

Addressing Multiple and Concurrent Partnerships
in Southern Africa:
Developing guidance for bold action

Gaborone, Botswana,
28-29 January 2009

Expert Meeting Report

Addressing Multiple and Concurrent Partnerships in Southern Africa: Developing guidance for bold action

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1. Background and rationale

More than 25 years into the global HIV epidemic, southern Africa remains the region carrying the highest burden of HIV and AIDS globally. Eight countries in the region have reported an adult prevalence rate in excess of 15%. In 2007, 1.5 million new infections occurred in the region accounting for almost one-third of all new HIV infections and AIDS-related deaths around the world.

In 2006 the SADC hosted an expert think tank meeting exploring HIV prevention in high prevalence countries. The frequency of multiple and concurrent partnerships (MCP) was identified as a key factor driving the HIV epidemic in the region alongside insufficient consistent correct condom use, low levels of male circumcision, gender inequality and low levels of male involvement and responsibility for sexual and reproductive health.

MCP reduction is now increasingly prioritized within HIV prevention efforts in the region including through research, planning and delivery of campaigns, advocacy and communication initiatives, primarily led by international, regional and national NGOs. Yet consolidated guidance to help shape these initiatives and to promote complementarity between approaches is lacking. National programming efforts on MCP are now being developed, for example in Botswana, Lesotho, Namibia and Zambia, and guidance to promote key common principles and approaches is urgently sought.

This meeting built on two previous meetings to discuss MCP in the region: one held by UNAIDS RST ESA and Soul City in Johannesburg in September 2008, bringing together MCP practitioners to share experiences and ideas; and a second held by PEPFAR in Washington in October 2008 to share programmatic experiences from the region and to deepen understanding of the contribution of MCP to the hyper-endemic epidemics in southern Africa.

2. Expert meeting: organisation, purpose, participants, process

Harvard, UNAIDS and the World Bank, in collaboration with PEPFAR, called this expert meeting on 28-29th January 2009 in Gaborone, Botswana, to bring together over 40 regional, national and international experts with the **purpose** of:

- 1) Contributing to the development of guidance for programming to address multiple and concurrent partnerships (MCP) in southern Africa: more specifically to clarify behavioural and other outcomes, key issues, programming principles and approaches, and targets and monitoring indicators for national, regional and local HIV prevention strategies and action plans on MCP
- 2) Agreeing next actions to support the rapid development and implementation of MCP components of national HIV prevention strategies in southern Africa.

Participants included programme managers and technical advisors from international, regional and national organisations with MCP programmes, researchers, international cooperating partners and others with expertise in HIV prevention, MCP programming and communications (see Annex 2 for the participant list).

The meeting was opened by Christopher Molomo, Director of NACA, Botswana, Mark Stirling, Regional Director, UNAIDS Eastern and Southern Africa, and Edward Green, Director of Harvard AIDS Prevention Research Project. The **process** involved two days of plenary presentations on findings from the two previous MCP meetings, programme experiences, illustrative media slots, group work, presentation and discussion of the measurement of MCP, and agreement of key principles, issues and gaps and the way forward. In December 2008, prior to the meeting, a small group of Johannesburg-

based practitioners and researchers had met to discuss the outline of a guidance document on MCP, and UNAIDS developed a draft ahead of the Botswana meeting so that the contributions of the meeting could refine and enrich this zero draft. After the meeting, UNAIDS revised the draft and circulated it widely for further comments and inputs (Annex 3). In addition, Harvard collected information on programme experiences through a short questionnaire administered in the region, summary information to be made available through the web. UNAIDS will develop a clearinghouse site in collaboration with other regional partners.

3. Main areas of presentation and discussion

After updates on the previous MCP meetings in Johannesburg and Washington, three presentations by non-governmental organizations provided examples of research and community experiences and approaches to MCP in the region. They included: research into the role of traditional leaders in informing HIV responses in South Africa, Swaziland, Lesotho and Botswana by Ubuntu Institute; a focus by the Pan African Christian AIDS Network, PACANet, on approaches by faith organisations in the region, including pre-marital counselling, but noting insufficient efforts to address MCP so far; and Population Services International's community participatory training approach to MCP in Mozambique.

