Responding to HIV and AIDS in Rural Lubombo Region:
A Prevention Strategy for the LUSIP Project Development Area 2008-2012

Prepared by
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Lower Usuthu Smallholder Irrigation Project (LUSIP)

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Note to the Reader

This Strategic Plan covers the period 2008-2012, coinciding with the completion of construction and resettlement activities in the Project Development Area (PDA) associated with the Lower Usuthu Smallholder Irrigation Project. It is intended that the responses in the PDA will be sustained after this period, following the completion of LUSIP-sponsored activities in the PDA.

The measurement of indicators specified in this Strategic Plan will occur at two junctures: 2010 and 2012. The first is two years after implementation start-up, while the second is upon completion of SWADE activities in the PDA, signalling full implementation of the smallholder farmers initiative.

This Strategy Document is comprised of three volumes:

Volume 1 Strategic Plan
Volume 2 Knowledge, Attitudes and Practices Study
Volume 3 Conference Proceedings

Readers who are interested in exploring the factors behind decisions arrived at in the Strategic Plan are encouraged to consult Volumes 2 and 3. Volume 2 represents findings from a knowledge, attitudes and practices study conducted in late 2006 in the Project Development Area, where quantitative interviews were conducted, complimented by a number of qualitative, focus group discussions. Volume 3 contains the results of a strategic planning conference held with stakeholders following completion of the study.
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Background and Overview

Background

Swaziland has the highest HIV prevalence rate in the world. As of 2007, out of a population of some 1 million people, some 250,000 are HIV+, and an estimated 750,000 are HIV negative. 2006 HIV seroprevalence data shows a rate among female ante-natal clinic attendees of 39.2%\(^1\). Swaziland’s small size, homogeneous culture, and good infrastructure has resulted in little differentiation across the country in terms of prevalence rates. In Lubombo Region, where LUSIP is located, the rate is 37.9%. Prevalence rates reached an astonishing 48% for young people aged 25-29, and even among 15-19 year olds, the prevalence rate is 20%. While the 2006 data suggest a decline from 2004 (where the rate was 42.6%), it is not clear whether this is evidence of a trend, or simply the result of measurement problems. It is nevertheless encouraging to note that trends in infection for 15-19 year olds suggest that there is a decline, with further evidence provided by a less dramatic, but similar decline for 20-24 year olds.

Factors behind the lower prevalence rate are not known, but it may be that there are emergent trends in terms of increased and consistent condom use, increased HIV testing, deferred start-up of sexual activity among teens, a slight reduction in the number of sexual partners, reduced infections arising from the provision of anti-retroviral drugs (reducing the degree to which those HIV+ can infect others, coupled with safer sexual behaviour among those aware of their status) and rapidly growing mortality rates due to AIDS. It has also coincided with a strengthened national response that has seen the rapid growth in prevention, care and treatment, and impact mitigation activities throughout the country. Despite the many challenges it still faces, Swaziland today is in a much better position to respond to HIV and AIDS than it was a decade ago.

Response to the Epidemic

Unfortunately, the severity of the epidemic, and the dramatic rise in new HIV infections during the 1990s, was not matched by a correspondingly strong national response. Opportunities lost due to this slow response meant that many deaths that could have been avoided were not, and the seroprevalence rate continued to rise rapidly:

Things changed rapidly in the late 1990s, culminating in the establishment of the National Emergency Response Committee on HIV/AIDS (NERCHA) in 2001, with the mandate to co-ordinate and mobilise resources for an expanded, scaled-up and co-ordinated response. Since its creation, progress has been made in terms of multi-sectoral planning, the roll-out of anti-retroviral drugs, and improved access to testing and counselling services. Progress has even been made, in recent years, in impact mitigation, with particular attention focused on orphans and other vulnerable children (OVC), and support for caregivers.

\(^1\) Unfortunately, no population-based HIV seroprevalence survey has been conducted in Swaziland, so the actual seroprevalence rate is not known. Evidence from other countries, including Tanzania, Zambia, and Kenya, suggests that the rate may be 25% lower than ante-natal clinic data suggest. If so, Swaziland’s HIV seroprevalence rate could be as low as 30%. This is still an extraordinarily high rate, and twice the rate of many neighbouring countries.
The current response is guided by “The Second National Multisectoral HIV and AIDS Strategic Plan 2006-2008”, released in early 2006 (Government of the Kingdom of Swaziland). The Vision of the Plan is (page 19) “By 2015, the people of the Kingdom of Swaziland shall have halted and reversed the AIDS epidemic resulting in improved quality of life which will be characterized by reduced HIV and AIDS related morbidity, mortality and socio-economic impact”. The Mission (page 19) is “Through this strategic plan, the country seeks to scale-up the multi-sectoral national response to HIV and AIDS and create an effective, comprehensive, decentralized, expanded, well coordinated and sustainable enabling environment at all levels”.

Under the thematic area Prevention, the following strategic areas were noted:

- Behavioural change communications.
- Blood safety.
- Prevention of transmission from mother to child during pregnancy, child birth, and through breastfeeding.
- Expanded workplace programme activities focused on prevention.
- Condom logistics, promotion and management.
- Prevention and management of sexually transmitted infections.
- Post exposure prophylaxis.
- Counselling and testing.

The Lower Usuthu Smallholder Irrigation Project

The Lower Usuthu Smallholder Irrigation Project (LUSIP) is a poverty alleviation project aimed at the transformation of smallholder agriculture in the Project Development Area (PDA) in the lowveld area of eastern Swaziland. The position of the Project in Swaziland is shown below:

The project consists principally of water infrastructure developments associated with a diversion weir on the Usuthu River, a consequent storage reservoir, a feeder canal to the reservoir and a canal from the reservoir, and a network of secondary canals linking the reservoir with irrigable lands. Over two phases, irrigation development will cover approximately 11,500 hectares. The main crop for the area is planned to be sugar, but the Project has decided to expand beyond sugar to consider a number of other cash crops. Infrastructure developments and a model of irrigation sites are shown on the following page.

It is estimated that there will be some 18,200 beneficiaries across 2,600 households, with the beneficiaries coming from the PDA itself. Additional benefits are expected to accrue to an additional 22,000 people through the creation of construction-related and seasonal jobs. Direct multiplier effects are estimated to affected two-thirds of the Lower Usuthu Basin.

While the Project is expected to result in the rapid transformation of smallholder agriculture, the Project nevertheless recognises that Swazi homesteads follow an integrated agricultural strategy that includes cropping for own use, livestock farming, off-farm employment, and cash crop production.
Construction began in early 2006, preceded by feasibility studies and detailed design. All infrastructure is expected to be completed by 2011.

The Health Response

Given the significant impacts of the Project on the lives and livelihoods of PDA residents and construction workers, LUSIP includes a health team focused on strengthening the health systems in the PDA to match the growing needs associated with Project impacts, and mitigating negative health impacts associated with construction, transformation, and implementation. The health team prepared a Comprehensive Health Mitigation Plan that formed part of LUSIP’s Comprehensive Mitigation Plan. The plan notes three phases:

1. Construction
2. Transformation of farming systems
3. Full implementation

During construction, there are particular challenges associated with the presence of large numbers of construction workers, as well as job seekers, as well as resettlement of directly affected populations. During transformation of farming systems, as homesteads re-establish themselves and begin to transform their agricultural systems, social cohesion will be challenged, there will be gaps in income, food insecurity is likely, and overall vulnerability will worsen. Following transformation (for those homesteads that indeed make the transformation), the PDA will be a very different place compared to before the Project. Substantially enhanced economic activity may result in reduced social capital and weakened social cohesion, as well as increased urbanisation, traffic, and migration.

While bringing development to the area, project activities are also resulting in changes that can significantly increase the risk of HIV infection. In a strongly traditional, rural area with a high HIV prevalence level, these risks are enormous. These risks affect homesteads themselves, but will also substantially affect the viability of the commercial farming systems that the success of the Project depends on. In this respect, HIV and AIDS affect the core mandate of the Project itself.

Responding to HIV and AIDS in the PDA

To mitigate the many impacts of HIV and AIDS on the Project, and to ensure that PDA homesteads receive the support they deserve due to the changes they encounter, LUSIP has endeavoured to include an HIV and AIDS response as part of its activities under the comprehensive mitigation plan. Given the severity of the epidemic, and considering the need to institute a long-term response, LUSIP is supporting the development of a PDA-based response (led by an HIV/AIDS Steering Committee comprising PDA residents and other stakeholders), and the building of a broad-based coalition to effect a response commensurate with need.
LUSIP’s role will be to facilitate, but not lead, such a response, supporting the sustainability of activities carried out in the PDA.

In 2005, using various channels of communication with PDA residents, LUSIP began a process of dialogue about HIV and AIDS in the PDA. This resulted in the formation of the HIV/AIDS Steering Committee, which included non-state actors and Government officers. In subsequent meetings between LUSIP and the Committee, it was decided to commission a Strategic Planning exercise involving:

- Conduct of a knowledge, attitudes and practices (KAP) study.
- National and regional stakeholder discussions.
- Holding a strategic planning workshop with local and regional stakeholders.
- Preparing a Strategic Plan, in collaboration with NERCHA and the HIV/AIDS Steering Committee.

KAP Study Findings

The KAP study included the design and administration of a highly-structured quantitative questionnaire targeting males and females aged 18-34, as well as focus group discussions with a variety of age groups and people across socio-economic status, and key informant interviews with opinion leaders.

The KAP study found considerable scope for enhancing levels of understanding about HIV and AIDS, the need for attitudinal change, and the importance of improved practices in reducing the risk of new HIV infection. Overall, while most people had heard of HIV and AIDS and knew how HIV could be transmitted, there were numerous problems in truly understanding factors that would reduce risk. Indeed, eight out of ten respondents concluded that they were ‘very confused’ about HIV and AIDS. There were also challenges associated with negative views about condom use and the role of women in sexual decision-making, while practices that could protect from HIV infection were only done in an erratic manner, and were rarely based on an actual self-assessment of risk.

Respondents also felt that, in the context of many development challenges in the PDA, and the rapid changes that were underway in the area, HIV and AIDS was just one problem among many. Particular concerns were raised about the period following construction where farming systems would be in transition, and lives severely disrupted.

There were nevertheless grounds for hope. Experimentation with condoms was quite common, the number of respondents who had gone for testing was quite high, and there was an openness to improved knowledge, the use of innovative communication channels and new ideas, and to accessing anti-retroviral drugs and improving nutrition if one were found to be HIV positive. Perhaps most important for the Strategic Plan, there was a strong belief that the response to HIV and AIDS must be a local response, grounded in local customs and ‘ways of doing things’, and that this would allow the creation of a strong, sustainable response to HIV and AIDS.

The KAP study findings are detailed in Volume 2.

Strategic Planning Workshop

From 12 to 13 April, 2007, a Strategic Planning Workshop was held involving a number of PDA stakeholders, as well as regional and national representatives from NERCHA. The Strategic Planning Workshop comprised presentations by LUSIP project management, NERCHA, the consultants who led the KAP study, and a presentation on circumcision by the Swaziland Circumcision Task Force, followed by
extensive group work. The group work was central to the success of the workshop, as it allowed stakeholders to define how to proceed with HIV and AIDS interventions in the PDA.

To facilitate group work, eight areas of prevention were identified:

- Behavioural change communications
- Condoms
- Counselling and testing
- Circumcision
- Prevention of mother to child transmission
- Sexually transmitted infections
- Nutrition and food security

In each of these prevention areas, each group discussed the particular problems facing the PDA, the objectives of prevention strategies, target groups, social norms that would inhibit or strengthen a strategy, and the strategies themselves. Participants were also asked to consider the feasibility of different strategies, and who might best be involved in implementation.

The results of the Strategic Planning Workshop are detailed in Volume 3.

**Principles Guiding the Strategic Plan**

1. *Prevention*: At this juncture, emphasis will be placed on the *prevention* of HIV infection. The focus is on the three-quarters of PDA residents who are not HIV positive. Other LUSIP health mitigation activities are designed to assist in terms of care and support and impact mitigation. In addition, there are a number of organisations working in the PDA focused on impact mitigation, particularly with regard to care for orphans and other vulnerable children.

2. *Diversity*: The Prevention Strategy for the PDA recognises that HIV and AIDS affect women and men, young and old, poor and non-poor differently, and that each need to be partners in the process. These differences will be considered during implementation.

3. *Local Initiative*: Consistent with the 2006-2008 National Multisectoral Strategic Plan, the *Prevention Strategy for the PDA* will be locally managed, locally monitoring, and locally evaluated. PDA residents will be active *participants* in the implementation of the Strategic Plan, rather than being viewed as *beneficiaries* of Plan activities. This means both rights and responsibilities, and accountability for performance by partners. It also means a strong focus on community capacity development.

4. *Alignment*: The Prevention Strategy for the PDA has been designed, and will be implemented, in a manner consistent with the 2006-2008 National Multisectoral Strategic Plan, and subsequent plans. It will also be implemented in close collaboration with NERCHA.

5. *Co-ordination and Scaling Up*: The Prevention Strategy for the PDA is based on recognition that there are already many activities and actors working in HIV and AIDS in Swaziland, and in the PDA. The challenge is to build a local response that brings these activities and actors together, identifies opportunities and gaps, to yield a more coherent, more effective, and sustainable local response in the PDA.

6. *Evidence-Based Response*: Finally, the Prevention Strategy for the PDA builds on an evidence-based approach in responding to HIV and AIDS in the PDA. This means commitment to baseline and repeat-measure evaluation activities, coupled with the monitoring of a small number of key indicators, themselves consistent with the National Multisectoral Strategic Plan.
The Strategic Plan

The Strategic Plan components include the following: 1) identification of strategic issues; 2) statement of objectives; 3) elaboration of strategies; and 4) listing of core indicators.

Behavioural Change Communication

Strategic Issues

The 2006-2008 National Multisectoral Strategic Plan (NMSP) identified a number of challenges associated with behavioural change communication that were consistent with the findings of the PDA KAP study. This included high levels of confusion about HIV and AIDS, in part due to inadequate information, but also poor communications outreach and numerous conflicting messages (often in English). The KAP study also found little relationship between perceived risk of HIV infection and the actual risk of infection, reflecting low levels of understanding of the epidemic. As with the NMSP, the KAP study also found that traditional systems of knowledge transfer had collapsed, and that nothing had arisen in their place that could adequately meet the challenges posed by HIV and AIDS. The result has been low levels of knowledge, problematic attitudes, and insufficient behavioural change.

Objectives

Objective 1 To improve levels of understanding about HIV and AIDS by 25%.

Objective 2 To increase knowledge of personal risk to HIV infection by 25%.

Strategies

Strategy 1 Promote the extended distribution of nationally developed BCC materials that are viewed locally as socially acceptable, relevant and effective.

Strategy 2 Where relevant, design culturally sensitive, target group differentiated, BCC materials locally in the PDA. This could include, for example, more extensive use of local radio soap operas, drama groups, artists, etc.

Strategy 3 Strengthen and/or create innovative channels of peer education that would help reduce high levels of confusion about HIV and AIDS. In particular, employ these channels to increase an understanding of the HIV asymptomatic phase, different levels of infectability during the HIV cycle, and how HIV is not transmitted, overcoming myths and misunderstandings. It is important to remember that peer education is not just for teenagers, but is also appropriate for men and women in other age groups.

Strategy 4 For PDA area schools, work with school authorities to strengthen peer education and counselling/education channels, and clubs in schools.

Core Indicators and Means of Verification

Core Indicator 1 Percentage of PDA residents who are able to list basic facts on HIV and AIDS. Means of Verification: KAP survey.

Core Indicator 2 Percentage of sexually active persons who have sex with more than one sexual partner in the last twelve months (disaggregated by age and sex). Means of Verification: KAP survey.
Condoms

Strategic Issues

Because most people are sexually active by the time they get married, and because of high numbers of sexual partners (including within marriage), condoms represent an important barrier to HIV transmission. However, condom use remains low and inconsistent. In an area like the PDA, where most people do not know their HIV status, and who do not test regularly, consistent condom use is important.

There are also problems associated with the narrow range of supply options, and difficulties (especially for women) to have easy, confidential access.

Objectives

Objective 1 To increase by 25% the proportion of sexually active persons who used a condom during the last sexual event with a regular partner.

Objective 2 To increase by 25% the proportion of sexually active persons who used a condom during the last sexual event with a casual partner.

Objective 3 To increase the percentage of sexual events where there is female or joint initiation of condom use.

Strategies

Strategy 1 Increase the availability of condoms through increased channels of deliver, and increase condom use, through social marketing in the PDA.

Strategy 2 Reduce the incorrect use of condoms through condom demonstrations, drama, and other channels of social marketing in the PDA.

Strategy 3 Improve female and joint initiation of condom use through condom demonstrations, drama, and other channels of social marketing in the PDA.

Core Indicators and Means of Verification

Core Indicator 1 The percentage of PDA residents who view condoms positively. Means of Verification: KAP survey.

Core Indicator 2 The percentage of sexually active PDA residents who use condoms consistently. Means of Verification: KAP survey.

Core Indicator 3 The percentage of condom use events that are female or jointly initiated. Means of Verification: KAP survey (will require ex post facto measurement of previous condom initiation).

Core Indicator 4 The number of outlets distributing condoms. Means of Verification: Monitoring systems.
Counselling and Testing

Strategic Issues

Awareness of HIV status is an important decision making tool in behavioural change. For those HIV negative, it represents an opportunity to consider behaviours and consider means to reduce risk. For those HIV positive, it represents an opportunity to protect others, and consider how to mitigate impacts. The expanded availability of anti-retroviral drugs is an important determinant of demand, as Swazis are now offered a means to manage HIV infection as a chronic illness.

