

Strategic Considerations
for communications on:

**multiple
& concurrent
partnerships**

within broader HIV Prevention
in Southern Africa

DRAFT

1.

Context

In 2006 the Southern African Development Community hosted an expert think tank meeting exploring HIV prevention in the high prevalence countries of southern Africa. Consistent with a substantial and growing body of research (see references) the meeting identified as critical to HIV transmission multiple and concurrent sexual partnerships (MCP) in a context of low condom use in longer-term relationships and low levels of male circumcision, along with factors such as insufficient male involvement and responsibility for sexual and reproductive health and gender inequality (SADC, 2006). In recent years, MCP has been increasingly prioritized within HIV prevention efforts including through the research, planning and delivery of campaigns, advocacy and communication initiatives. MCP programmes, alongside male circumcision programmes, are increasingly endorsed as two HIV prevention priorities in the hyper-endemic countries of southern Africa (Potts et al, 2008) that merit greatly increased funding and focus in the overall combination of prevention efforts at country level.

Epidemiological modeling (Morris and Kretzschmar, 2000, 1995; HELLERINGER et al, 2007; Mah and Halperin, 2008) suggests that even a relatively small reduction in MCP would break up extensive sexual networks and could significantly slow the spread of HIV in the sexually active population. And the real-world epidemiological evidence to date suggests that reductions in multiple sexual partnerships have probably already had a considerable impact on HIV transmission in several parts of Africa (Potts et al, 2008; Green et al, 2009; Halperin and Epstein, 2007). In Uganda, HIV prevalence declined dramatically following the intensive “Zero Grazing” campaign of the late 1980s; large WHO surveys conducted between 1989 and 1995 found an approximately 60% reduction in the number of men and women reporting multiple and casual partners (Stoneburner and Low-Beer, 2004). And in Kenya, partner reduction similarly is the main behavioral change associated with the more recent HIV decline there (Shelton, 2007; Cheluget et al, 2006). Similar reductions in multiple partnerships have been reported in DHS and other surveys in Zimbabwe (Gregson et al, 2006) where HIV has also fallen, in addition to Ethiopia, Côte d’Ivoire, and urban Malawi (Potts et al, 2008). In Swaziland, the number of people reporting two or more partners during the past month was halved after an aggressive 2006 campaign focusing on the danger of having a “secret lover” (Halperin and Epstein, 2007).

This guidance document arose from recognition of the need for regional guidance on the principles and good practice for MCP campaigning to assist national programmes, in particular, to strengthen HIV prevention efforts for MCP reduction.¹ Programming for MCP is complex and some issues are not yet completely understood, including the best ways to measure MCP, the relative importance of concurrent as opposed to multiple partnerships in general, and how MCP messaging should relate to other aspects of HIV prevention. Nonetheless, countries are seeking guidance now, and this document aims to provide basic guidance that can be built on and elaborated over time.

¹ This document results from interactions with civil society in the region and collaboration between UNAIDS, the Harvard AIDS Prevention Research Project and the World Bank, including an expert meeting on MCP held on 28-29 January 2009 in Gaborone, Botswana. The meeting report with list of participants is available on: <http://www.harvardaidsprp.org/symposia-events/Bots-presentations.html> and www.unaidsrstea.org

2.

Multiple and Concurrent Partnerships: Definitions

Concurrent partnerships can broadly be described as **relationships where an individual has two or more sexual relationships that overlap in time**. Experts use different time frames to describe MCP including concurrent relationships that last one month or longer and relationships that have been active in the previous three months (Mah and Halperin, 2008). Having concurrent partners greatly increases HIV transmission compared to sequential or serial partnerships because new infections can spread much more rapidly through the sexual network when its members are simultaneously connected, and also because of the greatly increased viral load in acute (early stage) HIV infection that facilitates transmission. Current population surveys often measure multiple partnerships as two or more sexual partners over the last 12 months, which does not differentiate concurrent or other multiple partnerships. Indicators and research methods that do identify concurrency are needed.