A further presentation focused on media slots on MCP, highlighting the range of approaches taken in the region. These include fear-generation; explicit instruction to avoid MCP, sometimes using cultural analogies to illustrate the point; messages to raise risk perception without being didactic on the response to choose, and both single and multiple messaging. Two presentations on national programming for MCP from Botswana and Zambia together highlighted processes of national strategy development, the need for social transformative approaches going well beyond individual behaviour change approaches, the need to strengthen risk perception in MCP and, in particular, to reach men.

Group work elaborated on issues concerning individual risk perception and behaviour change, social normative transformation, interpersonal/community based communications, mass media, and structural and contextual factors, with a wide range of possible points to consider in relation to each. In relation to these participants discussed the principles, interventions and programming approaches that have been effective or show promise in addressing MCP.

Finally, the meeting addressed indicators, targets and monitoring and evaluation, and explored gaps and issues and the way forward.

4. Analysis

Diverse issues arose regarding MCP reduction in hyper-endemic countries, but with common agreement that it is an essential and priority strategy that needs to link effectively with wider HIV prevention approaches, and national level MCP reduction strategies should be rapidly developed and implemented.

Key principles to guide MCP programming include that it must be based on sound evidence regarding the epidemic and the existing responses and unmet needs. It needs to be a coherent strategy and to operate at different levels, but with the specific solutions and messages to be community-driven. Both social transformative and individual behaviour change approaches are required, and there must be consistency and complementarity between them and in the approaches taken by the various stakeholders.

To be effective, reducing MCP, and particularly concurrency in long-term relationships, needs to be the overarching message for behaviour change in the sexually active population, with accurate risk perception the foremost objective. Beyond this, programming needs to address different sectors of the population in appropriate ways to promote and reinforce this social and behavioural change. It also needs to take into account that in high risk settings such as sex work or casual sex, for example, condom programming is key; among young people, MCP messaging, while critical, must also relate effectively to messaging about age-disparate sex and to condom use and delayed sexual debut. The way that MCP messaging is prioritised and the specific messages developed must resonate with and be drawn from the population groups they aim to influence.

Other considerations included: how best to involve faith organisations, and whether moralistic messaging from local faith groups could be useful provided it does not detract from condom messaging; the role of parents in reinforcing safe behaviours in their children, and how to deal effectively with negative role models among parents, teachers, traditional, faith and political leaders; developing approaches to help couples build relationship skills, respect, communication about relationships and their sex life, and positive conflict resolution skills; and considering a variety of clinical settings where MCP messages can be usefully brought in, for example VCT, STI clinics, antenatal and male circumcision services.

Discussion of mass media approaches also led to consideration of diverse approaches and messages. They included: whether appeal can be made to national pride in reducing HIV as well as to personal gain; the potentially constructive use of moralising if it comes from credible local role models and leaders; the potentially creative use of fear generation in balance with messages that enable action and positive benefits of reduced MCP and other safer behaviours; and using mass media to develop more complex and nuanced messaging over time, integrating MCP with other HIV prevention messages, while maintaining MCP reduction as the core theme. The meeting also discussed the negative side of many soap operas and other popular TV and radio programmes that glamorise MCP; and whether creative ways can be found to counteract them.

Insofar as structural and contextual changes may reduce risk environments for MCP, such as partner mobility and the splitting of families, gender issues and income inequality, alcohol availability, and relevant policies, laws and regulations, longer-term approaches also need consideration. Some contextual changes could be achieved quickly at local level to reduce the vulnerability of particular groups, and possibilities should be imaginatively explored in context, and be implemented and assessed. In some cases simple incentives to stay negative might have impact: one approach being assessed in Tanzania is making cash awards to those testing HIV negative at STI clinics.

Debate also focused on the extent to which concurrency is the critical issue or reducing multiple partnerships per se. However, in this region concurrency appears to be a much wider norm than serial monogamy, so reducing numbers of partners is largely reducing concurrent sexual networks in any case. Modelling also clearly indicates that open concurrent sexual networks facilitate far more rapid spread of HIV through the population than serial monogamy. Measurement of MCP remains problematic but it is essential to resolve and, linked with this, identifying appropriate indicators and targets in different settings needs further work.