There nevertheless remain important barriers to increased testing. Beyond access and continued limitations regarding anti-retroviral drug availability and use, these are largely associated with fears regarding serostatus, and a lack of support systems to help people cope with the results of positive findings. Inadequate knowledge about risk of infection and means of transmission are particular problems.

Objectives

Objective 1 To increase the percentage of sexually active PDA residents who have gone for testing by 25%.
Objective 2 To increase the number of PDA residents who are willing to know their HIV status by 25%.

Strategies

Strategy 1 Increase social marketing approaches to mobilisation for testing and counselling in the PDA, taking care to ensure that different age groups are reached through appropriate approaches.
Strategy 2 Enhance levels of knowledge about the benefits of counselling and testing through peer education.
Strategy 3 Support the development of community-based lay psycho-social counselling services to compliment counselling services provided pre- and post-testing.

Core Indicators and Means of Verification

Core Indicator 1 The percentage of sexually active PDA residents who had gone for testing. Means of Verification: KAP survey.
Core Indicator 2 The percentage of PDA residents who show a willingness to know their HIV status. Means of Verification: KAP survey.
Core Indicator 3 The percentage of PDA residents who have been reached with information and advice about counselling and testing through social marketing channels. Means of Verification: KAP survey (will require addition of questions).
Core Indicator 4 The percentage of homesteads in the PDA within five kilometres of a testing service. Means of Verification: Monitoring systems.
Circumcision

Strategic Issues

Emerging evidence from South Africa, Uganda and Kenya suggest that male circumcision helps to reduce the risk of male infection with HIV by some 60%. Anecdotal evidence also suggests that male circumcision may help to reduce the risk of infection in the female partner, although studies underway to measure have not yet yielded conclusive data.

Male circumcision is uncommon in Swaziland, but was practiced many years ago. Male attitudes about circumcision is not well known, but available information suggests that there are particular concerns about pain, and an inability to perform sexually. There is also confusion about the level of protection offered by male circumcision, with some believing that it acts as ‘natural condom’.

The Ministry of Health in Swaziland is currently exploring the roll-out of male circumcision services, but to date Government has not formally adopted it as a means of HIV prevention. Further, the extent to which the country can make services available if demand rises rapidly is of concern. A male circumcision task force has been created to explore roll-out, and as a pilot have been carrying out ‘circumcision Sundays’ where a skilled team is involved in circumcision of a number of men on a Sunday.

Objectives

Objective 1 To increase the percentage of males who indicate that they are willing to undergo male circumcision to 25%.

Objective 2 To increase the percentage of pregnant women who indicate that they intend to have their male child circumcised at birth to 25%.

Objective 3 To increase the percentage of males who undergo circumcision from nil to 25%.

Strategies

Strategy 1 Increase uptake of adult (aged 15-30) male circumcision through ‘circumcision Sundays’, peer education networks, traditional authorities, and traditional birth attendants.

Strategy 2 Increase uptake of infant male circumcision through peer education networks, traditional authorities, and traditional birth attendants.

Core Indicators and Means of Verification

Core Indicator 1 The percentage of males who indicate they are willing to undergo male circumcision. Means of Verification: Monitoring data.

Core Indicator 2 The percentage of males who have undergone male circumcision. Means of Verification: Clinical data.

Core Indicator 3 The percentage of male infants circumcised by the age of one month. Means of Verification: Clinical data.
Prevention of Mother to Child Transmission

Strategic Issues

Mother to child transmission in cases of HIV positive mothers is responsible for an estimated 95% of HIV infection among children (Government of the Kingdom of Swaziland. The Second National Multisectoral HIV and AIDS Strategic Plan 2006-2008, the Government of the Kingdom of Swaziland, Mbabane, 2006). Without any intervention, the risk of transmission from an HIV positive mother to her child during childbirth is estimated to be as high as one-in-three deliveries. This risk is increased further through breastfeeding, specifically if breastfeeding is not exclusive and complimentary liquids and foodstuffs are offered before the age of one. Knowledge about means of transmission from mother to child is considered to be problematic, and there are likely to be particular challenges associated with knowledge that transmission can be prevented.

In Swaziland, the vast majority of births are supervised by trained health professionals, offering important opportunities for the prevention of transmission during childbirth.

Even if transmission is prevented during childbirth, risks of transmission remain due to breastfeeding. Social norms strongly encourage breastfeeding, and it is unlikely that HIV positive mothers can exclusively bottle feed infants. The alternative is exclusive breastfeeding for the first six months, followed by the exclusive shift to substitutes, which may be more socially acceptable.

Objectives

Objective 1 To increase awareness of means of preventing HIV transmission from mother to child by 25%.

Objective 2 To double the percentage of HIV positive mothers who are administered drugs to prevent mother to child transmission during childbirth.

Objective 3 To increase by 1.5 times the percentage of mothers who exclusively breastfeed for the first six months.

Strategies

Strategy 1 Expand awareness of the means to prevent HIV transmission from mother to child during childbirth and during breastfeeding through health workers, Rural Health Motivators, PLHIV support groups, peer educators, school interventions, and social marketing channels.

Strategy 2 Expand the percentage of mothers who receive an intervention during childbirth to prevent HIV transmission.

Core Indicators and Means of Verification

Core Indicator 1 Awareness of PMTCT among women aged 18-34. Means of Verification: KAP survey.

Core Indicator 2 Administration of a health facility-based intervention for pregnant women during childbirth. Means of Verification: Clinic data.
Sexually Transmitted Infections

Strategic Issues

The presence of other sexually transmitted infections (STIs) increases the risk of HIV transmission. In Swaziland, those with an STI are almost 50% more likely to be HIV positive than those who do not have an STI. While significant progress has been made in the control of STIs in Swaziland, the rapid increase in HIV infection has resulted in the rapid growth in genital herpes, an STI that raises particular risks in terms of sexual partner infection.

While it is estimated that most of those showing symptoms of an STI (more commonly the case for males than females) seek medical help, in Swaziland it has been estimated that half of all of those seeking treatment do not receive all the support they require. Particular problems arising in terms of behaviour change during treatment (e.g., condom use), and avoiding re-infection.

Objectives

Objective 1 To increase to 90% PDA residents with knowledge about the increased risk of HIV infection with the presence of another STI.

Objective 2 To increase to 90% PDA residents exposed to information on STIs through an increase in exposure to materials and advice.

Objective 3 To increase to 100% the number of those with an STI who have received treatment who complete their medication.

Strategies

Strategy 1 Expand access to information on STIs and the increased risk of HIV infection through the distribution of behavioural change materials, using media channels, peer educators, and health workers.

Strategy 2 Strengthen STI management, treatment and follow-up routines at health facilities in the PDA.

Core Indicators and Means of Verification

Core Indicator 1 Percentage of adult males and females in the PDA who have been exposed to sources of information on STIs. Means of Verification: KAP survey (will require addition of questions).

Core Indicator 2 Percentage of adult males and females who have sought treatment for an STI and who have completed treatment. Means of Verification: Clinic data.
Nutrition and Food Security

Strategic Issues

A persistent problem associated with the use of anti-retroviral drugs has been side effects aggravated by these drugs in the case of inadequate food intake, and poor nutrition. Insecure livelihoods has also been noted as a risk factor for HIV infection, while poor nutritional status can also hasten the onset of AIDS-related illnesses among those HIV positive.

Objectives

Objective 1  To increase access to materials and other information on nutrition and its role in prolonging the lives of PLHIV to 90% among adult males and females.

Objective 2  To double the number of food insecure households with access to increased foodstuffs and improved information on nutrition and HIV.

Strategies

Strategy 1  Based on nutritional guidelines, prepare an action plan for strengthening the nutritional value of consumption of locally available produce.

Strategy 2  Train food insecure households in the PDA in culturally acceptable backyard gardening techniques.

Strategy 3  Working with local PLHIV groups, support their active involvement in backyard gardening to improve their nutritional status.

Core Indicators and Means of Verification

Core Indicator 1  Preparation of the action plan. Means of Verification: Monitoring data.

Core Indicator 2  Percentage of adults with access to materials and information on nutrition and its role in prolonging the lives of PLHIV. Means of Verification: KAP survey (will require addition of questions).

Core Indicator 3  Number of food insecure households with improved access to sufficient food and improved information on nutrition and HIV. Means of Verification: VAC data for the PDA.
Implementation

This section provides a framework which describes implementation principles and modalities.

Implementation Principles

The main principle governing implementation of the Strategic Plan is that activities must be driven through a process of participatory engagement with PDA residents, implemented in a culturally-appropriate and age/sex relevant manner. Sustained engagement with PDA residents means more than just participatory appraisal for planning purposes. Rather, it means involvement in implementation and participatory systems of evaluation. It also means that means must be found to engage with the disadvantaged, the marginalised, on a sustained basis throughout plan implementation.

It is also important that implementation of the Strategic Plan for the LUSIP PDA remain informed by the National HIV and AIDS Strategic Plan, requiring extensive co-ordination of activities with NERCHA.

Given the considerable influence of SWADE in the PDA, and given that the activities associated with LUSIP are having a significant impact on the lives of PDA residents, SWADE has a duty to help homesteads and communities to respond to the impacts the project has on the risk of HIV infection, and the impacts of such infection.

Finally, while this Plan is for the years 2008-2012, covering the period up to completion of construction, it is intended that the actions carried out during this planning period will serve as the basis for a sustained response in the years following. This is especially important in the PDA, given the socio-economic changes that PDA homesteads and communities will be going through, and the consequent heightened risks of HIV infection and the negative impacts that would result.

Implementation Modalities

NERCHA is in the process of strengthening its decentralised institutions. In the past year, regional offices have been established and personnel appointed, and over the next few years NERCHA will also be establishing Inkundla level offices, and staff these accordingly. Within the Inkundla, at the community level, Chief’s Clerks have been appointed to support decentralisation of NERCHA activities. They have begun activities in some areas, focused on mapping community resources for a strengthened local response.

NERCHA recognises that it will take some time for these decentralised structures to be enabled to effectively co-ordinate HIV and AIDS activities at the Inkundla level. Therefore, for the 2008-2012 implementation period, there is need for a facilitator to champion the Strategic Plan, with financing for the appointment of this agency and the implementation of activities under the Strategic Plan raised through development partners (e.g., Global Fund, UN Agencies, bilateral donors or similar, to complement local resources); NERCHA has indicated a strong willingness to assist in applying for financial resources. *Without such a facilitation agency, it is doubtful that there will be sufficient momentum to secure the necessary support and roll-out strategies in the PDA.*

There are three options for this facilitation agency:

1. Appointment of a non-governmental organisation to serve as the facilitation agent.
2. Appointment of an experienced contractor to serve as the facilitation agent.
3. Integration of a facilitation agency function within the health response in LUSIP.

For the first two options, Terms of Reference are required for the appointment of such an agent, and tenders solicited; elements of this Terms of Reference are included at the end of this section. For the third option, SWADE would need to make a decision about whether it is willing to accommodate such a unit within its operations, and partners would need to decide about whether this is the best approach; Terms of Reference are required as a basis for their operations.
A decision will need to be made on which of these modalities will be employed. Whatever the option selected, it would be important that the facilitation agency be an organisation with either its origins in Swaziland, or an agency with a long service in Swaziland.

The anticipated implementation structure of the Strategic Plan is as follows:
While this facilitation agent is central to the success of the Strategic Plan, it is important to note that it is intended as a temporary arrangement. During the course of the implementation of the 2008-2012 Strategic Plan, it is expected that NERCHA will strengthen co-ordination structures at regional and Inkundla levels. NERCHA has undertaken to support the development of these structures in Inkundla in the PDA to ensure that it can take over responsibilities from the facilitation agent by the end of this strategic planning period. An important responsibility of the facilitation agency will therefore be to strengthen the NERCHA structure and gradually move responsibility to this emergent entity.

The main responsibility of the facilitation agency is to oversee a process of participatory engagement of PDA residents, across gender, socio-economic status, age, and power. To do this, it will need to establish structures that sustain such involvement, secure the assistance of delivery agents to carry out activities in the PDA under the framework of the Strategic Plan, and ultimately be accountable to NERCHA.

The facilitation agency would report to the Regional Multisectoral HIV and AIDS Co-ordinating Committee at the Regional Level, which is headed by the Regional Secretary, with NERCHA serving as the Secretariat. It would also report to relevant development partners as per financing arrangements. The national HIV and AIDS response also functions by sectors, and given the strong presence of NGOs in the Strategic Plan, it is likely that this falls under the private sector for reporting purposes.

As Inkundla level, structures for NERCHA have not yet been put into place. Therefore, for the foreseeable future, the HIV/AIDS Steering Committee for the PDA will play a particularly important advisory role, assisting the facilitation agency with the smooth running of activities falling under the Strategic Plan. As NERCHA structures are strengthened within the PDA, this HIV/AIDS Steering Committee will gradually shift to a role as advisor to the Inkundla NERCHA, or act as a powerful interest group in the PDA.

It should be noted that there is some complexity at the PDA level, due to the fact that the area covers three Inkundla, rather than just one. The facilitation agency must show due recognition of this situation, and propose structures that would facilitate the smooth operations of any interventions. The agency must also build capacity in all three Inkundla to manage an HIV and AIDS response in future.

Request for Proposals for Appointment of a Facilitation Agency

The main principle governing implementation of the Strategic Plan is that activities must be driven through a process of participatory engagement with PDA residents, implemented in a culturally-appropriate and age/sex relevant manner. Sustained engagement with PDA residents means more than just participatory appraisal for planning purposes. Rather, it also means involvement in implementation and participatory systems of evaluation. It also requires that means be found to engage with the disadvantaged, the marginalised, on a sustained basis throughout plan implementation.

It is also important that implementation of the Strategic Plan for the LUSIP PDA remain informed by the National HIV and AIDS Strategic Plan, requiring extensive co-ordination of activities with NERCHA at national and regional levels. Further, it should be noted that NERCHA is in the process of strengthening its decentralised institutions. In the past year, regional offices have been established and personnel appointed, and over the next few years NERCHA will also be establishing Inkundla level offices, and staff these accordingly. Within the Inkundla, at the community level, Chief’s Clerks have been appointed to support decentralisation of NERCHA activities. They have begun activities in some areas, focused on mapping community resources for a strengthened local response.

The Role of the Facilitation Agency

Separate Terms of Reference (TOR) have been prepared to guide those interested in serving as this Facilitation Agency (FA) to prepare proposals for consideration by NERCHA and LUSIP. Here key elements of the TOR are included.

The FA should be guided by the philosophy that “ownership is the key to sustainability”, and all of its actions must contribute towards this ownership. All actions will be participatory and not directive, with constant recognition that PDA residents are in charge of the project, with the FA a facilitator.
The main role of the FA will be to co-ordinate the provision of goods and services in the PDA associated with the objectives of the Prevention Strategy as noted above. The FA should consider which agencies, in Swaziland, are in a position to provide various services of relevance to the project, and include these as possible service providers in their proposal. The FA should nevertheless include in its submission of the cost of all services to be delivered, including overheads associated with service provision by these other agencies, and direct service provision by the FA itself.

The FA should elaborate in its proposal the services that need to be provided based on the activities and goals noted above. Equally importantly, the FA should clearly elaborate the processes it will employ to ensure active participation, sustained throughout the life of the intervention. It should also include in the proposal an exit strategy for 2012, so that activities will continue and expand. In this regard, while the role of the FA will be central to the success of the Strategic Plan, it is important to underline that this is a temporary arrangement. During the course of the implementation of the 2008-2012 Strategic Plan, it is expected that NERCHA will strengthen co-ordination structures at Inkundla level. NERCHA has undertaken to support the development of these structures in Inkundla in the PDA to ensure that it can take over responsibilities from the FA by the end of the 2008-12 strategic planning period. An important responsibility of the FA will therefore be to strengthen the NERCHA structure and gradually move responsibility to this emergent entity, as a central aspect of sustainability.

Progress reporting will be to an HIV/AIDS Steering Committee that has already been established in the PDA. The performance of the FA will be assessed by LUSIP as part of its standard review processes instituted for all contractors, under the specific oversight of the Public Health Co-ordinator. In addition, a national Reference Group will be established to assist with project oversight, chaired by NERCHA’s Regional Co-ordinator for Lubombo Region, and deputy chaired by a national officer appointed by NERCHA’s national office. The FA should elaborate its reporting strategies in its proposal.

A mid-term review of the project, and of the performance of the FA, will be conducted in 2010, under the direction of the HIV/AIDS Steering Committee and the Regional NERCHA Office. Based on the results of this mid-term review, the FA may be asked to prepare a cost extension to include additional activities associated with impact mitigation and strengthening care and treatment activities in the PDA. This may also include additional prevention activities. Thereafter, an end-of-project evaluation will also be conducted, which will include issues around sustainability.

It should be underlined that NERCHA and LUSIP place considerable importance on learning from the intervention, and considering its applicable for other locations in Swaziland. The FA should therefore approach the project with an emphasis on learning from what goes well and what does NOT go well. It is therefore especially important to document, and respond to, problems that emerge in a progressive manner. Performance assessment will therefore be based less on project successes, and more on how well the FA responds to what works and what does not work, and adapts to and learns from this process.

Consistent with learning, the FA should include in its proposal how it intends to share information within the PDA, within Swaziland, and beyond.

Cost Proposal

The Facilitation Agency should prepare a cost proposal based on the above activities and the following parameters:
2. Provision of the following personnel:
   a. Project Manager (minimum 3 years experience in a similar position)
   b. Community Participation Officer (minimum 3 years experience in a similar position, must be a Swazi citizen)
   c. Procurement, Administration and Finance Officer (minimum 3 years experience in a similar position)
   d. Driver and Office Assistant (ideally from the PDA or Siphofaneni)
3. Provision of appropriate office space and office resources, to be established in Siphofaneni, if possible proximate to the LUSIP offices.
4. Provision of one 4x4 and one 2wd vehicle for the duration of the implementation period.

