# PERCEPTIONS ABOUT THE *O ICHEKE* MULTIPLE CONCURRENT PARTNERSHIPS CAMPAIGN AMONG YOUNG PEOPLE WHO ARE MEMBERS OF THE SELEBI PHIKWE DISTRICT YOUTH COUNCIL, BOTSWANA

**By**

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**DECLARATION**

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work and has not been previously submitted at any other university for a degree.

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## EXECUTIVE SUMMARY

The purpose of this study was to investigate the perceptions of young people regarding the *O Icheke* MCP campaign who are members of Selebi Phikwe District Youth Council, in a mining town in central Botswana. The main objective of the study was to explore young people's views about MCP, to solicit their views on the key strength and weaknesses of the campaign, and to make recommendations to further strengthen the campaign.

Within the framework of the Health Belief Model, a qualitative research approach was employed and data was collected using four focus group discussions categorised into the following strata

- Males aged 18-24 years
- Females aged 18-24 years
- Males aged 25-35 years
- Females aged 25-35 years

The overall study finding was that financial issues, the apparent need for sexual variety, quest for material possession, and the impact of unemployment, migration and alcohol abuse are seen as some of the major factors underlying MCP in Botswana. The *O Icheke* Multiple Concurrent Partnership campaign was positively viewed as playing a key role in addressing the apparent knowledge gap regarding the impacts of these partnerships and in changing people's attitudes towards MCP and discouraging wide sexual networks.

The campaign's target population, funding, stakeholders and delivery mode of the program were identified as its pillars and an effective vehicle to achieve its goals. The consultation between funding office and implementing organisations, coverage of the programme in surrounding areas and growing non-profit organisation were identified to affect the MCP campaign to

achieve its goals. The recommendation is that more has to be done to improve the implementation of *O Icheke* programme through more funding, consultation with programme implementers, tailor made for people with disability and covering surrounding areas.

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# CHAPTER 1
# INTRODUCTION

## 1.1 Background information

Several decades into the HIV and AIDS pandemic, HIV transmission remains a major public health concern in the world with far reaching consequences on socio-economic development (Lisk 2002). Among all major world regions, sub-Saharan Africa continues to have the highest HIV prevalence and incidence which is attributable to heterosexual transmission. UNAIDS (2011) estimates that 22.9 million people living with HIV reside in sub-Saharan Africa and this includes 2.3 million children. The region also carries the highest burden of HIV infections and HIV- and AIDS-related mortality in the world, with more than 80 percent of all global AIDS-related deaths occurring in this region. Indeed, AIDS has been identified as the leading cause of death ahead of malaria in sub-Saharan Africa (UNAIDS 2011).

However, due to intensive HIV prevention strategies, new trends show significant decrease on newly infected cases in sub-Saharan Africa. The number of newly infected people fell to 1.9 million in 2010 which is less than the 2.2 million newly infected recorded in 2001 (UNAIDS 2012). HIV and AIDS epidemic in the sub-region is occurring in a context of increased poverty, food insecurity, indebtedness, poor economic performance, gender inequality, gender-based violence, conflicts, natural disasters, ignorance, fear, stigma and discrimination (WHO 2012). However, the pattern of the epidemic varies across the region with West African states having the lowest prevalence followed by East African countries. Estimates show Southern Africa to be the most affected sub-region, with it being home to an estimated 31 percent of newly infected people with HIV, 34 percent of people dying from AIDS-related diseases, and 40 percent of women living with HIV globally (UNAIDS, 2012).

Within Southern Africa, Botswana is one of the most affected countries. According to the country's National AIDS Coordinating Agency (NACA), HIV prevalence in the country stood at 17.6 percent among people aged 18 months old and above in 2008; the corresponding figure for 2004 was 17.1 percent (NACA, 2012). As in other parts of the world, there are notable differences in HIV prevalence between males and females in Botswana, with the latter being more affected. In 2008 the HIV prevalence for females was estimated at 20.4 percent while for males it was 14.2 percent (NACA 2012). This is consistent with the Ministry of Health's 2011 Ante Natal Care Surveillance report which found that while HIV prevalence among adults aged 15-49 years is 25 percent; it is higher at 30.4 percent among pregnant women (NACA 2012). By the same token, females in Botswana accounted for 57 percent of all people living with HIV in 2009, while males accounted for the remaining 43 percent (NACA 2012).

