38.4% 243/633	36.0% 631/1752

*\*Sample sizes too small for any meaningful inferences to be made*

*\*\*Please check appendix 1 for definition (no stigmatizing attitude)*



### 4.3 Students from Tertiary Institutions

A total of 1,332 students from tertiary institutions were included in the BSS, of which 56.8% were males and 43.2% were females. The overall mean age of the students was 22.5 years. More than one-quarter (26.1%) of these students reported consuming alcohol in the last four weeks, 8.4% had used dagga and less than 1% had tried heroin, cocaine or mandrax.

Almost all students from tertiary institutions (99.8%) had heard about HIV/AIDS. Knowledge of prevention methods (abstinence, faithfulness to one partner and condom use) was slightly higher among females than males. A similar percentage of male and female tertiary students had “No Incorrect Beliefs about AIDS” (79% and 80%, respectively).

Approximately 57% of tertiary students reported having sex in the last 12 months. The overall mean age at first sex was 17.9 years, with 41.7% reporting first sex between age 16 and 19, and 10.4% when they were 15 or below. Non-regular sexual relationships were also common among tertiary students, with 47.6% and 39.5% of male and female tertiary students, respectively, reporting sex with non-regular sexual partner(s) in the last 12 months. (See Table 5.) Of those reporting non-regular sexual relationships in the last 12 months, 67.6% reported having one non-regular partner, with the remainder having two or more partners. Among students who had sex with a non-regular partner, 86.9% of males and 55.4% of females reported using a condom at the last sexual encounter.

The most frequently mentioned reason for not using a condom with a non-regular partner was trust of the partner. A small percentage of male students (0.3%) reported having sex with commercial sexual partner(s). None of the female students reported having sex for money.

Almost all tertiary students (98.1%) had heard about STIs. The most commonly mentioned symptoms in women were genital ulcers and discharge; these were mentioned primarily by female students. Male STI symptoms were cited as genital ulcers and burning during urination, mostly mentioned by males. Overall reported episode(s) of STIs among tertiary students in the last 12 months was 5.1%, with females having a higher rate (6.6%) than males (3.7%).



**TABLE 5: STUDENTS FROM TERTIARY INSTITUTION**

<b>BSS indicators</b>	<b>Male</b>	<b>Female</b>
Knowledge of HIV prevention method	57.9% 438/757	61.0% 351/575
No incorrect beliefs about AIDS Information	79.2% 592/757	80.7% 464/575
Ever had sex	76% 575/757	65.2% 375/575
Sex with non-regular partners in the last 12 months	47.6% 360/757	39.5% 227/575
Condom use at last sex with a non-Regular partner	86.9% 311/358	55.4% 179/323
Sex with commercial partners in the Last 12 months	0.3% 2/757	0% 0/575
Condom use at last sex with a Commercial partner	-* 0.5	-* 0
Reported episode of STIs in the last year	3.7% 28/757	6.6% 38/575
Ever tested HIV	14.8% 112/757	19.1% 110/575
Accepting attitudes towards people living with HIV/AIDS**	29.4% 220/749	31.3% 178/568

*\*Sample sizes too small for any meaningful inferences to be made*

*\*\*Please check appendix 1 for definition (no stigmatizing attitude)*



#### 4.4 Female Factory Worker

A total of 231 female factory workers were interviewed. The mean age of this population was 31.2 years, with 98.3% having been to school. Mean age at first marriage was 24.6 years. Of these factory workers, 42.9% reported being currently married, with 26% of this group not staying with their spouses and another 18.2% staying with a sexual partner other than their spouse. Of the 56.3% of surveyed factory workers who were not married, 27% were staying with a sexual partner (cohabitating). About 40% of the factory workers had stayed away from home for more than one month. About 10% of the surveyed factory workers reported consumption of alcohol in the last 4 weeks. An insignificant proportion reported ever using drugs.

Nearly all factory workers surveyed (99.1%) had heard about HIV/AIDS, with 73.6% able to cite appropriate ways of preventing HIV/AIDS. Almost half of the women had “No Incorrect Beliefs about AIDS.”