NERCHA and LUSIP would look favourably on proposals that include co-financing commitments from the FA.
RESPONSE TO HIV/AIDS IN RURAL LUBOMBO REGION:

KAP SURVEY REPORT

Prepared by
Social Impact Assessment and Policy Analysis Corporation (SIAPAC)
in collaboration with
the Lower Usuthu Smallholders Irrigation Project (LUSIP)

January, 2007
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<table>
<thead>
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<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral Treatment</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retrovirals</td>
</tr>
<tr>
<td>CANGO</td>
<td>Coordinating Assembly of Non-Governmental Organisations</td>
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<tr>
<td>FBO</td>
<td>Faith Based Organisation</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FLAS</td>
<td>Family Life Association of Swaziland</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HIV+</td>
<td>Human Immunodeficiency Virus Positive</td>
</tr>
<tr>
<td>LUSIP</td>
<td>Lower Usuthu Smallholder Irrigation Project</td>
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<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<tr>
<td>NERCHA</td>
<td>National Emergency Response Committee on HIV/AIDS</td>
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<tr>
<td>PDA</td>
<td>Project Development Area</td>
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<tr>
<td>SASO</td>
<td>Swaziland AIDS Support Organization</td>
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<tr>
<td>SHAPE</td>
<td>School HIV/AIDS and Population Education</td>
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<tr>
<td>SIAPAC</td>
<td>Social Impact Assessment and Policy Analysis Corporation (Pty) Ltd.</td>
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<tr>
<td>SNAP</td>
<td>Swaziland National AIDS Programme</td>
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<tr>
<td>SWADE</td>
<td>Swaziland Water and Agriculture Development Enterprise Ltd.</td>
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<tr>
<td>SWANNEPHA</td>
<td>Swaziland National Network for People Living With HIV and AIDS</td>
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<tr>
<td>NAC</td>
<td>National AIDS Committee</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>OVC</td>
<td>Orphans and Other Vulnerable Children</td>
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<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>ToR</td>
<td>Terms of Reference</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Agency for HIV/AIDS</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary: Findings and Conclusions

| Rationale, Goal, Aim and Objectives | The investigation was commissioned by the Project team in response to an HIV seroprevalence rate in the Project Area of over 40% for 15-49 year olds. |

The rationale for conducting the investigation is to provide data for evidence-based planning to respond to the HIV and AIDS-related needs of Project Area residents. The goal is to initiate a process of dialogue that will result in an enhanced response to HIV and AIDS in the Project Development Area (PDA) by a variety of actors involved in the HIV and AIDS arena, under the framework of the national response led by the National Emergency Response Committee on HIV/AIDS (NERCHA).

The aim of the investigation is to substantively inform the development of a communications strategy for responding to the high level of HIV infection in the PDA, and protect residents who are currently HIV negative. The communications strategy will focus on innovative, culturally-appropriate strategies for reducing the risk of HIV transmission by expanding knowledge, improving attitudes, and influencing behaviours, working with local and national partners.

The objectives of the investigation are as follows:

- To develop a strategic plan for LUSIP that describes its potential role in responding to HIV and AIDS in the PDA.
- To facilitate a process of consultation intended to lead to a broader set of HIV and AIDS responses by national and local actors in the PDA.
- To provide empirical data that can be used to measure change over time.

The approach to the investigation involved implementation of a highly-structured quantitative questionnaire focusing on the HIV and AIDS knowledge and attitudes of PDA residents aged 18-34, yielding statistically generalisable data for the entire PDA. In addition, eleven focus group discussions were held to explore key issues in more detail. Focus group discussions were held with adolescent males, adolescent females, community opinion leaders, wives in polygamous marriages, husbands in polygamous marriages, and wives of migrant workers.

| Overview of HIV and AIDS in Swaziland | Swaziland has the highest level of HIV seroprevalence in the world, with 42.6% of the population aged 15-49 HIV positive. |

The first case of AIDS was detected in Swaziland in 1986. In the first six years, the level of infection grew quickly, and by 1992, 3.9% of the population of 15-49 year olds were HIV positive. Thereafter, infections grew rapidly, and just twelve years later, the HIV seroprevalence rate had grown more than tenfold, to 42.6%. Of particular concern, rates of infection continue to grow rapidly among young Swazis aged 15-19.

HIV/AIDS has already taken its toll on Swaziland. Swaziland’s Human Development Index ranking dropped from 0.603 (on a 0 to 1 scale, with higher numbers reflecting a higher level of human development) in 1995 to 0.498 in 2003, while life expectancy dropped from 50 years in 1970-75 to 33 years in 2000-2005. This situation will worsen further, as the high numbers of HIV positive Swazis die over the next fifteen years. Indeed, even if no additional Swazis were infected with HIV from 2007, death rates would continue to be extremely high until at least
By 2015, ten times as many people will die of AIDS-related illnesses than will die from other causes. Unfortunately, the severity of the epidemic has not been matched by the national response. Swaziland was particularly slow in responding to HIV/AIDS in the early 1990s, when interventions could have helped to avoid many new infections. Nevertheless, it is important to note that much progress has been made in the years after AIDS was declared a national disaster in 1999. The National Emergency Response Committee on HIV/AIDS (NERCHA) was created in 2001, with the mandate to co-ordinate and mobilise resources for an expanded, scaled-up and co-ordinated response. Since its creation, progress has been made in terms of multi-sectoral planning, the roll-out of anti-retroviral drugs, and improved access to testing and counselling services. Unfortunately, progress has been less evident in terms of impact mitigation (orphans and other vulnerable children support programmes, sectoral responses) and prevention. In the case of the latter, clarity of message and message appropriateness is uncertain.

Overall, findings suggest that the response to HIV/AIDS in Swaziland is not sufficient to meet the challenges the country faces. An inadequate response to HIV/AIDS, especially in the early years, has resulted in the highest rate of infection in the world. Government recognises the many deficiencies in the past response, and is extremely open to new ideas on what can be done. There is particular support for an enhanced local response, suggesting that there would be important national backing for any local initiatives in the PDA.

<table>
<thead>
<tr>
<th>Knowledge</th>
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<tr>
<td>In general, respondents had sufficient basic knowledge about HIV and AIDS. However, findings suggest that many respondents are uncertain about the reliability of information they have received, and conflicting messages have led to high levels of confusion about HIV and AIDS. Findings are of particular concern with regard to levels of knowledge and understanding among female respondents.</td>
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</table>

Quantitative findings highlight fairly high levels of basic knowledge about HIV and AIDS. Almost all respondents had heard of HIV/AIDS, most could name at least two means of preventing HIV infection, most also knew how HIV could not be transmitted, almost all knew that there was a test to determine if one was HIV positive, and almost all knew that there were drugs that an HIV positive person could take to improve their health. Further, 94.2% of male respondents and 83.8% of female respondents gave correct responses to eight or more of fifteen true-false statements.

Unfortunately, this basic knowledge was not matched by a proper understanding of important nuances and details about HIV and AIDS. For example, only two-thirds of those who had heard of HIV/AIDS correctly noted the relationship between HIV and AIDS. Levels of knowledge in this respect was lower for married respondents, for younger respondents, and for respondents with lower levels of education. For the two-thirds that correctly noted the relationship between HIV and AIDS, only half of these knew how long the asymptomatic period for HIV was. Overall, only 46.7% of males and 40.8% of females had heard of HIV/AIDS, knew the relationship between the two, and knew the average length of the asymptomatic phase of HIV. Almost all female respondents and two-thirds of male respondents incorrectly noted that having sex with someone HIV positive would automatically result in infection, and there was a great deal of confusion about the role of condoms in preventing transmission (for example, 55% of female respondents argued that condoms themselves carried HIV). Over 85% of respondents agreed with the statement ‘really, we are very confused about HIV/AIDS’.

Qualitative findings suggest that much of the confusion arises from the ‘hit and miss’ nature of information channels and the unreliability of systems of assimilating knowledge. Peers were
major sources of information on HIV/AIDS, yet channels for properly understanding sexual and reproductive health matters meant that this information was largely unreliable, and often contradictory. Ignorance of sexual matters was felt to be important, especially for young unmarried women, to help prevent the spread of sexual diseases, so channels were largely informal. Parents tended to rely on fear and intimidation to protect their children.

The radio was also noted as an important source of information, but focus group discussion participants argued that messages were confused and often misdirected. For example, messages about ‘fighting AIDS’ were felt to be inconsistent with messages of compassion. Messages on how HIV is spread and not spread were unclear and often contradictory, and were not felt to be consistent over time. With low levels of understanding because of the absence of reliable systems for assimilating knowledge, these messages served to deepen confusion, rather than clarify matters.

Overall, findings suggest that a key priority would be to overcome high levels of confusion around HIV/AIDS by supporting local initiatives that improve the reliability of channels relied upon by most residents.

| Attitudes |
| Attitudinal findings underline the confusion found with regard to knowledge. Of perhaps greatest concern, the findings also suggest that people do not perceive HIV/AIDS to be a particular threat to them, nor do they see it as a priority issue affecting their lives. |

Only one-in-five of the respondents to the quantitative survey felt that they were at high risk of HIV infection, despite infection rates of over 40% in the Lubombo Region where the PDA is located. Risk perceptions did not vary with objective circumstances, suggesting that risk perception did not covary with actual risk. Part of the problem appears to arise from a common belief that HIV infection results from ‘inappropriate’ or ‘immoral’ behaviours, and that a ‘good person’ who behaved in a moral fashion would not be infected. Of interest, this low risk perception coincided with a belief that HIV was common in the area, and a degree of fatalism derived from a poor knowledge base, fatalistic messages such as ‘AIDS kills’, a sense of hopelessness that channels of communication will even yield reliable information, awareness that many people were engaged in high risk behaviours, and the confusion noted above.

There were particular concerns around testing and counselling for HIV. Over half of the female respondents agreed with the statement ‘I would be quite afraid to go for a test for HIV’, as did one-third of male respondents. In part this was due to a belief that their social support systems would not be able to cope with an open admission of an HIV positive status (that is, that family members and friends would not be supportive), but also reflected concerns associated with the cost of and access to antiretroviral drugs and adequate nutrition. Of interest, there was an equal concern about what could not be done to protect those who found that they were HIV negative. With low risk perceptions, people often felt that taking such a test would not change anything in their lives.

Putting HIV/AIDS into context, approximately half of the respondents felt that HIV/AIDS was not a priority issue. Qualitative findings in particular highlighted what were perceived to be more immediate and more important needs around basic livelihoods. Employment, on-farm production, access to schools, and retaining and expanding social capital networks to reduce risk were all more important, and more immediate, needs that resulted in either little consideration of HIV/AIDS, or a perception that it was an ‘acceptable risk’ to reach other desirable goals.

While in many respects attitudinal findings underline concerns about HIV/AIDS reflected in knowledge findings, there are also some encouraging findings. Levels of stigma are not that high, attitudes about testing and the use of antiretroviral drugs are positive, and many
respondents noted that, while perhaps not the priority in their lives, HIV/AIDS was still a concern. These findings suggest that there are important positive attitudes that any intervention could build on, and highlight key ‘entry points’ for attitudinal change. The important point is to consider interventions that fit the reality of the social context PDA residents face, and in particular how to reduce risk for young women.

| Practices | The majority of sexually active respondents became sexually active before marriage, most during their teens. Risk behaviours were evident, but were not excessive, and there was evidence of behaviours that could help avert infection. |

Despite threats and warnings from parents, young women tended to believe that sexual activity was an important means to secure a stable future. This need for security and enhanced social networks (that is, marrying into a family that would help guarantee economic stability over time) affected women at a young age, in the context of social norms that gave women few other options. These social norms tended to increase levels of risk, including within marriage. Attitudinal statements about the cultural acceptability of males having casual partners, and women in polygamous marriages having sexual partners outside of marriage, coupled with qualitative findings highlighting inconsistencies in behaviours that might protect a person from HIV infection, underline concerns that PDA residents are at high levels of risk of HIV infection.

**There are, nevertheless, positive practices that could be built on:**

- Most sexually active respondents are in stable, long-term relationships.
- While one-third of sexually active male respondents had casual partners, this dropped to 10% for females.
- Married males were less likely to have casual partners than single males.
- Most respondents had experimented with condoms (although behaviours were erratic).
- A number of negative sexual behaviours were uncommon in the PDA.
- Many respondents had been for testing for HIV, and most of these had received their results.

As with attitudes, of central importance in responding to HIV/AIDS in the PDA is to ensure that interventions are consistent with the social norms and realities faced by people in the area.
This report presents baseline findings from a sexual knowledge, attitudes, and practices investigation in the Lower Usuthu Smallholder Irrigation Project (LUSIP) Project Development Area (PDA). The aim of the investigation is to substantively inform the development of a communications strategy for responding to the high level of HIV infection in the PDA, and protect residents who are currently HIV negative. The communications strategy will focus on innovative and culturally-appropriate strategies for reducing the risk of HIV transmission by expanding knowledge, improving attitudes, and influencing behaviours, working with local and national partners. In the context of the project, the intent is to enhance the positive impacts of the project on beneficiaries.

This report presents findings from the baseline survey, supported by a review of literature on HIV/AIDS focused on Swaziland and the epidemic more broadly, and also supported by key informant interviews with officers involved in the HIV/AIDS response in Swaziland and team brainstorming sessions to consider what the findings suggest for the PDA. It also includes an annex that details the results of a conference involving PDA, regional, and national stakeholders.

The survey itself comprised both quantitative and qualitative components. The quantitative survey, using a rapid quantitative questionnaire, was designed to obtain factual data on knowledge, attitudes and (to a lesser extent) practices. The qualitative component was designed to better understand the factors determining behaviour, and soliciting insights on effective communication strategies. The findings are valid for the full PDA, with fieldwork being done throughout the area.

1.1 Objectives

The objectives of the investigation are defined in the Terms of Reference for the investigation:

1) To develop a comprehensive prevention strategic plan for LUSIP, in consultation with the Ministry of Health and Social Welfare (MOHSW) and the stakeholders in the project area, and targeting sexual behavioural changes in the rural farmers’ communities:
   a) The strategies of the plan will be based on a KAP survey (knowledge, attitudes and practices) specifically designed for our communities, focus group discussions with key informants, and on the lessons learned from existing reports on similar studies in the sub-region. The methodology will follow guidelines from the United Nations Agency for HIV/AIDS (UNAIDS) and the World Health Organization (WHO).
   b) The plan will explore all formal and informal communication channels available to the communities in the project area, or to be developed.
   c) A local conference with all stakeholders of the project will be organised to share and discuss the findings of the survey and strategic issues through participatory approach.
   d) A strategic plan will be finalised in consultation with the RHA and the HIV Steering Committee. The plan will also focus on innovative interventions, stigma reduction and other support to the PLWHA, and strengthening local and regional institutions.

2) To develop a list of indicators and a methodology for monitoring and tracking changes over time in behaviour in the PDA.

In response to these objectives, the Consultants and LUSIP counterparts have put forward an approach that comprises:
   a) A review of relevant literature.
b) Implementation of a Rapid Quantitative Questionnaire, allowing the statistical generalisation of findings from the surveyed respondents to the population in the same age groups in the Project Area.

c) Implementation of a Focus Group Discussion Instrument, providing detailed insights into sexual KAP issues and best approaches to countering the rise in HIV infections.

d) Conduct of key informant interviews at the national and regional levels, as well as in the Project Development Area.

e) An assessment of communication channels in the PDA.

f) Holding of a Strategic Plan development workshop, and the follow-up completion of the Strategic Plan for SWADE, and initial inputs into a Strategic Plan for a broader programme in the PDA.

g) Within the context of the SWADE Strategic Plan, develop a list of indicators for monitoring, and a plan for data collection, and an evaluation plan.

1.2 Methodology

A highly-structured quantitative questionnaire (Annex E) was drafted and finalised in the ninth version, following extensive training and pre-testing. It was, in large part, based on questions that had been used in previous surveys that had proven effective. Questions were adjusted based on: 1) appropriateness in the context of the PDA; and 2) appropriateness in the context of Project needs. The quantitative questionnaire was complemented by a focus group discussion instrument (finalised in version 7, see Annex F) designed to add insights into factors influencing attitudes and behaviours, and what strategies might be most effective in reaching young people and reducing the number of new HIV infections in the PDA.

A total of 240 quantitative interviews were conducted, 120 with males and 120 with females. Same sex interviews were conducted due to the sensitivity of the issues being covered. Interviews were conducted with males and females aged 18-34. The population census data were used for sampling purposes, with the random selection of same-size clusters, the random selection of households, and the random selection of interviewees within households, yielding statistically generalisable data to the PDA. Only 4.2% of males and 1.7% of females were classified as ‘unco-operative’ during the interview, with most respondents highly co-operative, particularly for females.

For the focus group discussions, participants were strategically identified based on demographic characteristics, with homogeneous group discussions. Groups included: 1) adolescent males aged 13-17; 2) adolescent females aged 13-17; 3) community opinion leaders; 4) wives in polygamous marriages; 5) husbands in polygamous marriages; and 6) wives of migrant workers. Levels of co-operation in the focus group discussions were also high. A total of eleven FGDs were held. It should be noted that there were numerous problems associated with administration of the FGDs, and it generally took two to three visits to arrange a single meeting. Reasons for these delays included: protocol channels in SWADE needed to be followed, and this resulted in some planned meetings being delayed; the fieldwork took place during a busy agricultural season; and some organised focus groups only resulted in half of the participants arriving, insufficient to conduct a focus group.