To date, concurrent partnerships have been described as being often long-term and **ongoing** in nature (such as an overlapping combination of main partner, co-wife/husband, mistress, "small house," sugar daddy/mummy, "nyatsi," "lishende," "makhwapheni," etc.). However, "MCP" by definition also includes **intermittent or occasional sexual contacts**, as well as **one-off sexual relationships** (sex worker, casual encounter). And with each type of MCP involving different levels of intimacy, communication between partners, commitment and of particular importance for HIV transmission, the likelihood of condom use.

Why particularly focus on concurrent partnerships?

Concurrent partnerships carry the increased risk that sex takes place with a second partner within a few weeks after someone is newly infected with HIV, when their viral load spikes. At this time, the risk of HIV transmission is particularly high (Pilcher et al, 2004, Wawer et al, 2005). In addition, if the second partner acquires the infection and also has sex shortly afterwards with another person, the risk is repeated – and so on. In this way, through an active sexual network where many people have two

or more concurrent partners, modelling shows that HIV can spread far more rapidly through a population than if there is a gap between sexual relationships (Morris and Kretzschmar, 1995; Morris, 2001; Watts and May, 1992; Gorbach et al, 2005; Halperin and Epstein, 2007). HIV spreads faster through the population because of both the increased likelihood of transmission per sex act in acute infection and also because of the repeated short time-frame for potential onward transmission.

Hence reducing concurrency in itself would slow down epidemic spread, even if the number of sex partners over time remained the same; in effect, serial monogamy is a less risky sexual strategy.

3.

Strategic Goals of an MCP Approach

The ultimate goal of all HIV prevention initiatives must be to **reduce HIV incidence**. To maximize prevention outcomes around MCP the following two outcomes need to be prioritized:

First Priority

A reduction in multiple and concurrent partnerships – through social and behavioural change and, where feasible, through addressing structural factors (such as lengthy separation of partners) that increase the likelihood of MCP

Second Priority

A reduction in the transmission of HIV within multiple and concurrent partnerships as well as within known discordant relationships – including through consistent correct male or female condom use, male circumcision, HIV testing (though antibody tests during the acute infection period are generally negative) and treatment adherence

To succeed in achieving the strategic goals we need to see changes in:

- sexual behaviours
- social values and norms that support and reinforce MCP and age-disparate sex
- implicit and explicit rules that "govern" societies
- the range of organizations involved in reducing MCP
- the scale of financial spending on MCP programming, so that it forms a far greater proportion of overall HIV and AIDS spending.

4.

Key Principles, Key Approaches

Certain key principles and approaches guide successful programming. First, key baseline data around knowing your epidemic and response need to be collected and available, with accurate understanding and expertise regarding the evidence for successful approaches and for programming. Early situation analysis should include information on: the size of populations in need; current coverage rates of MCP-related HIV prevention initiatives and estimated resources available for MCP-related HIV prevention activity; and methods to engage different populations in consultation on strategy, message and intervention development and delivery that resonates with their needs, experience and context. MCP reduction strategies and messages must be locally driven and locally relevant. Formative research should focus not just on people engaged in MCP but also on those who are not, and what motivates and sustains their behaviour.

MCP programmes need to be large-scale, national in reach and rapidly introduced – the time for pilot projects is over. National AIDS programmes should establish MCP reduction targets, strong, well-focused evidence-informed programmes to achieve them, allocate adequate resources and assign clear responsibility and accountability within the relevant unit for programme success.

Key principles MCP programmes need to:

1. Be nationally led, coordinated, sustained and brought to scale. They can be punctuated with intensive launches or bursts but must be planned and sustained for several years
2. Develop a hierarchy of staged interventions, with MCP reduction the overarching focus and priority
3. Be well-coordinated and both multi-pronged and multi-layered. They need to bring national, local and indigenous leadership on board with the same, mutually reinforcing focus and to utilise advocacy, mass media, community programmes, interpersonal communication, proven educational and other approaches. They should also address, where feasible, wider policy and contextual changes