About one-third (32.5%) reported having sex with a non-regular sexual partner(s) in the past 12 months; of these, 89.2% reported having one partner in that period. About half (48%) used condoms at last sex with this partner. Among those who did not use condoms, trust of the partner (29.4%) was the most-cited reason. A significant proportion (36.6%) reported never using a condom with a non-regular partner. Only 0.4% reported having sex in exchange for money in the last 12 months.

The proportion of factory workers who reported having a regular sexual partner in the last 12 months was 52.4%; condom use at the last sexual encounter in this relationship was 17.4%, much lower than condom use in non-regular sexual relationships. Trust of the partner was the most-cited reason for not using condoms in regular sexual relationships.

About 97.8% of factory workers had heard about STIs, with the majority of them spontaneously identifying genital ulcers/sores and foul-smelling discharge as STI symptoms in females. A relatively high reported incidence of STIs (14.7%) was recorded among the female factory workers in the last 12 months.

When asked about HIV testing, 11.3% said they had ever taken an HIV test; 38.5% of those who reported being tested said it was not voluntary. Nearly half (46.2%) of those ever taking an HIV test had done so in the last 12 months. The majority (86.3%) reported willingness to use VCT services if available, and 64.1% knew of a facility where they could have a test. Slightly more than half of the women said that if a member of the family became sick with HIV/AIDS, they would not want it kept a secret.



**TABLES 6: FACTORY WORKER**

<b>BSS indicators</b>	<b>%</b>
Knowledge of HIV prevention method	71.4% 165/231
No incorrect beliefs about AIDS Information	47.6% 110/231
Sex with non-regular sexual partners In the last 12 months	32.5% 75/231
Condom use at last sex with a non-Regular partners	48% 36/75
Sex with commercial partner in the Last 12 months	0.4% 1/231
Condom use at last sex with a Sexual partner	0
Reported episodes of STIs in the last year	14.7% 34/231
Ever tested HIV	11.3% 26/231
Accepting attitudes towards people living With HIV/AIDS*	29.9% 62/207

*\*Please check appendix 1 for definition ( no stigmatizing attitude)*

## 4.5 Female Sex Workers

A total of] 37 FSWs were interviewed in this BSS. The mean age of FSWs was 22 years. More than 90% were single and 9.4% reported being currently married. About 90.5% of FSWs had been to school, with 50% having secondary education and 16.9% having attained at least a secondary school education. Slightly more than one-quarter (27.7%) of FSWs were engaged in employment activities other than sex work: 31.6% were dressmakers/hawkers, 26.3% were domestic workers and 15% were factory workers. About 60% of FSWs had dependants; the mean number of dependents was 4.3. The majority of FSWs (87%) had consumed alcohol in the last four weeks. A small percentage (0.7%) had used injectable drugs. Other drugs use by FSWs included dagga, mandrax and cocaine. Less than 5% of FSWs had sniffed glue.





All FSWs had heard about HIV/AIDS, and about half could correctly name all three prevention methods and had “No Incorrect Beliefs about AIDS.” Slightly more than one-half (53.2%) of FSWs reported having sex with one to four paying clients in a week, with 22.6% reporting five to nine clients and 12.4% reporting 10 or more clients weekly.

One sex worker reported having sex with 21 clients in seven days. Worth noting is that 54.7% of FSWs did not have non-paying sexual partners. The amount of money FSWs received in exchange for sex during the last day they worked varied a great deal, from E 10 to E900 (U S \$ 1-\$90).

Condom use among FSWs with their commercial partners during their last working day was found to be high. About 90% reported using a condom during the last sexual encounter with a paying partner. Of those who did not, partner’s objection (38.5%) was the most-cited reason; respondent being drunk (15.4%) was another. A significantly high proportion of FSWs (74.4%) reported consistency in condom use with paying sexual partners but consistency was lower (45.8%) with non-paying partners. Of FSWs who reported having sex with a non-paying partner, 60% reported using a condom at last sex.