Quantitative data were entered into Microsoft Excel, and imported into the Statistical Package for the Social Sciences (SPSS) for cleaning and, thereafter, analysis and write-up. Qualitative findings were compiled into a qualitative report, and this report was used to integrated quantitative and qualitative findings into this report (see Annex C).

Because of varied behaviours, and often varied attitudes and levels of knowledge, quantitative findings for males and females are presented separately.
1.3 Review of the Literature

1.3.1 The Situation Internationally and in Sub-Saharan Africa

The 2006 UNAIDS report (UNAIDS, 2006) noted that, as of December 2006, some 39.5 million people worldwide were living with HIV/AIDS. Of these, over 10% were newly infected with HIV in 2006 (4.3 million), while 2.9 million people died of an AIDS-related illness in 2006. Of the 39.5 million living with HIV/AIDS, 37.2 million were adults, and 2.3 million were children aged 0-15. AIDS deaths among children HIV positive were higher than their proportion in the population of infected, at 13.1% of all deaths compared to 5.8% of all those with HIV, reflecting high death rates among infants who are infected at birth or during breastfeeding.

Of the 39.5 million living with HIV/AIDS, 24.7 million of these are living in sub-Saharan Africa, representing 62.5% of the total. While this is a considerable drop from the 90%+ that sub-Saharan Africa represented of the total in the mid-1990s, the percentage drop has been due to the rapid rise in infection rates in south Asia. The actual number of people living with HIV/AIDS continues to rise throughout most of sub-Saharan Africa. In 2004, there were 23.6 million sub-Saharan Africans living with the virus, rising to 24.7 million in 2006. New infections also rose, from 2.6 million in 2004 to 2.8 million in 2006.

In sub-Saharan Africa, as well as in most other developing countries in the Caribbean, Latin America, south Asia, and east Asia, the primary means of transmission of HIV is through heterosexual sexual intercourse (estimated at over 90% of all cases). This is followed by mother-to-child transmission during pregnancy, during childbirth, and during breastfeeding, and thereafter by contact with contaminated blood products.

Most new infections are among young people, and these infections are concentrated among young females. The United Nations estimates that young teenage women are up to six times more likely to be HIV positive than males their same age (UNAIDS, 2006). Males tend to be infected in their twenties and early thirties. In part these findings reflect high risk of transmission from older males to younger females in situations of cross-generational sex. For every year older the male, the chances of the female partner being infected rises some 4% (pers comm, PSI Washington, 2006).

1.3.2 HIV/AIDS and Rural Livelihoods

The impacts of HIV/AIDS on the lives and well-being of the sub-Saharan African population has been considerable. The loss of adult labour for on-farm production, rural enterprises and wage labour has been particularly devastating, especially when coupled with higher dependency burdens disproportionately affecting rural households. Expenditures have increased and asset bases depleted as households cope with chronic illness and premature death, and a rapidly increasingly caregiving burden with rising numbers of orphans. While quantification of impacts is difficult and, unfortunately, quite rare, discussions with affected households in a number of African countries leave no doubts that HIV/AIDS has worsened the living conditions of the very people that SWADE works with.

For Swaziland, Muwanga (2004) suggests that HIV/AIDS has increased the vulnerability of affected households to environmental shocks by fourfold. Equally to the point, HIV/AIDS has weakened the livelihoods of the productive poor, and the potentially productive poor, and as such directly undermines SWADE’s activities, entrenching poverty and weakening the very livelihood base that SWADE intends to strengthen. Available evidence suggests that, of households that have a member who died prematurely, there was a one-third drop in the area under cultivation, 42% had to change cropping patterns to accommodate labour loss, and 47% suffered from a decline in crop yields (Government of the Kingdom of Swaziland, 2005). Also of relevance, the impacts of HIV/AIDS tends to force households to consider investments that yield returns within a single agricultural cycle, and investments
that are not labour intensive. Investments that take longer to yield results are at least partially deferred, resulting in slower than anticipated uptake of even desirable, profitable investments.

There is also evidence that HIV/AIDS has weakened extended family ties, strained by the pressures of increased financial need yet reduced earnings, increased dependency rates and worsening vulnerability to economic shocks. Social relations between women and men have changed, with women especially vulnerable to both HIV infection and being forced to cope with the consequences of the pandemic. Strains exist with regard to community social organisation, with capacity erosion both from service providers -- in government, in non-governmental organisations, and in the private sector -- and among rural households. Here again HIV/AIDS impacts directly on the population that SWADE targets, by weakening the ability of the rural poor to organise for the greater good and broaden their livelihood strategies.

Having said this, it is important to note that, by focusing on the rural poor, by supporting community social organisation, and by strengthening rural livelihoods, the success of LUSIP would mean that SWADE would be doing much to mitigate the negative impacts of HIV/AIDS. However, the Project also brings with it real and potential risks, risks associated with construction, heightened social stratification, and increased power gaps between males and females.

1.3.3 Responses to the Epidemic

In the face of an unprecedented pandemic, it is often easy to forget that some progress has been made in responding to the problem. Senegal and Thailand have managed to keep HIV/AIDS below epidemic levels of 1%, while Uganda and Brazil have managed to reverse rapid rises in HIV infection rates. In two countries in the region -- Zimbabwe and Namibia -- HIV prevalence rates have stabilised, and there is evidence in both countries that the number of new infections is decreasing.

For sub-Saharan Africa as a whole, emergent evidence suggests that the percentage of the population of 15-49 year olds in sub-Saharan Africa living with HIV/AIDS has stabilised at around 6% from 2004-2006. In part this is a reflection of the maturation of the epidemic, with deaths in high prevalence countries with well-established epidemics exceeding the number of young people newly infected. It also reflects the reduction in infection rates in a few countries, most notably Uganda, but also Zimbabwe, Botswana and Namibia.

There is also evidence that a number of workplace programmes have been effective in reducing risk behaviours and extending the lives of those HIV positive. Best practice approaches are in particular evidence in the diamond mining industry, where the loss of skilled human resources in the 1990s highlighted the vulnerability of the industry to HIV/AIDS impacts. To a lesser extent, there is also evidence of change in the gold mining industry, with changes tracked through the use of sensitive actuarial models.

A sexual behaviours survey conducted in Botswana in 2000-2001 (SIAPAC, 2001) found evidence of significant changes in condom use rates, and the consistency of condom use in both casual and regular partnerships. Condom consistency use rates (that is, the percentage of sexual ‘events’ where a condom was used) rose from around 30% in the early 1990s to over 90% by 2001. In Malawi (Interact Worldwide, 2004), young people who had been reached by an adolescent reproductive health cadre had lower risk profiles than those who had not been reached (after controlling for possible demographic and other differences between the two populations). In Namibia, demand for voluntary counselling and testing services has grown rapidly as availability of services has expanded, and exposure to these services covaries with improved behaviours (SIAPAC, 2005). In Angola (IFAD, 2006), an evaluation of a CARE International intervention supported by IFAD found that the agency itself had made enormous progress on mainstreaming HIV/AIDS into its various interventions in the south central province of Bié, and had also managed to
significantly increase basic knowledge about HIV/AIDS among four pilot communities. However, the evaluation also noted the enormous challenges the programme faced in changing behaviours in line with expanded knowledge, as attitudinal change and overall living conditions provided severe challenges to improved behaviours.

Unfortunately, Swaziland has been slow in responding to the epidemic. The first case of AIDS was in 1986, and in six years later, in 1992, the HIV prevalence rate was 3.9%. Thereafter, infection rates grew ten-fold in a decade. Actions that could have been taken in the 1990s that could have helped avert many infections and deaths were not taken, and an effective multisectoral response was only put into place after 2000. It was only in 1999 that Swaziland declared AIDS a national disaster (Kaiser Family Foundation, 2005). The National Emergency Response Committee on HIV/AIDS (NERCHA) was only established in 2001, with a mandate to co-ordinate and mobilise resources for an expanded, scaled-up and co-ordinated response.

By that time, Swaziland had the highest HIV prevalence rate of any country in the world, at 42.6% among 15-49 year olds, and 38.8% for adults aged fifteen and older in 2004 (a rise from 3.9% in 1992; MOHSW, 2004). Much of this growth in infection has occurred among 15-19 year olds, an age group that saw a 6% increase in HIV prevalence from 2000 to 2002. Swaziland’s high rate compares to an average of 6% for sub-Saharan Africa overall. Over the past decade, Swaziland’s Human Development Index figure dropped dramatically from 0.603 in 1995 to 0.498 in 2003, largely due to the impacts of HIV/AIDS (UNDP, 2005), and life expectancy had dropped dramatically from 50 years in 1970-75 to 33 years in 2000-2005. By 2015, ten times as many people will die of AIDS-related illnesses than will die from other causes. Given the relatively small size of the country and high levels of mobility, the epidemic tends to be similar across regions. In Lubombo Region, where the PDA is, infection rates are 38.5%, compared to the national rate of 38.8%.

While Swaziland has been slow in responding to the epidemic, it is encouraging to note that Swaziland’s response since 2001 has accelerated quite significantly. The second national multi-sectoral HIV and AIDS strategic plan, covering the period 2006-2008, was issued in 2006 (Government of the Kingdom of Swaziland, 2006). It offers a candid review of failures to date and the many challenges the country faces, and puts forward a vision for the future (Government of the Kingdom of Swaziland, 2005: 19): “By 2015, the people of the Kingdom of Swaziland shall have halted and reversed the AIDS epidemic resulting in improved quality of life which will be characterized by reduced HIV and AIDS related morbidity, mortality and socio-economic impact”. Goals included a reduction in the number of new HIV infections through a range of behavioural change strategies, improved blood safety, the prevention and management of other sexually transmitted infections, increased access to HIV testing services, expanded care and treatment services, rapidly expanded access to anti-retroviral drugs and support services for those HIV positive, and a variety of impact mitigation strategies.
2 Knowledge

2.1 Introduction

In this chapter, findings from the quantitative questionnaire and focus group discussions are presented covering respondent knowledge about HIV/AIDS. As noted in Chapter 1, quantitative findings are presented separately for males and females.

2.2 Basic Knowledge

Respondents were first asked whether they had ever heard of HIV/AIDS. All male respondents (100%) indicated that they had heard of HIV/AIDS, as did 92.5% of the female respondents. Findings suggest high levels of basic knowledge in this regard, although the figure for women is of concern, as rates should also have approached 100%.

To gain insights into more detailed understanding about HIV/AIDS, two key indicators were used: 1) knowledge of the relationship between HIV and AIDS; and 2) knowledge of the asymptomatic phase of HIV before AIDS-related illnesses set in. For the former, the correct response is ‘HIV causes AIDS’, and the incorrect responses came down to a belief that HIV and AIDS were the same thing, or that the respondent did not know whether the two were indeed related. Findings are summarised in the following figure:

Figure 4-1: Knowledge of the Relationship between HIV and AIDS

![Figure 4-1: Knowledge of the Relationship between HIV and AIDS](image)

Only two-thirds of males and females correctly noted that HIV led to AIDS, with the remainder either believing that HIV and AIDS were the same thing, or did not know whether, or how, they were related; there was no variation across males and females (chi-square test insignificant at
Married males were significantly less likely to correctly note the relationship between HIV and AIDS than single males (chi-square significant at the .1 level; 13.502, \(p=.000\)). Married females were substantially more likely to correctly note the relationship between HIV and AIDS than married males, while there was no variation across married or single females (chi-square insignificant at the .1 level; 13.502, \(p=.000\)).

Similarly, older males were significantly less likely to correctly note the relationship between HIV and AIDS than younger males (and many of these men were married) (chi-square significant at the .1 level; 6.477, \(p=.011\)). For women, again, there was no covariation between age and knowledge (chi-square insignificant at the .1 level; .308, \(p=.579\)).

The higher the level of education, the higher the knowledge for both males (chi-square significant at the .1 level; 30.315, \(p=.000\)) and females (chi-square significant at the .1 level; 15.570, \(p=.000\)). It should nevertheless be noted that only half of females with primary education or lower correctly noted the relationship between HIV and AIDS.

Using cash income as a proxy for socio-economic status, males from households with regular cash income were more likely to correctly note the relationship between HIV and AIDS (chi-square test significant at the .1 level; 3.100, \(p=.078\)). This was not the case for females.

There was no variation across levels of knowledge and the sex of the head of the household.

Following the question on the relationship between HIV and AIDS, respondents were asked how long it took for someone infected with HIV to become chronically sick with an AIDS-related illness. Because of high levels of poverty in the PDA, resulting in numerous health challenges, a low cut off point was set for ‘correct’ knowledge of 3 years. Findings are indicated in the following figure:

Figure 1-2: Knowledge of Length of Time from HIV to AIDS

1 The chi-square test establishes whether there is a difference between the populations under study, in this case males and females. A \(p\) value of less than .1 indicates covariation between the two, and that therefore there is a difference. A \(p\) value of .1 or above indicates that the two populations are the same, that there is no difference.

2 Normally the cut off is six years, but in an environment such as the PDA, with poor nutrition a common problem, and numerous challenges to good health (e.g., using the bush as a toilet, lack of clean water, etc.), the cut off was set at a lower value.
Just over half of the respondents correctly noted the length of time between HIV infection and the ending of the asymptomatic phase of HIV and the onset of AIDS-related illnesses. Of those who did not give a correct response, 91.8% of the female respondents indicated that they ‘did not know’, as did half of the male respondents. In general, there was no variation across any demographic and socio-economic status variables and knowledge of the asymptomatic phase of HIV, with the exception of males with higher levels of education, who were more likely to know the correct asymptomatic phase.

Combining the three together, of the 120 male respondents and 120 female respondents, 46.7% of the males and 40.8% of the females had heard of HIV/AIDS, knew the relationship between the two, and knew the average length of the asymptomatic phase of HIV. For the study population, therefore, over half did not have a basic understanding of HIV and AIDS.

Focus group discussion (FGD) findings confirmed basic awareness of HIV/AIDS, but also highlighted misconceptions and a lack of understanding of the virus. FGD findings, in particular, underlined the ‘hit and miss’ nature of channels of communication that resulted in these levels of awareness. Only three channels were noted by FGD respondents as even raising issues around HIV/AIDS: 1) schools, where in recent years the social science curriculum has included HIV/AIDS; 2) peers; and 3) radio. Other sources, such as peer educators, health motivators, parents, etc. were felt to be largely unimportant. Even through these channels, however, there was considerable confusion and many information gaps.

Discussions around the role of parents in transferring knowledge about sexual matters was particularly interesting. Most of the FGD participants noted that traditional systems of knowledge transfer no longer existed, and that parents played little role in the transmission of information. Instead, their role was generally limited to threats and attempts to scare young people from being sexually active. The result was the absence of any transfer of knowledge and experience through parental channels, or from grandparents. A number of male and female FGD participants highlighted that these knowledge transfer systems had ceased to exist a number of years ago, and that this meant that they themselves had numerous ‘knowledge gaps’, hampering their ability to talk to their kids even if they wanted to.

Some of the older FGD participants felt that a further problem was that young people were ‘too aware of their rights’, and that this meant that they were not allowed to discipline their children. In this environment, parents became fatalistic about what could be done. It is nevertheless interesting to note that young people themselves did not raise this point, nor were clear examples given of young people ‘asserting their rights’ in this regard. It is also interesting to note that the concern of these participants was an inability to ‘discipline’ their children, rather than sanction against talking to their children about sexual matters. As one of the FGD facilitators noted, ‘it is likely that parents would not worry about being challenged about a child’s rights when instructing the child to care for livestock’.

2.3 Knowledge of Prevention

Those respondents who had ever heard of HIV/AIDS (120 males and 111 females) were asked whether there was any way of preventing infection with HIV. A high 98.3% of males and 99.1% of females indicated that there were ways of preventing HIV transmission (chi-square insignificant at the .1 level; .264, p=.608). A follow-up question asked what could be done, with findings indicated in the following figure:
The consistent use of condoms was most commonly mentioned by both males and females, followed by full abstinence, sticking to a single uninfected partner, and finally avoiding contamination with infected blood. Males were more likely to note having a single uninfected partner, while females were more likely to note the importance of avoiding contamination with infected blood. Findings suggest that most respondents are aware of the basic issues of condom use, abstinence, and faithfulness as mechanisms to prevent HIV transmission. Those with higher levels of education were more likely to note abstinence as a means of preventing HIV transmission, although there was little difference for other responses.

Other responses suggest certain limitations on knowledge of means of prevention, including judgement calls on when someone is infected ('use condom if suspect HIV'), and having only a single partner at one time.

2.4 True-False Statements

Following these initial questions, respondents were asked to indicate whether a variety of statements were true or false, or that they did not know. Findings are indicated in the following table:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>The AIDS virus can be spread by touching someone who has it, for example shaking hands</td>
<td>Correct: 95.0 Incorrect: 5.0</td>
<td>Correct: 82.9 Incorrect: 17.1</td>
</tr>
<tr>
<td>Kissing someone who has the AIDS virus can result in transmission of the virus</td>
<td>Correct: 67.5 Incorrect: 32.5</td>
<td>Correct: 57.7 Incorrect: 42.3</td>
</tr>
<tr>
<td>Mosquitoes can transmit the AIDS virus</td>
<td>Correct: 55.8 Incorrect: 44.2</td>
<td>Correct: 54.1 Incorrect: 45.9</td>
</tr>
<tr>
<td>You can see when someone has the AIDS virus soon after they are infected, because they show clear symptoms</td>
<td>Correct: 88.3 Incorrect: 11.7</td>
<td>Correct: 72.1 Incorrect: 18.9</td>
</tr>
<tr>
<td>A person who has the AIDS virus but looks and feels healthy cannot infect other people</td>
<td>Correct: 85.0 Incorrect: 15.0</td>
<td>Correct: 80.2 Incorrect: 19.8</td>
</tr>
</tbody>
</table>
Most respondents correctly noted that touching could not spread HIV. However, one-third of males and over 40% of females thought that HIV could be transmitted through kissing, or did not know, and even higher numbers thought that mosquitoes could transmit HIV, or did not know. A worrying 18.9% of female respondents thought that ‘clear symptoms’ of HIV infection would show up soon after infection, and 19.8% of female respondents and 15% of male respondents thought that a person who was infected but looked healthy could not infect others with HIV (or did not know). Findings were mixed in terms of males and females, with no variation for kissing, mosquitoes, and knowledge that someone with HIV but with no symptoms could transmit the virus.