5. Measurement

This section and the draft guidance note attached highlight some key issues regarding measurement of MCP and of MCP programming success, and further consultations are being held to elaborate more specific guidance, including on methods, indicators and target setting. MCP itself is complex to measure as survey methods tend significantly to under-estimate MCP, particularly among women, but qualitative studies on selected cohorts may not be widely generalisable.

Refining and improving measurements are important to monitor and evaluate specific programmes, but it is also necessary to be able to review wider trend data over time and to make comparisons between settings within countries and between countries. This requires some broad regional, national and local agreement on key indicators and methodologies. In addition, local communities need access to monitoring and evaluation of programmes that affect them, and their active involvement in participatory approaches to monitoring and evaluation and access to the findings in an accessible form should be assured.

Measurement objectives include agreeing on what success looks like, what is to be measured to show success, and how it should be measured: methods, indicators and targets. Proxy measures may be needed in some areas, and better incidence measures for HIV. One proxy for incidence measurement is prevalence measurement by year in adolescent cohorts.

Measures to show success would need to reflect positive changes in inputs, outputs, outcomes and impacts, with SMART indicators and targets at all four levels. At input level, success would be reflected

in increased spending on prevention and, within this, increased resource allocation to MCP reduction and high priority given to this strategy. It would also mean cost-effective and efficient expenditures.

Suggested outputs or process measures include: building on existing output indicators such as numbers of people reached by particular activities; tools developed; frequency and quality of relevant media articles; number and nature of policies developed to support MCP reduction.

Many suggestions were made for possible outcome measures, including for social norm and personal behaviour changes, for example:

- Percent of people reporting 2+ partners during the last month (or concurrently at any time during the past 12 months)
- Percentage of people with a partner who has other partners
- Percentage of couples going for HCT, or percentage of counselors who have talked about MCP in HCT settings
- Attitude measures – such as acceptability of having a relationship with a married partner, having more than one partner at a time, sexual relationships outside of marriage/long-term partnership
- Percent of people who have discussed the quality and satisfaction in their sex life with their partner.

Reduced HIV incidence is the ultimate goal of MCP programming, stemming from changes in risk perception and in individual behaviour, changes in cultural and societal norms, and changes in implicit and explicit rules and regulations in society.

6. Conclusions

Accepting that MCP reduction is a key approach for HIV prevention in the hyper-endemic countries of southern Africa, three primary elements must be in place to achieve the necessary quality, intensity and coverage:

- 1) National policy and programming efforts giving high priority to MCP strategies that incorporate social transformation approaches to complement approaches for individual behaviour change
- 2) Appropriate monitoring and evaluation methods and indicators agreed and applied with sufficient consistency and rigour to measure progress towards set targets
- 3) Continued sharing between country programmes and projects in the region to build on experience of what works, to learn by doing, and to avoid contradictory messaging and approaches.

To achieve these will require strong advocacy at all levels of political, traditional, faith and other leadership, and technical support to regional, national and local partners to develop the necessary information and skills base to implement effective programmes. Approaches will need to be multi-sectoral and multi-faceted, with close interactive involvement with communities, the media and other collaborative partners to develop a strong, supportive community of practice within and between countries. MCP reduction, while a priority in its own right, also needs to link effectively with other prevention strategies and messaging.

7. Next Steps

The way forward will involve the following initial steps in relation to developing an advocacy strategy and programming support for MCP reduction:

- Development and dissemination of the regional guidance note on MCP, with UNAIDS leading and seeking inputs from the core organising group, the meeting participants, and a wider constituency or practitioners in southern Africa. The preliminary guidance note is attached as an annex.
- Forming a hub of experts in MCP programming to provide technical assistance and capacity building in rolling out MCP programmes, and to elaborate an advocacy agenda
- Establishing a network of communication practitioners working on HIV prevention and social change communication. The network will organize around a virtual platform to share information,

promote synergies, workshop ideas and approaches, identify and seek support for obstacles in the implementation of programs. The hub of experts in MCP programming will be invited to join the network

- Mobilizing political awareness by engaging political and opinion leaders around MCP, e.g. members of the Champions; utilising SADC mechanisms such as partnership forums, Ministers of Health meetings
- Capitalizing on regional meetings (SA AIDS Conference and the USG Implementers meeting) to share country experience, the guidance document and developments in indicator and target setting.