Slightly more than 90% of FSWs had heard about STIs, and 16.1% reported having an episode of STIs in the last 12 months. More than one-quarter (27%) had ever been tested for HIV, and nearly three-quarters (75.7%) of those tested had done so in the last 12 months. Knowledge of an HIV testing facility among FSWs was 61.3%.



TABLES 7: FEMALE SEX WORKER

BSS indicators	%
Knowledge of HIV prevention method	54.0% 74/137
No incorrect beliefs about AIDS Information	51.0% 176/345
Sex with paying clients in the last 7 days	97.8% 120/134
Condom use at last sex with paying client	90.0% 120/134
Sex with a non-paying sexual partner in the Last 7 days	44.5% 60/137
Condom use at last sex with a non-paying Sexual partner	60.0% 36/60
Consistent (100%) condom use with paying Clients	74.4% 96/129
Reported episodes of STIs in the last 12 months	16.1% 22/137
Ever tested HIV	27% 27/137
Accepting attitudes towards people living With HIV/AIDS*	70.5% 91/129

*\*Please check appendix 1 for definition ( no stigmatizing attitude)*



## 5.0 Discussion and Conclusions

The high level of awareness about HIV/AIDS and knowledge of preventive practices in this survey indicate that the majority of the Swazi population, both youth and adults, have heard about HIV/AIDS and STIs. This may be a result of AIDS campaign efforts in the country. But the significantly high proportion of non-regular and multiple sexual relationships across all surveyed populations shows that the high level of HIV preventive knowledge does not match the desired safer sexual behavior. These behaviors were exhibited in both married and unmarried respondents.

Both in- and out-of-school youth start engaging in sex at an early age. Starting sex at an early age makes youth more vulnerable to HIV infection, particularly in the presence of high HIV prevalence rates in the general population, as is the case in Swaziland. The chances of young girls being infected are increased by the fact that young females tend to have sex with men who are much older than themselves the “sugar daddy syndrome” because chances are higher that their older male partners are HIV-infected.

Although both in- and out-of-school female youth reported having sex with older partners, the partners of out-of-school females were older than those of in-school females. Unemployment is a common phenomenon among out-of-school youth in most countries. It is likely that some of these out-of-school youth who have sex with older sexual partners do it to earn a livelihood.

Age at first sex for 15-19 year-old males and females both in and out of school was similar, but out-of-school youth in this age group were about twice as sexually active as in-school youth of the same age.

Condom use was relatively high in non-regular sexual relationships in the adult population, at first sex among youth and in non-commercial sexual relationships among youth. Although condom use rates in this survey seem relatively high, they are not high enough, considering the significant levels of non-regular and multiple sexual relationships shown in the survey.

Out-of-school youth were less likely to use condoms than in-school youth, perhaps because of exposure to health and HIV/AIDS education in schools. Reasons cited by youth for not using condoms included non-availability and partner objection. Condoms need to be made more accessible and available to potential users, both youth and adults. Generally, condom use improved significantly as perceptions of risk in sexual behaviors increased. Condom use in non-regular sexual relationships was higher than in regular sexual relationships. This survey also showed that consistent use of condoms was not 100% among those reporting to be using them.



Awareness about STIs was very high, but knowledge of symptoms was relatively low among youth. Reported incidence of STI episodes was rather high in all surveyed populations, with female factory and sex workers reporting the highest rates. Out-of-school youth had a higher reported incidence of STIs than in-school youth; this corroborates the survey's finding that out-of-school youth were more sexually active and less likely to use condoms than in-school youth. The high reported incidence of STIs among commercial sex workers in spite of their reported relatively high condom use rates raises two issues. Consistency of condom use among FSWs was not 100%, although this survey found it relatively high with paying clients. As well, FSWs may be getting STIs from their non-paying sexual partners who, in most cases, are regular partners with whom condom use is relatively low.