4. Be of high quality and intensity
5. Be based on a rapid but rigorous review of the social and cultural context, assisted by outreach to traditional leaders
6. Integrate MCP reduction messages wherever possible into existing programmes as well as developing specific MCP campaigns, and ensure complementarity with other prevention programmes
7. Without undermining the unifying, national MCP reduction message, widespread condom access must also be assured, and condom promotion targeted particularly towards sex work, casual sex, for discordant couples and people living with HIV, men having sex with men, and age-disparate sex
8. Focus on family, community and social normative change, and not simply on individual knowledge and attitudes, through building on existing responsibility to family and clan and, in some cases, fostering national "patriotic" responsibility and pride.
9. Seek campaign support from all segments of society, including indigenous and faith-based groups which might take a complementary values-based approach to conveying the risk of MCP and promoting positive behavior change
10. Avoid externally driven moralistic approaches or imposition of values
11. Be rigorously monitored and evaluated with baseline data and end points of behaviour change and, ideally, of reduced HIV incidence as well.

Key messaging approaches MCP programmes need to:

1. Reflect overarching, harmonized regional themes, particularly in culturally similar regions such as the SACU region (including Southern Mozambique), while specific messages are tested and developed locally
2. Develop a hierarchy of messages beneath the core theme of MCP reduction, with staging of messages that are mutually reinforcing and contribute to the core concept
3. Use clear, simple, direct, understandable, culturally-relevant, unambiguous messages
4. Particularly highlight the need to reduce and break up sexual networks based on overlapping concurrent partnerships
5. If feasible, include clear messaging about the initial period of very high infectivity that occurs right after new infection

6. Develop messages that capture the grave seriousness of AIDS, including appropriately and sensitively handled "fear-appeal"-based approaches, yet also offer positive models and examples
7. Develop messages tailored to address the particular vulnerability of people in long-term concurrent networks with relatively low overall numbers of sexual partners, who are not adequately addressed by existing messages and who might not feel at particular risk. The specific needs of their partners, who may only have one sexual partner and not see themselves at risk, also need to be addressed
8. Include messages to address behavioral formation among the young, behavior change among those with formed behaviors and behavioral maintenance among all groups
9. Encourage delayed first sex among young people as this can contribute to avoidance of MCP in the adolescent population or in the future as sexually active adults
10. Develop messages that also target MSM concerning the risk of MCP
11. Link messages about MCP to messages about the interface between alcohol, MCP, casual sex, and unsafe sex.

How does MCP messaging fit with wider HIV prevention messages?

Prevention practitioners increasingly agree that MCP messaging is one of the highest priorities in HIV prevention in southern Africa's hyper-endemic epidemics. But other campaigns are also needed to address specific situations such as sex work, and other high-risk settings, where condom messaging takes centre stage; and to address other key strategies such as male circumcision.

The best ways to link different priority messages without creating confusion are still being developed, and closely evaluated country experiences will provide clearer answers over time.

It has been proposed that one key overarching slogan be suggested at regional level that can be adapted for local situations; that can be addressed in complementary ways by mass media, interpersonal responses and at societal/structural level; that encourages both personal behaviour change and a sense of national pride and communal action for the benefit of the nation; that is not prescriptive of one type of behavior change for all but is adaptable to individual and cultural circumstances; that is simple and clear, and readily communicable and understood. In Uganda this was achieved in the late 1980/early 90s through the **Zero grazing** message (Epstein, 2007; Stoneburner et al, 2004). After extensive field testing Soul City has adopted **onelove** as its unifying theme in country programmes. Another possibility at regional level today might be **Break the network**, that can be readily rephrased and adapted for local use. Some organizations report that this type of message is readily understood and can be simply and pictorially communicated (e.g. Population Services International in Mozambique). Further, it can be interpreted to include a hierarchy of prevention approaches, including reduced concurrency, multiple partnership reduction, and making sex safer through e.g. male circumcision and consistent correct condom use. It will need further validation as to what the national unifying theme will be for each country.

5.