The following table shows findings from two true-false statements about condoms and HIV transmission:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Correct</td>
<td>Incorrect</td>
</tr>
<tr>
<td>Using a condom during sex does little or nothing to prevent the transmission of HIV</td>
<td>44.2</td>
<td>55.8</td>
</tr>
<tr>
<td>Condoms themselves carry HIV</td>
<td>68.3</td>
<td>31.7</td>
</tr>
</tbody>
</table>

A high 55.8% of male respondents felt that the use of condoms did little or nothing to prevent transmission of HIV, falling significantly for females to 27.3%. Of the male respondents, few indicated ‘do not know’, but rather said that it was true that condoms did little. Of interest, a high 55% of female respondents indicated that condoms themselves could carry HIV, with almost one-third of males also holding this view.

Respondents were presented with two statements about the ability of medical services and traditional healers to ‘cure’ HIV/AIDS. One-third of female respondents (34.2%) thought that medical services could actually cure HIV/AIDS, as did a much lower 15.8% of males. For traditional doctors, fewer women and men felt that they could offer a cure (27% for females, and 10% for males). The higher levels of agreement by women with regard to medical services may perhaps be due to confusion about the effects of anti-retroviral drugs (confusing the enhancement of the immune system with a cure), given that they are more likely to come into contact with health workers and attend clinics.

Only a few respondents agreed that ‘if someone has a sexual disease, this reduces the chances that they can contract HIV’ (1.7% for males and 6.3% for females). An additional 2.5% of males and 9.9% of females indicated that they ‘did not know’ whether it would have this effect or not. In total, therefore, 95.8% of males but a much lower 83.8% of females knew that having another sexual disease did not lower risk of HIV infection. The finding for women is especially of concern, given that having another sexual disease may increase the risk of HIV infection dramatically (between six and thirty times the risk).

Respondents were presented with the following statement: “Having unprotected sex with someone who has the AIDS virus will inevitably mean that this person will become infected”. Findings are summarised in the following figure:
A very high 84.7% of female respondents, and two-thirds of male respondents incorrectly noted that HIV transmission was inevitable if one had unprotected sex with another who was HIV positive (chi-square significant at the .1 level; 12.298, p=.002). Of interest, the vast majority of these agreed with the statement, rather than note ‘do not know’. It is perhaps findings like this that explain a high degree of fatalism noted in the FGDs. Many of the FGD participants, both male and female, felt that HIV/AIDS was so common in Swaziland that those who had sex were likely to get infected, so there was little that one could do.

Despite thinking that HIV transmission from one sexual partner to another was inevitable, when specifically asked, many respondents were aware that it was possible to reduce the risk of transmission from a mother to a child during childbirth. A high 91% of female respondents, and a lower but still high 72.5% of male respondents, noted that the statement ‘There are drugs that make it less likely that a pregnant woman would transmit the virus to her child’ was true. Only 4.5% of female respondents argued that the statement was false (chi-square significant at the .1 level; 13.441, p=.001). Further, 61.3% of female respondents and 40.8% of male respondents indicated that the statement ‘If someone is raped, there is emergency treatment that could help prevent infection from HIV’ was true, although over half of the male respondents thought that this was not true or did not know (chi-square significant at the .1 level; 10.197, p=.006).

Respondents were asked whether there was a test to see if one were HIV positive. Findings are summarised in the following figure:
Virtually all of the respondents were aware of HIV testing, holding for both males and females (chi-square test significant at the .1 level; $\chi^2 = 243$, $p = .886$).

As a final true-false statement, respondents were presented with the statement ‘If someone with the AIDS virus has access to the right drugs and good food, they can live fifteen years or more after infection’. Similarly high percentages correctly noted that this was true (96.7% for males, 94.6% for females), and almost all the remainder indicated ‘do not know’. Findings suggest a high level of awareness that improved nutrition and access to anti-retroviral drugs could significantly prolong the lives of those HIV positive. This is a particularly important finding in light of the fact that just over half of the respondents correctly noted the length of time from HIV infection to the onset of AIDS-related illnesses that would require ARVs. Clouding this point, however, is findings from the FGDs that suggested that people who knew that they were HIV positive had little to live for. Concerns were raised in terms of being able to get married, raise a family, and avoid infecting spouses, to concerns about orphans, and the stigma associated with others finding out your HIV positive status. Some FGD participants also noted serious concerns about side effects associated with anti retroviral drugs (most of it based on rumours), and problems in maintaining sufficient food intake year round to stay healthy. With such concerns, high levels of awareness about drugs and nutrition are not likely to translate into any sense of hope if one finds themselves HIV positive.

A composite variable was created that tallied the number of correct responses out of fifteen total responses to the true-false statements. Out of 15 possible correct responses, male respondents answered an average (median) of 11 correctly, with the mean slightly higher at 11.2. For females, the median number of correct responses was still high, but was lower than for males, at 10 (with the mean much lower, at 9.2). Classifying those who answered seven or less correctly as having ‘low knowledge’, and those who answer eight or more correctly as having ‘high knowledge’, the following is the result;
A significant 94.2% of male respondents, and a lower but also quite significant 83.8% of female respondents had 'high' levels of knowledge about HIV/AIDS, with males more likely to answer eight or more correctly than females (chi-square significant at the .1 level; 6.441, p=.011). Findings indicate very high levels of knowledge among both males and females in the PDA. FGD participants noted that there were two principal sources for basic knowledge about HIV/AIDS: schools and the radio. While both transmitted factual information, however, there was a widespread concern that the information so provided was not properly contextualised (that is, it did not seem relevant for the lives of people), nor did it provide information that would enable behavioural change.

2.5 Other Qualitative Findings

Four ‘knowledge’ questions were put to FGD participants under the general question “as practiced in communities in this area, how do young people learn about sexual issues, reproduction, sexual diseases, etc.:

1. How has this changed over time?
2. How has it strengthened over time? That is, how has it gotten better?
3. How has it weakened over time? That is, how has it gotten worse?
4. Are these traditional channels of teaching as effective as they once were?

Virtually all of the groups responded to the main question by initially noting that ‘nothing is being taught to anyone’. It was only after some probing that the majority of the groups noted that, however minor, some things were being done, but that channels were rarely systematic, and that the information was uniformly felt to be inadequate, confusing, and of little use. While basic ‘facts’ could be repeated, such as the utility of condoms in prevention the transmission of HIV, or information on how HIV is spread, FGD participants did not feel that this was effectively translated into ideas that had meaning in their lives. For the young, the schooling system represented essentially the sole channel of any substance in understanding things such as sexual diseases, but that such issues were considered in a largely biological manner, and had no relevance for the situations they faced as young people. Information from the schooling system was supplemented by things heard over the radio and from friends, but
neither of these did much to changes behaviours. As one group noted, ‘this is not useful for the lives we live here’.

Former systems of ‘communal education’, liguma for girls and lisango for boys, had disappeared many years ago, and nothing has replaced them. None of the respondents felt that the system could ever ‘come back’, with one putting it quite succinctly: “there is no going back”. Some of the older respondents noted that there was no need to go back to these systems in any event ‘because young people learn about these things in school’. Further, older respondents often noted that younger people were better informed of sexual matters than those in the family, such as the grandmother, who might try and inform them.

Younger respondents, on the other hand, noted how inadequate the information was in the schooling system. While the majority of respondents felt that covering these issues in school was important, and a positive development, there was a sense that there were important gaps in knowledge that the school system did not cater for, and that much more was needed. Many participants, young and old, concluded that young people today were significantly more ill-informed about sexual matters today than their age cohorts from many years ago, from basic information about puberty, to information on how to prevent sexual diseases and pregnancy. One group put it quite succinctly, ‘sexual issues are approached in school at an academic level, they do not make sense in our society’. Without any systems in place to contextualise this information, it was not felt to be especially useful.

Discussions with married women and men yielded interesting insights into knowledge about sexual matters, sexual diseases included. Traditionally, it was the duty of the husband’s mother or the wife’s mother to educate a new wife on what was expected of her. This was built on a history of discussions between the grandmother and the young girl following the young girl’s first menstruation, and as such was a ‘natural’ process. With the loss of this traditional system, information tended to focus on biological matters, and even this was not reinforced in future through any other learning channels. As one FGD facilitator noted, “women are expected to go from being sexually inexperienced and ignorant to being sexually mature and well-informed” when they get married, without any mechanisms in place to help them in this regard.

For young men, traditional systems had broken down as well, and often young men were even more ill-informed about sexual issues than women of a similar age. Participants noted two reasons for this: 1) while young men had lost important channels of information on sexual matters, they retained a view that they were expected to be sexually active and promiscuous and ‘in charge’ of sexual decision-making; and 2) cross-generational sex was felt to be common, with younger women preferring older men who were felt to be better off economically and more competent sexually. A few of the younger groups added that it was not just in terms of the transfer of information on sexual matters that had changed in the relationship between young and old. Broader socialisation patterns were felt to have changed. The increasing ‘distance’ between the young and old was commonly noted, with adults perceived to have little time for the young. As one group in KaGamedze noted, ‘we don’t spend time with adults because they say we like hearing their business. We should sit with our peers, we are told’.

It is interesting to note that respondents who had children felt that they had lost the ability to educate their children about sex. There were two main reasons for this: 1) a belief that younger people knew more than they did; and 2) the often repeated statement that young people ‘knew too much about their rights’. For the latter, it is notable that the issue revolved around corporal punishment for being sexually active, such as impregnating/being impregnated outside of marriage, or for that matter any sexual activity, rather than improved knowledge or positive approaches to changing behaviours.
3 Attitudes

3.1 Introduction

In this chapter, findings from the quantitative questionnaire and focus group discussions are presented covering a variety of attitudes about HIV/AIDS, prevention of infection, risk, and testing. Attitudinal scale statements were presented, with the statement read by the enumerator, and respondents asked to 'strongly agree', 'agree', 'disagree', or 'strongly disagree' with the statement.

3.2 Stigma and Discrimination

Two statements covered stigma and discrimination:

- I would let children from this family play with children from another family, even if you suspected that the other children had HIV.
- I would be willing to buy fresh fruits and vegetables or prepared food from a shopkeeper even if you thought the shopkeeper had HIV.

Findings are indicated in the following figures:

<table>
<thead>
<tr>
<th>Figure 1-6: Let Children Play Even if HIV+</th>
<th>Figure 1-7: Willing Purchase Food One HIV+</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Figure 1-6" /></td>
<td><img src="image2.png" alt="Figure 1-7" /></td>
</tr>
</tbody>
</table>

Approximately three-quarters of the respondents held positive attitudes about factors normally associated with stigma and discrimination, with no variation across males and females. There was no covariation between a number of demographic and socio-economic status variables and responses to these two questions, with the exception of education status where it tended to covary with education (that is, the higher the level of education, the more likely they were to agree with the statement). While this finding is quite positive, findings from the FGDs highlight some limitations in this regard. Both male and female respondents, especially older ones,
noted that people who were found to have AIDS were often felt to have contracted HIV because of their ‘immoral’ behaviour.

3.3 Perception of Risk

One question and two statements were asked associated with perceptions of risk of HIV infection:

- Based on what you know about how HIV is spread, what would you say are your chances of infection? Would you say that they are high, medium, low or none?
- HIV/AIDS is really only a problem in other areas, it is not here in our area.
- I do not think that any of my peers have HIV, even those who are sexually active.

Findings for the question on risk perception (the first question) are indicated in the following figure:

![Figure 1-8: Risk Perception](image)

Only one-in-five felt that they were at high risk of HIV infection, despite Swaziland having perhaps the highest HIV prevalence in the world. One-third are uncertain, and the remainder feel that they are not at high risk (almost half, at 45% for males and 46.4% for females), with males in particular feeling that they are not at risk (chi-square significant at the .1 level; 10.861, p=.028). Younger males are significantly less likely than older males to believe themselves at risk (chi-square significant at the .1 level; 5.326, p=.021), while there was no difference across age group for women (chi-square insignificant at the .1 level; .415, p=.626). There was also no covariation between risk perception and marital status, nor was there any covariation between education status and risk perception, or income status and risk perception.

Quantitative respondents were asked to agree or disagree with the statement ‘sexual decision-making has little to do with the risk of HIV infection’. The aim was to establish whether people felt that sexual behaviour might have something to do with risk. A high 81.4% of females and
79.6% of males disagreed with the statement, noting that they felt that risk behaviours were associated with infection.

The low risk perceptions are particularly interesting given that almost all of the respondents disagree with the statement ‘HIV/AIDS is really only a problem in other areas, it is not here in our area’ (94.5% of males and 89% of females disagreed with the statement). To add further support, 97% of females and 93.9% of males disagreed with the statement ‘I do not think that any of my peers have HIV, even those who are sexually active’. In addition, 86.2% of male respondents and 78.1% of female respondents disagreed with the statement ‘The actual risk of contracting HIV is very low’. Females with higher levels of education were especially likely to disagree with the statement (chi-square insignificant at the .1 level; 3.267, p=.071). Findings suggest a ‘disconnect’ between actual risk and perceptions of risk in this regard.

FGD participants were asked about levels of risk perception. The first question was as follows: “Studies elsewhere in southern Africa have found that single people usually do not take HIV/AIDS into consideration when making decisions about sex. Here in your area, what factors determine sexual decision-making”. In considering the broad significance of the comments made by participants, the FGD facilitators came to the conclusion that people felt that there was a general awareness that the risk of HIV infection was high in Swaziland, but that this had little relevance for the lives of the respondents -- they themselves were not at risk.

In part this comes from an understandable state of denial about the risk one faces, but it also reflects significant confusion about HIV/AIDS and the threat it poses. There is much about HIV and AIDS that is difficult to understand, and the evolution of the response to HIV/AIDS and the messages associated with the response has added to this confusion. A number of the participants noted that what they had heard tended to be ‘academic’ in presentation, and often dealt with details that different leaders and experts disagreed over. Some noted, for example, that conflicting information had been received about the percentage of Swazis HIV positive, how long one could live if one was HIV positive, the level of risk of infecting someone else with HIV if one were HIV positive, etc. Further, FGD findings suggest that one possible reason for lower than expected risk perception, in the context of perceptions of high ‘community’ risk, arises from a feeling that they themselves will not contract HIV if they behave in a ‘moral fashion’, even if other ‘moral’ people had died of AIDS. Some commented that they had heard on the radio, and through peers, about people who ‘misbehaved’ (mentioning ‘high risk groups’ such as truck drivers and sex workers), and through this became HIV positive. As they themselves did not fall into a high risk group, their risk of infection was felt to be low, regardless of their own behaviour.

There was also a distrust arising from the reliance on statistics to elaborate on the extent of the epidemic in a situation where many did not understand how statistics works. One group of adolescent females at Mphilingo, for example, asked how it was known that Swaziland had a high rate of HIV infection, ‘how can they know before they have tested everyone?’ Adolescent males at Ngcamphalala noted that ‘Swaziland is a tiny country so it cannot possibly have the highest rate of infection in the world’, adding ‘how do you know all the countries in the world have been tested’; this was echoed by wives of migrant workers at Maphaphati.

A number of participants also highlighted their confusion over messages around HIV/AIDS and their own risk profile. Of particular concern were the messages around ‘AIDS Kills’, ‘Casual Sex Kills’, and ‘Secret Lovers Kill’, because if one had not already died, one must be HIV negative.

Two further attitudinal statements pertain to the response to risk:

- Abstinence is not really realistic for people my age.
- If I was a teenager today, I doubt that I would be able to abstain from sex until I got older.
Just over half of the respondents (60% for males and 51.9% for females) felt that abstinence was realistic for their age groups, while an even higher percentage felt that abstinence was even more realistic for teenagers (68.6% for males and 67.9% for females). Yet the vast majority of respondents, across age groups, were not abstinent, as will be seen in Chapter 4.

3.4 Discussion of Sexual Matters

Respondents were read the statement ‘People don’t talk openly with others, even their peers, about sexual issues, and certainly not sexual diseases’. Most respondents agreed with the statement (85.4% for females, and 62.6% for males; chi-square significant at the .1 level, 14.501; p=.000), with most of the female respondents strongly agreeing. For males, most of those who did not agree ‘disagreed’, rather than ‘strongly disagreed’. There was no variation across education status and the response to this question for either males or females.

FGD findings underlined the lack of dialogue about sexual issues. With a lack of information about sexual matters, knowledge was felt to be inadequate, and rumour and confusion existed instead of knowledge sharing. In this respect most participants did not feel that peers were discussing important sexual matters, but instead simply adding to the confusion. For men, male FGD participants often noted that discussions in peer groups were meant to show that one was sexually experienced and a ‘good lover’ able to attract many girlfriends. For women, female FGD participants often noted that peer discussions around sexual issues were more focused on their roles as wives or girlfriends, not around effective sexual decision-making to protect oneself from HIV infection.