Annexes:

1. *Agenda*
2. *Participants list and contact information*
3. *Strategic Considerations: Addressing Multiple and Concurrent Partnerships within HIV Prevention in Southern Africa*

Annex 1: Agenda

Addressing Multiple and Concurrent Partnerships in Southern Africa: Developing Guidance for Bold Action

28-29 January 2009, Gaborone, Botswana

GOALS

Contribute to the development of guidance for programming to address Multiple and Concurrent Partnerships (MCP) in Southern Africa: more specifically to further clarify the behavioral and other outcomes that are needed, the key issues needing to be addressed, programming principles and approaches that should be applied, and targets and monitoring indicators to be considered – in the design of national, regional and local HIV prevention strategies and action plans.

Agree on next actions and coordinate the arrangements required to support the rapid development and implementation of MCP components of national HIV prevention strategies in southern Africa.

EXPECTED OUTPUT

Technical guidance document on addressing MCP in HIV prevention in southern Africa

Day 1 – Wednesday, 28 th January 2009		Moderator
08:30-09:00	Registration, set-up of display materials, tea	
09:00-10:00	<u>Session 1: Opening Session</u> - Welcome, priority setting, meeting aims and programme - Introductions and expectations	- Chris Molomo, <i>Director, NACA, Botswana</i> - Mark Stirling, <i>Regional Director for Eastern and Southern Africa, UNAIDS</i> - Ted Green, <i>Director, Harvard AIDS Prevention Research Project (APRP)</i>
10:00-10:45	<u>Session 2: Setting the Stage and Learning from Current Initiatives</u> - Background from three recent MCP Meetings - Ms. Ramafoko (Swaziland, Johannesburg) - Richard Delate (Washington, D.C.)	- Richard Delate, <i>Center for Communication Programs (JHUCCP)</i> presenting for Timothy Mah, <i>USAID</i> - Lebo Ramafoko, <i>Soul City</i>
10:45-11:15	Tea/coffee break	
11:15-12:45	<u>Programmatic Experiences</u> - Presentations on community experiences and approaches - Viewing and discussion of TV/media spots - Q & A and time for discussion	- Daniel Halperin, <i>Harvard APRP</i>
12:45-13:00	<u>Session 3: Developing MCP Programming Guidance</u> <i>The following sessions aim to develop collective agreements on MCP programming outcomes, programmatic approaches, and targets and monitoring/evaluation approaches.</i> - Orientation to key questions/tasks Formation of break-out groups and agreement on outputs	- Mark Stirling, <i>UNAIDS</i>
13:00-14:00	Lunch break	
14:00-15:15	<u>Behavioral issues and social norms</u>	- Ted Green, <i>Harvard APRP</i>

	What specific changes in behaviour and associated changes in social norms are needed to address MCP?	
15:15-16:30	<i>Programmatic principles and approaches:</i> What principles, interventions and programming approaches have been effective or show promise for addressing MCP	- Edward Baralemwa, <i>PACANet</i>
16:30-16:45	Tea/coffee break	
16:45-18:00	<i>Consolidation of draft guidelines</i>	- Jim Shelton, <i>USAID</i>
	Dinner	
Day 2 – Thursday, 29th January 2009		
08:30-09:15	Addressing Unresolved Questions	Jim Shelton, <i>Science Advisor, Bureau for Global Health, USAID</i>
09:15-09:45	<i>Targets and monitoring</i> What targets should orient MCP programming and what indicators could best be used to monitor and evaluate progress and success?	Marileze Gorgens, <i>World Bank</i>
09:45-11:15	<i>Table Breakouts and plenary</i>	
11:15-11:30	Tea/coffee break	
11:30-12:30	Building Consensus, Identifying Gaps in Analysis	David Wilson, <i>World Bank</i>
12:30-13:00	Next Steps and Closing	Mark Stirling, <i>UNAIDS</i>
13:00-14:00	Lunch	

Annex 2: Participants list and contact information

Title	First Name	Last Name	Title	Organization	Email
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Strategic Considerations:

Addressing Multiple and Concurrent Partnerships within HIV Prevention in Southern Africa

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

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

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.

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.

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.

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.

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 behavioral change and, where feasible, through addressing structural factors (such as lengthy separation of partners due to employment practices) 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 prevention 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 addressing MCP 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 behaviors

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 behavioral 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
 - d. 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.

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