Willingness to use an HIV testing facility if available was high across all surveyed populations. The proportion of those ever tested for HIV was low in spite of reported high levels of willingness to have an HIV test. Limited knowledge of where to go for an HIV test was observed mainly among youth. This may serve as a "proxy indicator" of the availability of VCT services in the country. Surprisingly, many people who reported having an HIV test did not receive pre- or post-test counseling.

Stigma and misconceptions about HIV/AIDS were observed across all surveyed populations in spite of high levels of knowledge about HIV/AIDS. Stigma and misconceptions are likely to have a negative effect on care and support programs for people infected and affected by HIV/AIDS. Stigma may also pose an obstacle to behavior change if not addressed. However, it was encouraging that the majority of the surveyed population expressed willingness to care for a family member if he or she falls ill with HIV/AIDS.



*The burden for caring for the sick falls on everyone in the community.*



## 6.0 Recommendations

According to the survey, the Swazi people are highly knowledgeable about HIV/AIDS/ STIs, though this knowledge has not translated into desirable behavioral change. Across all surveyed populations, respondents reported multiple sexual partners. Sex with non-regular partners (“casual sex”) was highly prevalent, as was premarital sex among in- and out-of-school youth. Condom use during last “casual” encounter and during last premarital encounter among youth was relatively high, though condoms were not used consistently.

Given this situation, there is urgent need to improve, intensify and scale up targeted HIV/AIDS prevention and care programs in workplaces, for in- and out-of-school youth, in tertiary institutions and among hard-to-reach populations (e.g., sex workers, LDDs, kombi drivers and assistants). For LDDs and kombi drivers, interventions should be implemented at border posts and bus terminals at times convenient to both these groups. It is also important to intensify and expand interventions geared toward the general population.

The Government needs to develop a national Behavior Change Communication (BCC) strategy with appropriate messages and strategies for the various target populations. Interventions should include a combination of mass media, drama, music, person-to-person interaction, peer education, life-skills training for youth and counseling and education. The BCC strategy will help ensure that implementers speak with the same voice and avoid sending mixed messages. The strategy will also minimize misconceptions and myths about HIV/AIDS.

In Swaziland, high incidence of STIs was reported in the last 12 months. The Government and its partners should conduct educational campaigns to improve health-seeking behavior and promote early STI detection, diagnosis and treatment. The existing health program trains health workers in syndromic management of STIs, but the training needs to be expanded to include all providers in the country, including private practitioners. Ensuring that all health facilities have adequate STI drugs and appropriately trained staff will help achieve the goal of reducing STI incidence in Swaziland.

Sex workers in Swaziland are at increased risk of HIV infection and are influencing spread of HIV to the general population. The Government and its partners need to target a range of interventions to sex workers, including peer education, condom distribution and promotion, STI case management, and discussion of risk, risk settings and risk solutions. Out-of-school youth are also at increased risk of HIV infection. Out-of-school youth reported higher levels of sexual activity than in-school youth, were less likely to use condoms than their in-school counterparts and reported higher STI prevalence. The Government needs to develop and implement policies and strategies to keep most, if not all, Swazi youth in school. For out-of-school youth, the Government and its partners should promote delay in sexual initiation, consistent availability and use of condoms, STI prevention and reduction in the number of sexual partners.



Most out-of-school youth are unemployed, which may be contributing to high-risk sexual behavior among this group. The Government, NGOs and other key partners need to equip out-of-school youth with life and entrepreneurial skills. It is also beneficial to help out-of-school youth form associations that could receive seed money for income-generation programs.

To address in-school youth, the Government should incorporate population and family life/sex education into curricula and make life-skills training available in schools. Teachers must be trained and equipped to communicate with students on issues related to HIV/AIDS/STIs. There is also a need to expand youth-friendly services and recreational centers to reach youth that may not be covered by traditional health facilities and the few available youth recreational facilities.