3.5 Sexual Norms

Respondents were presented with the following statements regarding cultural norms about sexual issues:

- In this area, it is normal for a man to have sexual partners outside of marriage.
- Women in polygamous marriages are more likely to have casual sexual relationships outside of marriage.
- In our community, there are many good role models that show us how to only have sex within marriage.
- The messages that people are getting today about things like HIV/AIDS don’t reflect the fact that there are many traditional factors on how we make decisions about sexual issues.
- Current messages on HIV/AIDS show disrespect for Swazi culture.

Respondents noted that it was normal for men in their area to have sexual partners outside of marriage, as indicated in the following figure:
A high percentage of both males and females agreed with the statement (chi-square insignificant at the .1 level; 2.101, p=.147), with females particularly likely to ‘strongly agree’, and males likely to ‘agree’ with the statement. Only 1.7% of respondents indicated that they ‘did not know’, and only 2.6% ‘strongly disagreed’ with the statement. FGD findings yielded similar results, with both male and female participants noting that such relationships were common, and were not necessarily frowned upon.

A similar question was asked about women, with specific relevance to women in polygamous marriages: ‘Women in polygamous marriages are more likely to have casual sexual relationships outside of marriage’. An even higher 94.1% of males and 93.5% of females agreed with the statement (chi-square insignificant at the .1 level; .027, p=.869). Female respondents were more likely to ‘strongly agree’ with the statement, and males to ‘agree’. Female FGD participants argued that married women also tended to have sexual partners outside of marriage, and not just women in polygamous relationships.

Despite this, 85.1% of males and 77.9% of females agreed with the statement ‘In our community, there are many good role models that show us how to only have sex within marriage’ (chi-square insignificant at the .1 level; 1.883, p=.170). While there were high levels of agreement, most of the respondents who agreed with the statement only ‘agreed’, with few ‘strongly agreeing’.

Turning to the two questions on culture and HIV/AIDS, respondents were read the statement ‘the messages that people are getting today about things like HIV/AIDS don’t reflect the fact that there are many traditional factors on how we make decisions about sexual issues’. A second statement said ‘current messages on HIV/AIDS show disrespect for Swazi culture’.

Findings for both of these are indicated in the following two figures:
A very low percentage of males agreed with the first statement on message content not accounting for traditional factors (16.8%), although most who disagreed only 'disagreed', rather than 'strongly disagreed'. Even for females, two-thirds disagreed with the statement (chi-square significant at the .1 level; 10.093, p=.001). Regarding ‘disrespect for Swazi culture’, two-thirds of males and one-half of females disagreed, but this nevertheless indicates that the other half of female respondents and one-third of male respondents felt that the message did indeed show disrespect for Swazi culture (chi-square significant at the .1 level; 3.054, p=.081). Findings suggest some concern, among females, for the appropriateness of HIV/AIDS-related messages and Swazi cultural norms; this was much less the case for males. For males, those with lower levels of education tended to be more concerned about the appropriateness of messages, although this was not the case for females.

Findings from the FGDs tended to be consistent with these findings. The issue was not necessarily one of traditional factors that influenced behaviours (‘there is no going back’ to previous systems of learning about sexual issues, two groups noted), but rather coming to terms with the lack of effective systems now in place. Central to this is sufficient knowledge and understanding of HIV/AIDS, and placing HIV/AIDS within the context of sexual decision-making, so that people could do what they could to avoid infection, and properly understand their risk.

3.6 Condoms

Respondents were presented with the following statements regarding condoms:

- Really, the reason we use condoms is mostly to prevent pregnancy.
- When a relationship moves from casual to serious, it is very difficult to continue to use condoms because a serious relationship is about trust.
The real problem regarding condoms is that people my age don’t feel comfortable going to current sources to get them.

Findings about condom use and pregnancy are indicated in the following figure:

Figure 1-12: ‘Really, the reason we use condoms is mostly to prevent pregnancy’

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>71.2</td>
<td>67.3</td>
</tr>
<tr>
<td>Agree</td>
<td>28.8</td>
<td>32.7</td>
</tr>
</tbody>
</table>

Only one-quarter of males and one-third of females agreed with the statement (chi-square insignificant at the .1 level; .410, p=.522), suggesting that condom use may be equally used for the prevention of sexual diseases (condom use levels are discussed in the next chapter). Three-quarters of female respondents (76.3%) and two-thirds of male respondents (62.1%) agreed with the statement ‘the real problem regarding condoms is that people my age don’t feel comfortable going to current sources to get them’ (chi-square significant at the .1 level; 4.954, p=.026). This was especially a problem for younger males (72.7% of 18-24 year olds agreed, compared to 41% for 25-34 year olds; chi-square significant at the .1 level; 11.051, p=.001), although this did not hold for younger females chi-square insignificant at the .1 level; .351; p=.554).

Two-thirds of respondents agreed with the statement ‘when a relationship moves from casual to serious, it is very difficult to continue to use condoms because a serious relationship is about trust’ (67.6% for females and 64.6% for males; chi-square insignificant at the .1 level, .222; p=.638). For male and female respondents, most of those who agreed ‘agreed’ with the statement, rather than ‘strongly agreed’.

Condom use for married couples was checked to see if marriages with high age gaps had lower levels of condom use than marriages with low age gaps. Findings indicate that there is no difference between the two groups (f-test insignificant at the .1 level; f=.949, sig=.394).

3.7 Testing

Respondents were presented with the following statements regarding HIV testing:

- I would be quite afraid to go for a test for HIV.
- Why bother going for testing for HIV, there is nothing that can be done if one has the virus.

Findings regarding ‘I would be quite afraid to go for a test for HIV’ are indicated in the following figure:

Figure 1-13: ‘I would be quite afraid to go for a test for HIV’

![Bar Chart]

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>68.1</td>
<td>44.5</td>
</tr>
<tr>
<td>Disagree</td>
<td>31.9</td>
<td>55.5</td>
</tr>
</tbody>
</table>

Female respondents were much more likely to agree with the statement, at 55.5% versus a much lower 31.9% for males (chi-square significant at the .1 level; 12.887, p=.000). The differences between males and females is particularly stark given that most females who agreed with the statement ‘strongly agreed’, while most males that disagreed with the statement ‘strongly disagree’. The findings are particularly surprising given very low levels of agreement with the statement ‘why both going for testing for HIV, there is nothing that can be done if one has the virus’, which only 7.5% of females agreed with (as did 14.3% of males; chi-square insignificant at the .1 level; 2.655, p=.103). This latter finding suggests that most respondents were aware that people who were HIV positive could do something to prolong their lives (this is consistent with knowledge findings in Chapter 2). The ‘disconnect’ could be associated with a concern about not wanting to know that one might be HIV positive, coupled with a concern that, even if drugs do exist, they would not be able to afford to access them, or know the complexities in accessing anti-retroviral drugs (they can only be obtained at hospitals, which are some distance from the PDA, CD4 counts can only take place at hospitals, etc.), or improve their nutrition.

FGD participants highlighted the importance of testing and access to drugs in changing behaviours that could reduce rates of infection, but also to help those who find that they are HIV positive. Numerous examples were given of the stated ‘futility’ of prevention efforts without knowing what could be done if one were to become infected, and without knowing how to protect oneself in difficult situations. Prevention was felt to be one element in responding to HIV/AIDS but, without care and support and help in alleviating major impacts, it was uncertain what role prevention alone could play. Nevertheless, younger FGD participants in particular argued that testing would never ‘catch on’ in the wider population if there was nothing that could be done for those who were found to be HIV positive, or nothing that could be done for those HIV negative to stay negative. Stigma was felt to be a problem, access to ARVs was felt
to be limited (as was access to condoms), and many homesteads in the area were not capable to meeting the nutrition needs of those found to be HIV positive throughout the year.

3.8 Other

Two final attitudinal statements were covered:

- There are so many problems that we face here in this area, HIV/AIDS is just one more problem that we cannot afford to be too concerned about.
- Really, we are very confused about HIV/AIDS.

Regarding ‘one problem among many’, 57.8% of female respondents but a much lower 38.1% of male respondents agreed with the statement (chi-square significant at the .1 level, 8.783, p=.003), highlighting the many challenges facing women in the PDA.

Findings on ‘really, we are very confused about HIV/AIDS’ are indicated in the following figure. Findings are presented for ‘strongly agree’, ‘agree’, ‘disagree’, and ‘strongly disagree’ to highlight differences between males and females:

Figure 1-14: ‘Really, we are very confused about HIV/AIDS’

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>10.0</td>
<td>3.6</td>
</tr>
<tr>
<td>Disagree</td>
<td>6.7</td>
<td>9.0</td>
</tr>
<tr>
<td>Agree</td>
<td>35.0</td>
<td>9.0</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>48.3</td>
<td>78.4</td>
</tr>
</tbody>
</table>

An extremely high 78.4% of female respondents ‘strongly agreed’ with the statement, reflecting high levels of confusion. A much lower 48.3% of male respondents ‘strongly agree’, but most of the remainder of both males and females ‘agreed’ with the statement. Taken together, 87.4% of female respondents and 82.3% of male respondents agreed with the statement, with only 12.6% of female respondents and 17.7% of male respondents indicating that they were not confused.

The level of confusion around HIV/AIDS was highlighted in the FGDs. Over and over again participants noted that there was substantial confusion about what HIV ‘really’ was, how it was transmitted, how it could be prevented, how common it was in the area, and what one could do
about it. When considering that systems for knowledge transfer about sexual matters had collapsed, in the context of rapid social change (including the many changes being brought about by the Project), and in the context of the continuation of high risk behaviours, the level of confusion is especially worrisome.
4 Practices

4.1 Introduction

In this chapter, findings from the survey and focus group discussions are presented covering practices. Issues covered comprise basic sexual behaviours, cross-generational sex and sex in exchange for gifts/money/economic security, regular and casual sexual relationships, alcohol use and casual sexual relationships, physical and emotional pressure for sex, testing, and chronic illness. In addition, attitudinal statements of relevance to behaviours are included in this chapter.

4.2 Sexual Activity

Respondents were asked questions about ‘ever had sex’ and current sexual behaviours. Ever had sex is indicated in the following figure:

Figure 1-15: Ever Had Sex

Only 76.7% of male respondents had ever had sex\(^3\), compared to a higher 90.8% of female respondents. Findings were checked against age group, dividing them into the two groups 18-24 and 25-34. For the older age group, almost all were sexually active. The difference between males and females is in the 18-24 age group, where 85.7% of female respondents but only 68.8% of male respondents were sexually active. The mean age at first sex was 17 for female respondents and a higher 18 for male respondents. In part the gap between males and females appears to arise from females being married, presumably at a younger age, than males, but even single females were significantly more likely to have ever had sex than single males. The gap between males and females was tested against a variety of variables around being forced to have sex, being in a relationship where the woman was dependent on the man

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\(^3\) If a respondent indicated that s/he had never had sex, the enumerator sought to confirm the statement before moving on.
for material goods in exchange for sex. Surprisingly, none of these were common. It emerged from focus group discussions that it was, simply put, a 'social norm' for young women to enter into sexual relationships to try and secure a stable relationship and, eventually, marriage. Most of these relationships were likely to be with slightly older men (but not cross-generational sex, as measured as ten years or more older), reflected in lower sexual entry ages for females compared to males, and lower numbers of males sexually active until their early twenties. This may reflect strongly rural social norms, compared to more fluid situations in more urban environments.

Sexually active respondents were asked about current sexual activity (defined as any sexual activity over the past year), and the number of ‘regular’ and ‘casual’ partners. Regular partners were defined as ‘partners whom the respondent felt was serious, and with whom they were having, or expected to have, a long-term relationship’. Casual partners were defined as ‘partners whom they did not, do not, or do not intend to have a serious relationship with’. Of the 90.8% of sexually active females and 76.7% of sexually active males, the majority were sexually active over the past year (87.8% for males, 84.8% for females; chi-square insignificant at the .1 level; .370, p=.543). Regular and casual partnerships can be summarised as follows:

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only 4.9% of males had</td>
<td>Only 1.1% of females had no regular partners, only had a casual partner.</td>
<td>Only 1.1% of females had no regular partners, but a casual partner.</td>
</tr>
<tr>
<td>the median number of</td>
<td>The median number of regular partners was 1, with 22% having more than one regular partner. This meant that only one-in-five of the male respondents had more than one regular partner in a year.</td>
<td>The median number of regular partners was 1, with only 4.2% having more than one regular partner. This means that only a small number of females had more than one regular partner in a year.</td>
</tr>
<tr>
<td>regular partners was 1,</td>
<td>A high 35.6% had at least one casual partner in the year before the survey. The median number of casual partners was 0, but the mean was much higher at 1.15, reflecting the fact that those with casual partners had more than one such partner.</td>
<td>Only 9.6% of females had a casual partner in the year before the survey. The mean figure was only .154, reflecting the high number of respondents with no casual partners, but also the relatively low number of casual partners for those who had any.</td>
</tr>
<tr>
<td>with 22% having more</td>
<td>Most of those who had casual partners were unmarried.</td>
<td>Unlike male respondents, married female respondents were equally likely to have a casual partner as single female respondents, although it should be remembered that few in either category had casual partners.</td>
</tr>
<tr>
<td>than one regular partner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Median refers to the middle observation, that is, where the observation marking half way appears, while the mean reflects the total number of cases added in for interval measure variable, divided by the total number of cases. For example, if there are a small number of people who have a large number of partners, the mean will increase, and be above the median.

Most of those currently sexually active had a regular partner; this held for both males and females. In the case of males, almost one-quarter had had two or more regular partners in the course of a single year, compared to only a small number of women. One-third of males had had at least one casual sexual partner, compared to less than 10% for females. Most of the males who had had a casual partner were single, rather than married. While it is likely that there is systematic under-reporting of the number of casual partners for married men, the differences between those who were married and those who were single was substantially different, suggesting actual behavioural differences.

The findings are interesting in light of the high levels of agreement with statements about married women (in polygamous marriages) and married men with outside casual partners. Beyond the possibility of under-reporting, which can explain in part what might be going on, it is likely that there are traditional social norms that encourage polygamous marriage for men rather than external casual sexual partners, and women seeking regular partnerships, rather
than casual ones. While such relationships may therefore be felt to be common, perhaps because ‘everyone knows someone’ who is engaged in such a relationship, it does not apply to the majority of males or females; this is consistent with high levels of agreement with the statement about positive role models in the community.

4.3 Condom Use

Given that most sexually active respondents are in relationships with regular partners, but with one-third of males involved in casual relationships as well, and considering high levels of HIV infection in the population, means to prevent transmission within stable relationships, and between males and casual partners, is especially important. Condoms have a particularly important role to play in this regard.

Three questions were asked about condom use: 1) ever used; 2) use with regular partner; and 3) use with casual partner. Findings are summarised in the following table:

<table>
<thead>
<tr>
<th>Table 1-5: Condom Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males</strong></td>
</tr>
<tr>
<td>* 78.9% had used a condom at least once in their lives.</td>
</tr>
<tr>
<td>* 50.7% of respondents had used a condom with a regular partner the last time they had had sex.</td>
</tr>
<tr>
<td>* Males are significantly more likely to use a condom in a casual sexual partnership than a regular one, likely reflecting higher levels of sexual decision-making in casual relationships for the female partner.</td>
</tr>
<tr>
<td>* There was no relationship between condom use and a belief that condoms could prevent HIV transmission.***</td>
</tr>
<tr>
<td>* Those who felt that condoms might themselves carry HIV were more likely to have not used a condom.******</td>
</tr>
</tbody>
</table>

* Chi-square insignificant at the .1 level; 1.106, p=.293.
** Chi-square insignificant at the .1 level; .266, p=.606.
*** Chi-square insignificant at the .1 level; .015, p=.903.
***** Chi-square significant at the .1 level; 2.978, p=.084.
****** Chi-square significant at the .1 level; 3.945 [sig=.050] for males and f=9.175 [sig=.003]).

‘Ever use’ of condoms was quite high, at some three-quarters of the respondents. Of these, the majority had used a condom the last time they had had sex, particularly in the case of casual partnerships. For the most part, condom use did not appear to be related to particular concerns about HIV, nor to current perceptions of risk, nor actual risk, but was more likely to be associated with the prevention of pregnancy. Focus group discussion findings highlighted the particular concern, on the part of males and females, of unwanted pregnancy and, conversely, the desire at a certain point among single or married females of becoming pregnant.

Condom use was checked against overall levels of knowledge, using the composite variable that calculated how many of the fifteen responses each respondent got right. For both males and females, those who had ever used a condom had a significantly higher level of knowledge about HIV/AIDS (for males, the mean was 11.3 for those who had used a condom, and 10.1 for those who had not; for females, the respective figures were 9.8 and 7.5; f-test significant at the .1 level for each, f=3.945 [sig=.050] for males and f=9.175 [sig=.003]).
4.4 Negative Sexual Behaviour

Respondents were asked a number of questions designed to get at sexual relationships that could be viewed as problematic, such as sex in exchange for gifts and improved lifestyle, alcohol use and sex, cross-generational sex involving teenagers, and emotional pressure for sex. Respondents were also asked about rape.

A very low 2.8% of females and 8.7% of males had exchanged gifts or money for sex. An even lower 1.9% of females and 5.4% of males had been in a relationship where sex was ‘traded’ for ‘being taken care of’. And no female respondents indicated that they had been emotionally pressed into having sex. Of interest, 26.1% of males felt that they had been emotionally pressed into having sex (chi-square significant at the .1 level, 32.290, p=.000), reflecting a common belief, as noted in the focus groups, that women were ‘tempting’ them into having sex as part of a need to ‘find a man’ that will remain, with sex used as a key element in keeping the man. Of sexually active women, only 2.8% noted that they had been raped; the figure for men was zero.