HIV and AIDS in Botswana has had negative implications for socio-economic development as reflected in reduced life expectancy, increased mortality rates, loss of skilled human resource, and diminution of the state capacity to optimally perform in delivery of services (Econsult Botswana 2007; Abt Associates Inc & Metropolitan Life Limited 2000). Economic projections also show that economic growth will be reduced by between 1.5 and 2.0 percent over the period 2001-2021 as a result of reduced labour force and productivity (Econsult Botswana 2007). Socially, many families have been pushed into poverty as a result of loss of income as family members leave jobs or die from the epidemic, and due to increased costs of taking care of those who are sick. Furthermore, there has been an increased number of orphans due to AIDS which has amplified the care burden of families, especially grandparents (NACA, 2005; UNAIDS, 2010).

Against these negative impacts of HIV and AIDS, the government of Botswana declared the epidemic a national emergency and established

multi-sectoral partnerships with development partners, civil society and the private sector to create a solid ground to help reduce the spread of the epidemic and to prevent new infections. These partnerships realised the development and implementation of several national prevention, treatment, support and care programmes. The key prevention programmes include: Prevention of Mother to Child Transmission (PMTCT), Safe Male Circumcision (SMC), Voluntary HIV Counselling and Testing (VCT), and Routine HIV Testing or RHT (NACA, 2010).

According to NACA (2010) the provision of VCT facilities across the country has contributed to lower risk of HIV infection for many people, as well as increased safe sexual behaviour. The PMTCT programme, on the other hand, offers an opportunity to prevent transmission of HIV to unborn babies from mothers who are HIV positive (Ministry of Health, 2011). In this programme, pregnant mothers who are HIV-positive receive prophylaxis that prevents the HIV transmission to unborn babies. Nationwide, public hospitals are performing SMC procedure on the basis of research evidence showing that circumcision can reduce risk of HIV infection. The SMC programme uses television and radio advertisements to educate men on SMC and to encourage them to undergo safe circumcision surgery (NACA 2010).

In addition to the foregoing HIV prevention programmes, a national Multiple Concurrent Partnerships (MCP) campaign known as *O Icheke was* launched in 2009 with the main aim of advocating for behaviour change and the reduction of sexual partners. The campaign is seen as the key to addressing Botswana's long term goal of zero new HIV infection (Lillie 2010). The *O Icheke* campaign was launched against the background of research showing that MCP is one of the key drivers of high HIV prevalence in Botswana, others being intergenerational sex, alcohol abuse, risky sexual practices, stigma and discrimination, gender-based violence, and sexual abuse (Matlhare 2009). For example, research shows that 21 percent of males reported having sex

with more than one partner compared to 2.3 percent of females in 2010 (NACA 2012). These relationships have contributed significantly to high HIV prevalence, accounting for 21.5 percent of new infections in the general population (NACA, 2012).

The *O Icheke* campaign thus serves to address lack of knowledge about the risk of concurrency and HIV, intergenerational and transactional sex and to provide information regarding norms and values about sex and relationships (Matlhare 2009). According to Lillie (2010) the campaign is coordinated by the National AIDS Coordinating Agency in close partnership with the existing multi-stakeholder structure that includes civil society organisations, community faith-based organisations, District AIDS Multi-Sectorial Committees as the implementing partners. The National Prevention Technical Advisory Committee took charge to oversee the campaign plan. As the lead technical advisory, the role of PSI is to ensure centralised material production and consistency of messages while the involvement of various stakeholders strengthens implementation at national, district and local levels (Matlhare 2009). The major funding partner which is the African Comprehensive HIV/AIDS Partnership (ACHAP) provided funding for the development of the national MCP campaign plan (Lillie 2010).

According to Matlhare (2009); Lillie (2010); NACA (2010) the strategic focus of the campaign is based on behaviours and populations such that it targets young women engaged in MCP for personal or material gain (18-24 years old), men engaged in MCP for sexual variety (25-35 years old). These included cross generational sexual partnerships between older men and young, vulnerable girls (Matlhare 2009; Lillie 2010; NACA 2010).

The other focus of the campaign is based on knowledge and risk perception that focuses on values such as consumerism, relationships aspirations, dignity and friendships for women (Matlhare 2009). In addition, the campaign

focuses on values for men such as beliefs about benefits of MCP, male to male norms, communication with primary partners and empowering young girls (Matlhare 2009).