Strategic Individual and Social Transformation

All strategies addressing MCP within HIV prevention should seek to lower HIV incidence through clearly describing the changes they seek to achieve. Change may occur at three different levels: **individual knowledge, attitudes and behaviors; community social norms and contexts and, underlying these, societal policy, leadership, environment and infrastructure.**

Individual knowledge, attitudes and behaviours

To achieve positive changes in behavior it is useful, though not essential, to understand the motivations

and reasons that drive people to engage in the different types of multiple and concurrent partnerships.

A Soul City analysis of attitudes towards MCP in 10 southern African countries in 2007 (Soul City Institute, 2008) highlighted a number of motivators for MCP behavior including: low appreciation of risk; sexual dissatisfaction; emotional and physical dissatisfaction; the influence of culture and social norms; the desire for money and material possessions; the influence of alcohol; the belief that men cannot control sexual desire; and pressure, male domination and abuse. Women are often active in pursuing partnerships in order to access various benefits, rather than being passive victims (Leclerc-Madlala, 2003). Structural factors (such as long or frequent separation of partners for work or other reasons) and economic necessity may also create environments conducive to MCP.

Underpinning all efforts it is important to ensure that sexually active people engaged in or exposed to MCP clearly perceive the enhanced **risk** of MCP in hyper endemic situations and are **motivated** and capacitated to **act** on this perception. Four results are required: that growing numbers of men and women, including young people:

1. **Have heightened and accurate risk perception, notably regarding:**
 - Previous and current exposure to risk
 - The concept of sexual networks for HIV transmission
 - The enhanced HIV risk with multiple and concurrent partners
 - Age-disparate relationships
 - Exposure through one's partner's risk behaviour not just one's own
 - Heightened viraemia and risk of HIV transmission/acquisition in acute infection, with other infections, and linked with progression to AIDS
 - The influence of alcohol and drugs, and that visiting related venues such as bars and shebeens, is conducive to sexual disinhibition regarding sex with high risk partners and non-use of condoms
 - The recognition that trust and intimacy in a relationship do not equate to low risk for HIV
2. **Aspire to mutual monogamy or, if in a polygamous relationship, ensure this is a closed circle of relationships; and believe that men can control their sexual impulses**

3. Are able to take protective action and reduce their personal risk by:

- Reducing their own and/or try to reduce their partner's MCP
- Using male or female condoms consistently and correctly at least with all non-regular partners
- Supporting males to whom they are close to access, or themselves to access safe, modern male circumcision.

Measurable behavioural changes that would contribute to strategic MCP-related results would include:

- Decreased numbers of sexually active men and women with two or more partners in the last month
- Decreased numbers of men and women engaging in two or more long-term concurrent relationships
- Increased numbers of men and women in multiple and concurrent partnerships who have adopted harm reduction strategies and approaches (e.g. partner reduction, male circumcision, treatment adherence, increased condom use, seeking early treatment for STIs).

Community Social Norms and Wider Cultural, Political and Economic Contexts

Individual attitude, knowledge and behavior change takes place within a community context that can support, facilitate or frustrate such behavior change efforts (Carter et al, 2007; Gregson et al, 2002, Parker et al, 2007). Underlying this, are the wider socio-cultural, political and economic factors that influence people's attitudes, values, norms and behaviour. Examples of economic factors include long absences from home in the migrant labour system, ease of opportunity, need for access to the benefits of partnerships and inability to access power or resources through other means. Activities to tackle these layers of influence should also be incorporated into MCP strategies and could include efforts that aim to result in:

- Increasing the number of influential leaders at all levels and other opinion makers who choose not to engage in multiple and concurrent partnerships or in age-disparate sexual relationships, and thereby set positive role models to change the social acceptability of MCP
- Increasing the number of well-informed political, faith, traditional and celebrity leaders engaging

in informed public discourse around multiple and, particularly, concurrent partnerships, including age-disparate sex, and HIV

- Increasing access to quality services to support enhanced communication and intimacy between couples in relationships
- Increasing access to accurate and clear information on MCP and HIV risk from mutually reinforcing sources through media, community initiatives and interpersonal approaches.
- Where feasible, increasing economic opportunities for partners and families to stay together.

6.