Female youth, in and out of school, tend to have sexual partners who are much older than them. There is urgent need for special programs to empower girl children and equip them with life and negotiation skills. Only a small proportion of survey respondents reported ever taking an HIV test; a significant proportion of those who had ever taken a test did not receive pre- or post-test counseling. Given that a high proportion expressed willingness to use VCT services if made available, it is recommended that affordable VCT services health providers to be counselors be established throughout the country. As soon as the VCT centers are established, the Government and its partners should publicize their existence and motivate use through all media, particularly radio because of its wide coverage. There is a specific need to develop counseling guidelines and training manuals and to train.

This BSS has provided valuable baseline information on behavior. It is hoped that the results of the BSS will be used to redesign and improve interventions as well as renew efforts to curtail the spread of HIV/AIDS/STIs in Swaziland. To measure the success of the interventions, it is necessary to conduct a BSS among the same target populations every two years. Additionally, more studies, mainly qualitative, need to be conducted to provide insight into some of the behaviors observed in this survey and to shed light on issues that this survey did not address.





Indicators appropriate for all target groups	
No. Sex- Specific Indicator	Denominator
<b>1. Knowledge of HIV prevention methods</b> % of target group who correctly identify 3 effective means of protecting themselves from HIV infection (prompted) by saying YES to all the three methods. <i>Correct answers: sex with one uninfected faithful partner, abstain from sex, use condoms correctly with all sex partners</i>	Entire sample
<b>2. No incorrect beliefs about AIDS</b> The number of male/female respondents who correctly respond that a person who looks healthy may pass on HIV and who also correctly reject the two most common local misconceptions about AIDS Transmission or pervention	Entire sample
<b>3. Accepting attitudes towards people living with HIV / AIDS</b>  Willingness to share meal with HIV positive persons (YES) Willingness to buy food from a shopkeeper / food seller whom one knew was HIV positive (Yes) If member of family become ill with HIV, would respondent want it to remain a secret (No) Willingness to care for a male relative infected with HIV (Yes) Willingness to care for a female relative infected with HIV (Yes) Should an HIV infected employee be allowed to continue working (Yes) Should an HIV Infected Manager be allowed to continue working (Yes) (For students only a questions on Teachers)	Entire sample

Indicators appropriate for all target groups		
No.	Sex- Specific Indicator	Denominator
1.	Number of non-regular partners during past 12 months (“on-regular” regular” defined as non-spousal, non-cohabitation) is the numerator.	Entire sample
2.	% Of target group with commercial partners during past 12 months (‘ commercial’ partners refer to individuals who received money for Sex). The numerator is the no. Of people who say yes to having commercial partners in this period)	Entire sample
3.	% of target group reporting condom use during most recent sex act with non-regular partner in last 12 months.	Number who had non-regular partner



	Numerator is the no. Of people who had no regular sexual partners in the 12 months and also used a condom at the last Sexual encounter with a non-regular sexual partner.	in last 12 months
4.	% Of target group reporting condom use during most recent sex act with Commercial partner in last 12 months	Number who had commercial partner In last 12 months
5.	% Of target group reporting consistent condom use with Commercial partners over past 12 months	Number who had commercial partner In last 12 months
6.	% Of target group reporting unprotected sex with any non-Regular or commercial sex partner during past 12 months	Entire sample (Sexually) active

#### Indicators appropriate for youth

No.	Sex-Specific Indicator	Denominator
1.	Median age at first sex.	Entire sample
2.	% Of target group with non-commercial partners during past 12.	Entire sample
3.	% Of youth reporting condom use in most recent sex act with non-Commercial partners over past 12 months	Number who had at least one non-
4.	% Of youth reporting consistent condom use with all non-Commercial partner in last 12 months	Number who had at least one non-Commercial partner in the last 12 months
5.	% Of youth reporting condom use in most recent sex act with Commercial partner	Number who had at least one commercial partner in last 12 Months
6.	% Of youth reporting unprotected sex with any non-regular or	Entire sample

#### Indicators appropriate for FSWs

No.	Sex-Specific Indicator	Denominator
1.	% of FSWs reporting condom use during most recent sex act with client.	Entire sample
2.	% of FSWs reporting consistent condom use with clients during	Entire sample





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