Alcohol use did not seem to be related to sexual decision-making with casual partners. This may be a seasonal issue (focus group discussion participants noted that when the marula fruit ripened and was made into alcohol, alcohol use rates rose substantially), but findings suggest that casual relationships and casual sex are not directly related to alcohol consumption. Nevertheless, as the FGD participants noted during marula season, broader patterns of alcohol misuse may be related to poor sexual decision-making, with alcohol associated with particular socialisation practices that may increase risk behaviours.

A total of 15.6% of female respondents, and a lower 5.4% of male respondents, reported having a sexual partner ten years or more older while they were teenagers. Given that there were so few cases of ‘sugar daddies’ in terms of gift or money exchange or ‘taking care of someone’, findings suggest that these relationships are inconsistent with social norms.

4.5 HIV Testing

Respondents were asked whether they had ever gone for an HIV test (they were told that they would not be asked their test results). Findings are indicated in the following figure:

**Figure 1-16: HIV Testing**

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>68.3</td>
<td>53.3</td>
</tr>
<tr>
<td>Yes</td>
<td>31.7</td>
<td>46.7</td>
</tr>
</tbody>
</table>
A high 46.7% of female respondents and a lower, but still high, 31.7% of male respondents had been tested, at least once, for HIV (chi-square significant at the .1 level; 5.666, p=.017). A high three-quarters (75%) of female respondents and 84.2% of male respondents had received the results of these tests (chi-square test insignificant at the .1 level; 1.147, p=.284). There was no relationship between chronic illness over a period of three months over the past year and having gone for an HIV test. There was also no relationship between perceived levels of risk of HIV infection and testing, meaning that those who were concerned about their HIV status were no more likely to have gone for testing than those who were not concerned. Of interest, all of the women who had gone for testing were sexually active, while for males, those who had tested were equally likely to be sexually active or not sexually active (chi-square insignificant at the .1 level; 2.114, p=.146). Findings suggest that men are going for testing either out of duress as part of a job application, or because they were informed they needed to for another purpose4. For females, testing is likely to be associated with pregnancy, and nurses suggesting that they go for testing as part of ante-natal care.

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4 In 2006 Government also conducted a nationwide population-based sero-prevalence survey, including in the PDA. It may be that some of those indicating that they were tested were reached through the sero-prevalence survey.
5.1 Key Conclusions

Historical systems of knowledge transfer and behaviour control have broken down, and nothing adequate has replaced them. Within families, emphasis has been placed on the absence of sexual knowledge transfer, in the belief that such knowledge would encourage sexual activity. Other social norms remain, such as the need for a young woman to show fertility, but this is now taking place in the context of Swazis delaying marriage, and married men and women continuing to have sexual partners outside of marriage. It is not surprising that, in such a context, young people feel little power to protect themselves from HIV infection, and little power to do anything about being found to be HIV positive. In such a situation, it will be especially difficult for interventions to have much impact unless they are: 1) well grounded in social systems in the area (that is, reflecting an understanding of how people make decisions as individuals, but also as members of families and broader communities); and 2) coherent and comprehensive.

With regard to the latter -- coherence and comprehensiveness -- it is especially important to underline that activities focused on enhanced knowledge must reinforce each other. A focus on increasing knowledge, aimed at deepening levels of understanding, must also broaden knowledge, aimed at helping people to 'connect' information on one area of importance to HIV/AIDS to others. For example, there is a need for people not just to understand the relationship between HIV and AIDS, but to also know the length of the asymptomatic phase of HIV. Without such knowledge, decision-making based on appearance is common. This understanding of the long asymptomatic phase needs to be coupled with a proper understanding of how condoms can protect from HIV infection. Without such reinforce, it is likely that the 'hit and miss' character of existing messages will continue.

At the same time, it is difficult to see how a focus strictly on prevention can have the desired impacts. Behavioural change is not simply driven by knowledge, but also on attitudinal change, and an enabling environment. The enabling environment includes, but is not limited to, access to services (condoms, anti-retrovirals, testing, counselling, etc.), social norms that encourage protective behaviours, means of protection for those in need (social networks that improve women's self-esteem, social networks that protect women from rape, places of safety, etc.), and a national response that is consistent with prevention of HIV infection and positive living (particularly political leadership). Beyond this, there are also broader factors that also affect the degree to which people can be protected from HIV infection. Of particular importance in this regard are improved access to education and economic opportunities, especially for women, reduced social inequalities, strengthened decision-making equality between women and men (including within marriage), and positive reinforcement for positive behaviours.

It should be highlighted that there is much to build on. Condoms, testing and counselling care and support, anti-retroviral drugs, male circumcision -- none were rejected outright by respondents.

There is also an openness, indeed a demand, for improved knowledge and innovative communication channels. However, it requires a clear understanding of the different mechanisms, and the different messages, that are required to successfully reach a varied target audience. For example, systems that effectively reach young people with vital information would likely be quite distinct from systems that change parental views about their children learning about sexual matters. Both are important, yet they require quite distinct approaches.

Perhaps the most important conclusion is associated with the message that must consistently be made in any intervention in the PDA. In contrast to negative messages and threats and
negative systems (focused on what not to do, rather than on what to do), an emphasis on hope is central to any intervention success. Hope in remaining HIV negative, hope in living positively if one is HIV positive, hope for one's family, and hope for one's community are all key to responding to the epidemic. Giving people the power to control their own decisions, within the context of a supportive environment, is of central importance.

Finally, as part of a broader message of hope, it is important to highlight that countries with generalised epidemics, some almost as severe as the epidemic in Swaziland, have managed to reverse trends and protect their people. Trends in the epidemic in Botswana, for example, show that young people are changing their behaviours and are protecting themselves from HIV infection. In Uganda, infection rates have dropped across all age groups. And in Zimbabwe, despite a severe economic crisis, evidence suggests that infection rates are declining due to behavioural change. Swaziland has the potential to do the same, and a coherent response to HIV/AIDS in the PDA can help show the way.

5.2 Key Findings

Findings were noted in the executive summary and elaborated in the report. These include the following:

- There were high levels of confusion and uncertainty about HIV/AIDS. This was coupled with an absence of a wide range of ‘life skills’ necessary to make informed decisions.
- Few respondents felt themselves to be personally at risk of HIV infection. This was not generally related to actual levels of risk, but rather perceptions that HIV/AIDS affected people who were not ‘moral’, people who were at high risk. This was coupled with a level of denial associated with a sense of hopelessness if one were HIV positive.
- The messages around HIV/AIDS are focused on fear, and this is taking place in the context of poor knowledge of sexual matters overall.
- Information on HIV/AIDS reaching people in the PDA is felt to be ‘hit and miss’, neither coherent nor consistent, and largely adding to confusion already felt by people arising from the collapse of traditional systems of knowledge transfer.
- Testing and counselling was not valued, as there is little one could do if they were HIV positive or even HIV negative.
- HIV/AIDS was not the priority concern in the PDA.
- Male circumcision was not know as a means of reducing the transmission of HIV, but respondents were open to considering it as a possibility. However, in the absence of concerns about personal risk, it is difficult to see how male circumcision would be commonly practiced.
- There are no effective communication channels for transmitting HIV/AIDS knowledge and changing sexual behaviours. Common channels, including schools, peers, and radio, all had severe deficiencies.
Annex A: Bibliography


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Responding to HIV and AIDS in Rural Lubombo Region:
Conference Report

From a conference held at the
NISELA SAFARI LODGE
LUBOMBO REGION
12 - 13 April 2007

Report prepared by
Social Impact Assessment and Policy Analysis Corporation (SIAPAC)
in collaboration with the
Lower Usuthu Smallholder Irrigation Project (LUSIP)

June, 2007
Background

In November 2006 an investigation was commissioned by the LUSIP project team in response to an HIV seroprevalence rate in the project area of over 40% for 15 to 49 year olds. The aim of the investigation was to substantively inform the development of a communications strategy for responding to the high level of HIV infection in the Project Development Area (PDA) and protect residents who are currently HIV negative. The communications strategy would focus on innovative, culturally appropriate strategies for reducing the risk of HIV transmission by expanding knowledge, improving attitudes and influencing behaviours working with local and national partners under the framework of the National Emergency Response Committee on HIV/AIDS (NERCHA).

In April 2007 a conference was held for the LUSIP HIV and AIDS KAP results to be disseminated and for the development of a strategic plan for HIV and AIDS prevention in the LUSIP development area. Participants were representative of the range of local and national partners working in the HIV prevention arena. The conference was chaired by the Regional Lubombo Health Administrator (lists of workshop participants for each day are included in Annex A; the conference agenda is included as Annex B).

Day 1:
Activity - Opening

The Conference opened with a prayer at 9:35am. Thereafter, opening remarks were made by the Master of Ceremonies (MC), the Regional Health Administrator, Mr. M. Mndzebele. He explained that the Conference was dealing with a serious matter -- HIV/AIDS -- and that it was the duty of those attending to plan a way forward. He introduced the Project Director of LUSIP.

Activity – Introduction to LUSIP

The LUSIP Project Director, Arthur Belsey, gave participants an overview of LUSIP. He began by noted that LUSIP felt it was of utmost importance to have a dialogue with local communities, so that the project met their needs. He also noted that the project served as a large national investment, with the aim of maximising benefits for all of the people of Swaziland.

He presented a slide show (included as Annex 2 to this volume) that noted that LUSIP was primarily a poverty alleviation initiative that was aimed at wealth creation for people in the Project Development Area (PDA) and, thereafter, for the nation as a whole. It comprised the provision of irrigation water to smallholder farmers, thereby promoting the conversion from rainfed subsistence agriculture to irrigated, commercial cash crop production involving a number of crops, including sugar.

The irrigation scheme was intended to directly benefit 2,600 homesteads and +-18,200 beneficiaries, create 3,000-4,000 jobs, and reach an additional 22,000 beneficiaries through income benefits. Based on calculations done for the Project, it was estimated that 67% of the total population of the Lower Usuthu Basin stand to benefit from the Project, while others would benefit as well. He thereafter presented the technical aspects of the Project.

In closing, he urged participants to take an active part in the workshop, and then answered questions.
Questions and Answers

Q: What will the Project provide to local farmers as these farmers await the first crops?

A: Farmers will need to apply for loans to finance their cropping.

Q: The project appears to concentrate on sugar cane farming when the indications are that the sugar price is falling. Will farmers really benefit?

A: Yes, the European Union price for sugar has indeed declined because they have shifted away from country quotas. However, at the same time the world price of sugar has actually gone up. The project feasibility study was based on a sugar price of US$8.50 per pound, but the current world price is around US$13, and this is further expected to rise to US$15 soon. In addition the sugar industry is trying to look at ways to reduce the cost to small farmers. In addition, the Swaziland Electricity Board is restructuring its prices to farmers, which is expected to lower costs. Further, SWADE itself is looking at what could be done to alleviate the burden of high initial debts by farmers in the PDA.

Activity – Presentation by the Head of the LUSIP Health Team

Dr. Jacques Myaux, head of the LUSIP health team, explained the link between the issue of HIV and AIDS and LUSIP (see presentation in Annex D). LUSIP has supported the establishment of a PDA steering committee on HIV and AIDS which has been active in organising the study and the subsequent conference. He emphasised that the aim of this conference was to share information following the detailed study carried out within the community with PDA residents and partners such as NERCHA, and seek innovative approaches to the prevention of HIV transmission.

He noted that the problem of HIV and AIDS was very serious, and that PDA residents and their partners, including LUSIP, needed to respond. There was a particular challenge related to the transition period, lasting two years, where the project would start-up, but no benefits would have yet been derived. This ‘transformation’ period was a period of particular economic and social vulnerability, and this has important implications for HIV transmission. While LUSIP was there as a partner, the PDA residents themselves must lead any effort to respond to HIV and AIDS.

He ended by noting that prevention interventions needed to be innovative, as there are numerous prevention interventions, but they are apparently not having the desired impacts. Why not? We need to consider the problem carefully. Male circumcision is one example of how to respond in an innovative manner.

Questions and Answers

Q: The project does not plan to build any hospitals which is very worrying because many of the vulnerable and sick people cannot afford to reach the current health facilities. A clinic should be part of the project plan.

A: There is a fair distribution of health services in that the community is covered in terms of distances to health facilities. There are government standards that are adhered to. It was noted

1 This point was supported by the Regional Health Administrator who confirmed that the standard is a 3 hour walk.
that LUSIP has already agreed to help upgrade the Siphofaneni Clinic to a Health Centre, rather than building a new one, and that this Health Centre would serve as a referral facility for the PDA.

**Activity – Presentation of KAP results by SIAPAC**

The consultant, Dr. D. Cowrie, explained to the conference that the KAP study focused on three aspects of HIV and AIDS:

- What do PDA residents know about HIV and AIDS?
- What do PDA residents think about what they know about HIV and AIDS?
- What do PDA residents do in terms of behaviours that might affect levels of HIV infection?

Further the study helps to look at how a local response can be made more effective as it is often the case that knowledge improves but not attitudes or practices. It also helps to look at how regional and national partners can contribute to the local response.

In the presentation (see Annex E), Dr. Cownie outlined how the survey was conducted, and who was involved. He noted that both quantitative and qualitative approaches were employed. The survey was a first step in consultations, with the conference representing an important second step, and strategic planning discussions to be held thereafter an important third step. He also noted that Swaziland had the highest HIV seroprevalence rate in the world, that life expectancy had consequently declined dramatically, and that by 2015, ten times as many people will die of an AIDS-related illness than will die from all other causes in Swaziland. While historically the national response was weak, this was changing rapidly.

He then went on to discuss knowledge, attitudes, and practices, highlighting opportunities and challenges. In responding to HIV and AIDS, an enhanced local response was especially important.

**Questions and Answers**

Q: Participants agree with the findings but the important issue is to know how to communicate with our children about these issues and how to protect ourselves when we get home.

A: The purpose of the conference is to answer this question, it is now up to you to decide how you want to proceed.

**Activity – Overview of HIV/AIDS in Swaziland, by NERCHA**

The NERCHA representative thanked SWADE for the partnership, especially in recognition of the fact that LUSIP is not a health project *per se*. It was emphasised that there was a need to talk about the positive aspects of all findings, for example the slight decrease in levels of HIV infection among some age groups, in order to give people hope. Some of these positive outcomes are the result of joint efforts by all the partners.

A presentation thereafter followed (see Annex F), giving an overview of HIV/AIDS in Swaziland, and how the country was responding to the epidemic. Trends in infection since the early 1990s were presented, including what appeared to be a decline in levels of infection from 2004 to 2006 that offered
some hope. Given Swaziland’s relatively small size and the fact that it was easy to move around the
country, HIV prevalence did not vary dramatically by region. Lubombo Region, where the PDA was,
had a lower rate than the national average, at 37.9%, but this was not substantially lower than for the
national as a whole (39.2%). The presenter noted that there were an estimated 200,000 HIV positive
Swazis out of a population of just over one million. An estimated 10% were in need of ART, and
70,000 orphans. However, while there are 200,000 Swazis who were HIV+, 800,000 were HIV-, and
this underlined the importance of focusing on prevention.

Five ‘working principles’ existed for the national response:

- Local solutions were needed
- Community driven approaches
- Existing structures should be used for implementation
- Reach should be equitable
- Interventions must be sustainable

Key ‘drivers’ of the epidemic included multiple concurrent sexual partners and high mobility, male
dominance in sexual relations, the loss of traditional norms, lack of understanding of HIV, and poverty.
Urgent behaviour change needed to concentrate on the reduction in the number of sexual partners, and
young people delaying their first sexual contacts.

Development context was thereafter presented, following which the national response was discussed.
It was noted that a multi-sectoral response, nuanced to meet the varied needs of different target groups,
was developed. The national response, co-ordinated through NERCHA, covered prevention, care and
treatment, impact mitigation, monitoring and evaluation, and finance and administration. NERCHA,
established in 2002, served as a co-ordinating body, not as an implementation agency.

Questions and Answers

Q: Messages about ART are too broad, how involved is the IEC section in the Ministry of Health in
the messages being communicated?

A: The next speaker from NERCHA would talk about the billboard campaigns and the presentation
containing more details would be handed out.

Q: As the interventions are externally funded there are always strings attached. How then can we
have a local response?

A: Chiefs complain that too many people with different messages come into the community but they
are unable to turn away any promise of help. NERCHA tries to coordinate and influence the
nature of assistance given.

Q: AIDS will not end because those on ART now look healthy and our children have relationships
with them. How can we show that these people are infected?
A: There is a need to teach people that HIV+ people do not necessarily show symptoms. There are human rights issues as well that prevent us from exposing infected people.2

**Activity – NERCHA Strategic Management Plan Presentation**

A second presentation was made by Cebile Manzini, also of NERCHA (see Annex G). The presentation was of NERCHA’s Strategic Management Plan. The speaker outlined how the Plan was developed, and is designed to establish a common understanding among the various actors in the HIV and AIDS arena with regard to the institutional framework and co-ordination mechanisms. As part of the discussion of partners, the speaker noted the growing importance of the regional NERCHA offices and, through them, the involvement of tinkhundla and community level institutions. The response was also divided into ‘sectors’, comprising civil society, the public sector, the private sector, and the traditional sector.

Thereafter, a presentation was given on the National Minimum Package. The Package is intended to identify the basic needs of those affected by HIV/AIDS. The Package was divided into two components, one comprising the ‘non-clinical component’ which could be delivered at community level, and the ‘clinical component’, which could be delivered at the clinic level. Minimum package elements were noted for prevention, care and treatment, and impact mitigation.

A presentation was thereafter made on Swaziland’s Behaviour Change Communication Framework for the prevention of the sexual transmission of HIV. Four ‘outcome areas’ were noted, comprising a strengthened enabling environment, safer sexual behaviour, increased update of HIV prevention services, and strengthened institutional frameworks. The speaker emphasised behavioural change as a change in social norms as well as changes in individual behaviours. There needs to be an enabling environment through leadership and the elimination of stigma. There needs to be an increased adoption of safer sex practices and an uptake of HIV services such as access to condoms, prevention of mother-to-child transmission, and circumcision.