Measurement

Measurement of MCP programmes requires an understanding of (a) what needs to change (to know when we have been successful), (b) what measurements are required to assess whether the changes are taking place, and (c) appropriate tools with which to measure.

- a) Changes to indicate the success of MCP programmes:** Changes are needed in: individual risk perceptions, attitudes and risk behaviours; social norms; explicit and implicit societal rules and regulations; and in the resource and programming priorities of all stakeholders regarding HIV prevention in order to address MCP. Information is needed on inputs and outputs (both quantity and quality), programme outcomes in the form of behavioural, social and structural change, and impacts on reduced incidence.
- b) What we should measure to track whether changes are taking place:** To measure whether anticipated changes have taken place, it is necessary to understand
 - a) the *inputs* (financial, human and technical resources) provided to stakeholders involved in MCP programming
 - b) how stakeholders have used the funds to implement programmes (i.e. outputs that stakeholders have achieved)

c) how these outputs have translated into changes amongst beneficiaries (i.e. outcomes such as changes in social and community norms, changes in behaviour and changes in the implicit and explicit rules that govern society), and finally how these changes have translated into reduced numbers of new infections.

c) Which measurement tools are appropriate:

Measurements of the success of an MCP intervention strategy should be integrated into the measurement of the National Strategic plan for HIV and AIDS and into any national annual HIV-related bio-behavioural surveys. Additional research may also be needed to better understand society norms and values. Both quantitative and qualitative tools can be used for measuring MCP, none of which are perfect (Kretzschmar and Morris, 1996). Whereas a national population-based survey can provide statistically-generalisable data, there are serious limitations as to the data collection method employed. Methodological reviews of research into sexual behaviour have acknowledged that the validity and reliability of behavioural self-reports may not be high (Mah and Halperin, 2008; Cleland et al, 2004). In some household surveys where respondents may not feel assured of privacy and confidentiality, for example, there is a high likelihood of substantial under-reporting of MCP, particularly by women. One study in Zimbabwe found that young unmarried women reported 2-3 times more partners using an interview method that afforded greater confidentiality compared with face-to-face interviews (Gregson et al, 2002). Qualitative data yield important results, but are not statistically-generalisable. A battery of MCP measurement tools need to be deployed by a national AIDS programme and MCP programme implementers. Such measurement tools need to include:

- i) Real-time programme and behavioral monitoring for rapid tactical programme changes (learning by doing)
- ii) Qualitative research to understand and measure changes in social norms and behaviours including disaggregation of data by sex, age, SES and other criteria
- iii) Having rigorous longer-term measures with both behavioural and biological markers including HIV.

A detailed M&E framework for MCP within a national IV M&E plan – including indicators, measurement tool options and how to embed it in a national strategy – will be available soon to guide policy makers and M&E professionals as to how to measure whether their MCP programmes have been successful.

7.

Conclusion

Effectively addressing MCP in the hyper-endemic countries of southern Africa is a central and essential national and regional prevention strategy that requires intensive and long-term national and multi-sectoral commitment. Well researched, closely monitored and evaluated strategies must be flexible for the evolution of messaging and approaches as impact is achieved (or not), and as social norms, knowledge, attitudes, behaviors change over time. Strategies should be multi-layered and organized around one of the several social ecology models that relate to fields of influence at individual, social network, community and societal levels, with mutually reinforcing approaches for MCP reduction and for other key HIV prevention approaches.