**Questions and Answers**

Q: As participants are from different areas how should our plan be focused in order to compliment the NERCHA structures?

A: At present it can be a generalised plan at the regional level. In the future issues will be dealt with at a much more local level such as the chieftaincy.

**Activity – Group work**

Following the presentations and questions and answers, participants were divided into four groups to focus on strategies in specific areas, covering education, workplace, nutrition, PMTCT, STI Management, Male Circumcision, Counselling and Testing, and Condoms. For each, issues discussed included problems, objectives, targets, social norms, and strategies. Groupwork was followed by group presentations. The matrix used to facilitate discussion is as follows:

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2 An additional comment was made that it is normal for people to love and want to be loved. The answer is in taking preventive measures.
<table>
<thead>
<tr>
<th>Area</th>
<th>Education</th>
<th>Workplace</th>
<th>Nutrition</th>
<th>PMTCT+</th>
<th>STI Management</th>
<th>Circumcision</th>
<th>Counselling and Testing</th>
<th>Condoms</th>
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<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td>State the problem What are the objectives? What are your targets? What social norms need to be considered? What strategies would you recommend?</td>
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<tr>
<td><strong>Attitudes</strong></td>
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<td><strong>Practices</strong></td>
<td>State the problem What are the objectives? What are your targets? What social norms need to be considered? What strategies would you recommend?</td>
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Day 2
Activity – Presentation on Circumcision

A presentation on male circumcision was made by Dr. Adam Groeneveld, who is with the Male Circumcision Project in Mbabane (see Annex H). The speaker began with an overview of the AIDS epidemic, and showing how this coincided with areas with low male circumcision. He explained how male circumcision could reduce the chances of female-to-male transmission of HIV, and overviewed the results of studies carried out in South Africa, Kenya and Uganda. He then introduced the Swaziland Circumcision Take Force, created in early 2006, and explained that the Task Force was supporting the roll-out of male circumcision operations throughout the country. Central to this was what was called ‘circumcision Sunday’s’, where large numbers of circumcisions could take place following a sensitisation exercise. The most serious concern related to the lack of personnel to perform the operations, as well as facilities that could accommodate the operations. The Task Force was focusing attention on increasing the number of health workers trained in circumcision, anticipating a rapid uptake.

A lengthily question and answer period followed, reflecting high interest in the subject:

Q: How long does it take before someone who has been circumcised to be sexually active again?
A: All operations cause discomfort initially. Proper healing should take no more than 6 weeks. They should wait for wounds to heal before having sex again, and that averages six weeks.

Q: Is there any chance that such an operation will make someone impotent?
A: Circumcision does not affect potency either way.

Q: Many people have heard stories of Xhosa people dying after the initiation in the mountains. Are these true?
A: People need to be more informed. Deaths are often a result of poor training and hygiene practices by those who carry out these operations.

Q: The cost of circumcision appears to be prohibitive.
A: In Swaziland, male circumcision will be offered free.

Q: Is HIV status considered?
A: WHO suggests that those who are HIV positive should not be targeted. However, in Swaziland we have a generalised epidemic. We will therefore not be using HIV status as a means to exclude someone from the operation, but we want to target those who are HIV negative.

Q: Is there the possibility of penile paralysis?
A: None.

Q: Is there an upper age limit for male circumcision?
A: No. But, younger males are the target, as they tend to have more sexual partners. We are emphasising those aged 15-30.

Q: Why focus on ages 15-30?

A: There is no age limit but this focus is only as an emergency response.

Q: Other than HIV risk reduction, are the any other benefits to circumcision?

A: There are a number; Phimosis, Paraphimosis, UTI in boys, cervical cancer in women and penis cancer can all be reduced.

Q: Diabetics tend to heal slowly, if at all. Can they undergo the surgery?

A: Yes they can. But, at the time of the operation, they have to have blood sugar at the right level, so that the wound heals.

Q: Is it advisable for HIV positive people to get circumcised, in light of the need for the wound to heal?

A: Yes, but they need a CD4 count of at least 200, because if not the healing goes too slowly.

Q: Swazis stopped circumcising their boys many years ago. There is now some stigma associated with it. What mass mobilisation would it take to make it acceptable again?

A: Our existing survey work suggests that there are no cultural constraints in Swaziland, it is rather a matter of proper information and understanding. When we asked, for example, whether males would want to be circumcised, 54% agreed, rising to 87% if it was confirmed to prevent the transmission of HIV. 71% agreed that they would want it for a son. 81% felt that circumcision would reduce the risk of STIs.

Q: How long will it take to train enough doctors?

A: We have an enormous shortage of doctors. We are not yet certain what to do about this, but it is likely that we will rely on medical personnel in Swaziland, rather than importing additional personnel.

**Activity – Group presentations**

It was acknowledged that the group work had a very limit time. However it was concluded that inputs into the strategic plan would continue to be made over a longer period.

Throughout the process, the facilitators tried to encourage groups to think about such issues as: What will make these strategies work? Who will carry out implementation - traditional structures? - Local counsellors such as Rural Health Motivators? Most groups found it difficult to identify ‘who is responsible’ at a local level.

Specific findings by topic area are indicated in the following matrices:
Knowledge
Problems:
1. Varied levels of understanding of HIV/AIDS for communicators and recipients.
2. Communicators not well prepared.
3. Lack of differentiation across target groups.
4. Inappropriate methods used that do not understand group being reached.
5. Lack of consistent outreach, lack of follow-up.
6. Loss of traditional mechanisms to deal with sexual issues.
7. Lose interest due to ‘the same old thing - HIV/AIDS’

Objectives:
1. Standardise communication methods and IEC materials.
2. Revive traditional means of child nurturing.

Strategies:
1. Initiate peer dialogue to ascertain information gaps.

Problems:
1. Lack of management interest and commitment.
2. Lack of interest by employees, believe that ‘we already know these things’.
3. HIV/AIDS not perceived as a workplace issue, it is not the company’s core issue.
4. Lack of communication on workplace programme content, and lack of understanding of policies.

Objectives:
1. To promote maximisation of use of available water sources for homestead gardens.
2. To promote the use of other sources of food.

Social Norms:
1. Taboo foods (goats milk, crabs, prawns, etc.)

Strategies:
1. Community education on trench gardens and organic micro-

Problems:
1. Misunderstanding that an HIV+ pregnant women will definitely infect her child.
2. Lack of knowledge that breastfeeding will result in the transmission of HIV to her child.
3. Confounding factors create knowledge gaps between service providers and pregnant women.
4. Lack of knowledge about the risks associated with home delivery.

Objectives:
1. Provision of accurate messages on PMTCT issues.

Targets:
1. All women of reproductive age.
2. Birth

Problems:
1. Lack of knowledge of STIs, their symptoms and management.
2. Lack of information on how to proceed with circumcision.

Objectives:
1. Provision of information on how to use condoms.
2. Provision of accurate messages about the benefits of counselling and testing.

Social Norms:
1. STIs are associated with promiscuity - people are afraid to disclose and treat them.
2. Sex education and STI prevention is associated with delinquency - people are discouraged for fear of rejection from society.

Strategies:
1. Break the barrier between adults and the youth on sex education.
2. Revisit education tools and systems towards STI prevention.

Objectives:
1. Provision of information pertaining to circumcision and available facilities for circumcision.

Social Norms:
1. Insufficient emphasis on counselling and testing.

Strategies:
1. Mobilise local counsellors and testing facilities at community-level.
2. Initiate community support groups people who need counselling and testing.

Objectives:
1. Provision of proper information on condoms.
2. More emphasis on sex education, and how and when to use condoms.

Areas
Education
Workplace
Nutrition
PMTCT+
STI Management
Circumcision
Counselling and Testing
Condoms

Targets:
1. All PDA residents.

Social Norms:
1. Insufficient knowledge about circumcision.

Strategies:
1. All PDA residents.
<table>
<thead>
<tr>
<th>Targets:</th>
<th>Social Norms:</th>
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| 1. Adults.  
2. Youth.  
3. Communities.  
4. Educators. | 1. Unacceptable not to breastfeed, mothers do not have a choice.  
2. Poverty means that alternative foods cannot always be offered.  
3. Sex education and STIs in the early primary education. |
|  | Strategies: |
|  | 1. Standardised training for HIV/AIDS educators. Based on what is needed, what is stated as needed, by PDA residents.  
2. Standardised training manuals.  
3. Use of community centred and community participatory methods of education.  
4. Introduce informal child education at home, school and churches. |
|  | 1. Health education on PMTCT issues targeting the whole family, birth attendants, and the community at large considering issues of disability. |

**Social Norms:**

1. Unacceptable not to breastfeed, mothers do not have a choice.  
2. Poverty means that alternative foods cannot always be offered.  
3. Sex education and STIs in the early primary education.

**Strategies:**

1. Standardised training for HIV/AIDS educators. Based on what is needed, what is stated as needed, by PDA residents.  
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<th>PMTCT+</th>
<th>STI Management</th>
<th>Circumcision</th>
<th>Counselling and Testing</th>
<th>Condoms</th>
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</thead>
<tbody>
<tr>
<td><strong>Attitudes</strong></td>
<td>- Problems: 1. Making money (NGOs are only there for the money, not for the people, it is a job). 2. Religious beliefs. 3. Too many groups educating on one thing. 4. Bad attitudes, in particular males, towards groups bringing information.</td>
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<td><strong>Objectives:</strong></td>
<td>1. Combine methods of teaching (western and traditional).</td>
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<td><strong>Targets:</strong></td>
<td></td>
<td>1. Traditional authorities. 2. Parents. 3. Youth.</td>
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<tr>
<td><strong>Social Norms:</strong></td>
<td>1. Recognise the fact that males are kings in their homesteads. 2. Swazis use their culture as an excuse to do what they want.</td>
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<td><strong>Strategies:</strong></td>
<td>1. Participatory methods must be used to engage the community, not just lecture us. 2. Involve</td>
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<td><strong>Goals:</strong></td>
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<td><strong>Problems:</strong></td>
<td>1. Usually HIV/AIDS programmes are brought by employers, which results in employees doing it to impress employers. 2. Lack of co-ordination across departments of the same employer, hence resulting in HIV being viewed as a health issue.</td>
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<td><strong>Objectives:</strong></td>
<td>1. Provide communities with water for irrigation. 2. Provide communities with water for domestic use. 3. NGOs and UN agencies to provide seed.</td>
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<td><strong>Targets:</strong></td>
<td>1. Community members.</td>
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<td><strong>Social Norms:</strong></td>
<td>1. All HIV programmes must involve people directly affected from the start, e.g., workers.</td>
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<td><strong>Strategies:</strong></td>
<td>1. Understand what people eat that is nutritious, keep with this.</td>
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<td><strong>Problems:</strong></td>
<td>1. Lack of supplemental food which leads to people not wanting to test.</td>
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<td><strong>Targets:</strong></td>
<td>1. All pregnant women.</td>
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<td><strong>Social Norms:</strong></td>
<td>1. Fear of exclusive breastfeeding. 2. Poverty (lack of resources).</td>
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<td><strong>Strategies:</strong></td>
<td>1. Awareness raising on STIs, IEC materials even at community level. 2. Education in schools on STIs. 3. Encourage health clubs in schools.</td>
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<td><strong>Problems:</strong></td>
<td>1. HIV+ mothers not believe can prevent transmission.</td>
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<td><strong>Objectives:</strong></td>
<td>1. To ensure mothers understand that they can prevent.</td>
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<td><strong>Social Norms:</strong></td>
<td>1. Once one has an STI, they are immoral, and they are HIV+.</td>
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<td><strong>Strategies:</strong></td>
<td>1. To ensure reduced fear/embarrassment with regard to STIs</td>
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<td><strong>Problems:</strong></td>
<td>1. Embarrassment towards/fear of going to clinic for treatment.</td>
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<td><strong>Social Norms:</strong></td>
<td>1. All sexually active.</td>
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<td><strong>Strategies:</strong></td>
<td>1. All clinics to have ANC. 2. RHMs should educate in communities.</td>
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<td><strong>Problems:</strong></td>
<td>1. Fear of knowing your status and finding it better not to know it. 2. Benefits of testing are not known.</td>
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<td><strong>Objectives:</strong></td>
<td>1. To be aware of your status before you develop AIDS.</td>
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<td><strong>Targets:</strong></td>
<td>1. All people who are sexually active.</td>
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<td><strong>Social Norms:</strong></td>
<td>1. They test for incentives (food parcels).</td>
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<td><strong>Strategies:</strong></td>
<td>1. Involve traditional authorities in sensitising about condom use. 2. Accessibility and availability of condoms at community level. 3. Traditional healers should encourage condom use.</td>
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<td><strong>Problems:</strong></td>
<td>1. The use of condoms at an early stage, then after trust, stop using.</td>
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<td><strong>Objectives:</strong></td>
<td>1. To prevent unwanted pregnancies. 2. To prevent STIs.</td>
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<td><strong>Targets:</strong></td>
<td>1. All those sexually active.</td>
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<td><strong>Social Norms:</strong></td>
<td>1. Belief that sex is not enjoyable when using condoms.</td>
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<td>Community members in all aspects of education, decisions. 3. Be friendly, be a part of the community. 4. Listen to people, get their ideas to solve their own problems.</td>
<td>Employing resources in the community to offer comprehensive, holistic care. 3. Strategies should target the traditional healers because they still serve a large proportion of the public.</td>
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<td><strong>Problems:</strong></td>
<td>1. Inconsistent information, conflicting messages.</td>
<td>1. Lack of employer support.</td>
<td>1. Eating what is available at the time.</td>
<td>1. High level of mother-to-child transmission.</td>
<td>1. STIs increase the risk of HIV transmission.</td>
<td>1. Low uptake of HIV counselling services, especially among males.</td>
<td>1. Inconsistent use of condoms.</td>
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<tr>
<td><strong>Objectives:</strong></td>
<td>Need to standardise information.</td>
<td>Education on proper nutrition.</td>
<td>Encourage pregnant women to go to health facilities.</td>
<td>1. STIs are the same risk groups as for HIV.</td>
<td>1. Reduce risky sexual behaviour - casual partners.</td>
<td>1. Increase update of VCT.</td>
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<tr>
<td><strong>Social Norms:</strong></td>
<td>1. Unwillingness to listen to those of a different age or sex.</td>
<td>2. STI is a sign of prowess for males.</td>
<td>Social Norms:</td>
<td>Social Norms:</td>
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<tr>
<td><strong>Strategies:</strong></td>
<td>1. Better targeting.</td>
<td>2. Promote NGOs and firms to have strong values that discourage practices that promote HIV/AIDS.</td>
<td>1. Peer education within the PDAs.</td>
<td>1. Social pressure for mothers to breastfeed.</td>
<td>1. Spiritually active.</td>
<td>1. Religiously influences not pro-contras.</td>
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<td><strong>Strategies:</strong></td>
<td>2. Strategies appropriate by group.</td>
<td>3. Form support groups to embark on income-generating projects.</td>
<td>2. Encourage people to establish background gardens.</td>
<td>2. Stigmatisation of mothers who do not breastfeed infants.</td>
<td>2. First time sexual encourager believed to be proper if undertaken without a condom.</td>
<td>2. No condom on first sexual encounter.</td>
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<tr>
<td><strong>Goals:</strong></td>
<td>3. IEC materials appropriate for various target groups.</td>
<td>3. Peer education within the PDAs.</td>
<td>3. Siphofaneni clinic strengthen to be able to respond to PMTCT demands.</td>
<td>3. Siphofaneni clinic strengthen to be able to respond to STIs.</td>
<td>3. Siphofaneni clinic strengthen to be able to respond to STIs.</td>
<td>3. No sweet in a wrapper.</td>
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<td><strong>Goals:</strong></td>
<td>4. Promote positive attitudes that help to avoid HIV/AIDS.</td>
<td>4. A day of educational entertainment for the PDA.</td>
<td>4. Example of Mbabane Project, where breastfeeding mothers offer support to others.</td>
<td>4. Encourage couples counselling.</td>
<td>4. Encourage use of female condoms.</td>
<td>4. Encourage use of female condom.</td>
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</table>
Activity - Closing Comments

The LUSIP Health Coordinator, Dr. Jacques Myaux, offered a few closing comments. He noted that homesteads and their members had varied needs, and therefore needed to be reached appropriately. How could this best be done? We have a great deal of complexity in the PDA, and we have many project activities going on. What do we do? A number of related strategies may have to be devised for an effective, holistic response to emerge. Co-operation between all partners would be key to an effective response.

The meeting was officially closed by the Regional HIV/AIDS Co-ordinator for the Lubombo Region, Themba Hleta. In closing remarks, he noted that, ultimately, commonalities between the suggested approaches were identified:

*Community involvement.* It was suggested that each chieftaincy must be responsible for identifying problem and identifying the appropriate individuals to educate the community. In addition it was noted that the influence of traditional leaders and traditional healers should not be undermined.

*Harmonise / standardize approaches.* The community must decide on approaches within the regional and national framework. Care needs to be taken that the same individuals are not relied on to do everything in the community.

*Reach the unreached / difficult to reach.* Rural Health Motivators\(^3\) need to be more empowered to carry out education rather than merely focus on helping the sick. Peer groupings are appropriate for education as are traditional leaders.

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\(^3\) One of the Rural Health Motivators at the conference asked the meeting for a mandate to carry out more prevention work. Other participants took this as a worrying indication that the Rural Health Motivators do not currently know how they fit into existing activities.
HIV prevention for LUSIP
NISELA SAFARI LODGE
12 - 13 April 2007