Reference materials

- Carter, M. W., Kraft, J. M., Koppenhaver, T., et al. (2007). 'A bull cannot be contained in a single kraal': Concurrent sexual partnerships in Botswana. *AIDS and Behavior*, 11(6), 822-830.
- Cheluget B., Baltazar G., Orege P. et al. (2006). Evidence for population level declines in adult HIV prevalence in Kenya. *Sex Transm Inf.*, 82 (Supplement 1):i21-i26.
- Cleland J, et al. (2004). Monitoring sexual behaviour in general populations: A synthesis of lessons of the past decade. *Sex. Transm. Inf.* 2004;80;1-7.
- Epstein H. (2007). *The Invisible Cure: Africa, the West, and the Fight Against AIDS*. New York: Farrar, Straus, and Giroux.
- Gorbach, P.M., Drumright, L.N., Holmes, K.K. (2005). Discord, discordance, and concurrency: Comparing individual and partnership-Level analyses of new partnerships of young adults at risk of sexually transmitted infections. *Sex Transm Dis*, 32(1):7-12.
- Green, EC., N. Hearst, T. Mah, A. Herling-Ruark. (2009). A Framework of sexual partnerships: Risks and implications for HIV prevention in Africa. *Studies in Family Planning*, 40[1]: 63-70.
- Gregson S., Garnett G.P., Nyamukapa, et al. (2006). HIV decline associated with behaviour change in Eastern Zimbabwe. *Science*, 311:664-66.
- Gregson S et al. (2002). Methods to reduce social desirability bias in sex surveys in low-development settings: Experience in Zimbabwe. *Sex Transm Dis*, 29:568-75.
- Halperin, D., Epstein, H. (2007). Why is HIV prevalence so severe in southern Africa? The role of multiple concurrent partnerships and lack of male circumcision: Implications for AIDS prevention. *Southern African Journal of HIV Medicine*, 8(1):19-25.
- Helleringer, S, Kohler, H.P. (2007). Sexual network structure and the spread of HIV in Africa: Evidence from Likoma Island, Malawi. *AIDS*, 21:2323-332.
- Kretzschmar, M., Morris, M. (1996). Measures of concurrency in networks and the spread of infectious disease. *Mathematical Biosciences*, 133,(2):165-95.
- Leclerc-Madlala, S. (2003). Transactional sex and the pursuit of modernity. *Social Dynamics*, 29(2):213-233.
- Mah, T., Halperin, D.T. (2008) Concurrent sexual partnerships and the HIV epidemic in sub-Saharan Africa: The evidence to move forward. *AIDS and Behavior*.
- Morris, M. (2001). Concurrent partnerships and syphilis persistence: New thoughts on an old puzzle. *Sexually Transmitted Diseases*, 28(9): 504-07.
- Morris, M., Kretzschmar, M. (1995). Integrating social network research and epidemiology: Concurrent partnerships and transmission dynamics in networks. *Social Networks*, 17:299-318.
- Morris, M. Kretzschmar, M. (2000). A microsimulation study of the effect of concurrent partnerships on the spread of HIV in Uganda. *Mathematical Population Studies*, 8(2):109.
- Parker, W., Makhubele, B., Ntlatlathi, P., Connolly, C. (2007). Concurrent sexual partnerships amongst young adults in South Africa. Johannesburg, South Africa: CADRE.
- Pilcher, C. D., Tien, H. C., Eron, J. J., et al. (2004). Brief but efficient: Acute HIV infection and the sexual transmission of HIV. *Journal of Infectious Diseases*, 189(10):1785-1792.
- Potts, M., Halperin, D. T., Kirby, D., et al. (2008). Reassessing HIV prevention. *Science*, 320(5877):749-750.
- Shelton, J.D. (2007). Ten myths and one truth about generalised HIV epidemics. *Lancet*, 370:1809-811.
- Soul City Institute. (2008). *Onelove: Multiple and Concurrent Sexual Partnerships in Southern Africa, A Ten Country Research Report*.
- Southern Africa Development Community. (2006). *Expert think tank meeting on HIV prevention in high-prevalence countries in Southern Africa report*. Maseru, Lesotho: SADC.
- Stoneburner R. L., Low-Beer, D. (2004). Population-level HIV declines and behavioural risk avoidance in Uganda. *Science* 304(5,671):714-718.
- Watts, C. H., May, R. M. (1992). The influence of concurrent partnerships on the dynamics of HIV/AIDS. *Mathematical Biosciences*, 108(1):89-104.
- Wawer, M. J., Gray, R. H., Sewankambo, N. K., et al. (2005). Rates of HIV-1 transmission per coital act, by stage of HIV-1 infection, in Rakai, Uganda. *Journal of Infectious Diseases*, 191(9):1403-1409.