The campaign is implemented in the districts through Community Based Organisations (CBOs), non-governmental organizations (NGOs) and the Districts AIDS Coordinators lead the rollout. Lillie (2010) indicated that the three main players to implement the campaign are CBOs and NGOs, World Bank and Ministry of Local government district officers. The author states that there around 50 NGOs and CBOs trained to deliver interpersonal communication interventions by integrating existing MCP messages into the campaign. These organisations are supported by the World Bank through funding to implement MCP activities (NACA 2010). Lastly, the Ministry of Local Government through districts offices are also rolling out the campaign. The implementing partners use different community level activities such as one-on-one discussion and in group discussions, dramas, testimonies by People Living with HIV, community and church events, youth clubs and music groups (NACA 2010).

The campaign has been rolled out countrywide with the use of mass media such as radio, television, newspapers and billboards. Lillie (2010) note that the most successful key program is the radio serial drama, *Makgabaneng.* The drama airs episodes weekly on radio, a 45 minutes call-on show and host community health fairs. In addition, a popular television show, *Morwalela* was aired in 2010 that shows the sexual networks and risky behaviours of MCP (Lillie 2010). The overall aim is to stimulate discussions about MCP among the general population, especially those found most likely to engage in MCP such as young people and males (Gourvenec et al, 2007). In the media messages, particular focus is placed on personalising risks; highlighting cost and benefits of MCP; and reaffirming positives that result from desisting from MCP (Lillie 2010). Media messaging is also used to acknowledge other

benefits of desisting from MCP such as self-worth, dignity, freedom from financial stress, emotional commitment than transaction, time and resource to family.

Given the importance of regular evaluations and assessments of health programmes and interventions for the strengthening of the quality of existing programmes, and for improved outcomes for the populations served (American Psychological Association, n.d), the aim of the study is to examine the perceptions of young people regarding the *O Icheke* MCP campaign. The study was undertaken in Selebi Phikwe, a mining town in central Botswana.

## 1.2 Problem statement

Almost five years after its launch, it is deemed important to examine the extent to which the *O Icheke* campaign has met its objectives. Selebi-Phikwe is chosen as a case study for a number of reasons. Firstly, according to the Central Statistics Office (2009), Selebi Phikwe had the highest HIV prevalence of about 26.5 percent in Botswana in 2008. The corresponding figure for other urban areas such as the capital Gaborone and the second city of Francistown were 23.5 and 24.5 percent respectively (World Health Organisation 2008). Secondly, the Social Assessment Survey (2010) revealed that more than 50.0 percent of men and 42.1 percent of women in Selebi-Phikwe reported having multiple concurrent partners. This is high compared to, for example, Francistown (48 percent for males and 17 percent for females) and the national average of 32 percent for men and 26 percent for women (Gourvenec et al. 2007). Additionally, the researcher's own observation is that high unemployment of women in the area is interrelated with MCP in Selebi-Phikwe and hence aggravates high HIV prevalence in the town.

## 1.3 Objectives of the study

The **broad** objective of the study is to assess young people's views on the strengths and weaknesses of the *O Icheke* MCP campaign in Selebi Phikwe. The **specific** objectives are:

1. To explore the views of young people on MCP.
2. To explore the young people's views on the key strengths of the *O Icheke* campaign.
3. To explore the young people's views on the key weaknesses of the *O Icheke* campaign.
4. To make recommendations for further strengthening of the campaign and improvement of its effectiveness.

## 1.4 Research questions

The study addresses the following research questions:

1. What are the views of young people in Selebi Phikwe on MCP?
2. What are their views on the strength of the campaign?
3. What are their views on the weakness of the campaign?
4. What recommendations can be made to further strengthen the campaign and improve its effectiveness?

## 1.5 Rationale of the study

The *O Icheke* campaign is seen as key to addressing Botswana's long term vision of zero new infection by 2016 (Lillie 2010). However, since its launch in 2009, no studies or evaluations have been done to determine the extent to which the campaign had achieved its main goals. The study will therefore contribute to closing this research gap by exploring the views of those who are closely associated with the campaign, namely young people who are registered members of the Selebi Phikwe District Youth Council. Further

description of this target group is provided in Section 3.4 of the methodology chapter.

## 1.6 Operational definitions

The following concepts were operationalized for the purpose of the study: multiple concurrent partnerships; *O Icheke*; perception; drivers; knowledge; attitudes ; young people; , and effectiveness.

### 1.6.1 Multiple Concurrent Partnerships

Saunders (2008) describes MCP as sexual relationships with more than one partner at the same time over the same period. This characteristic links people in long chains of sexual networks and has been posited as key driver of HIV infection.

### 1.6.2 *O Icheke*

The term *O Icheke* is a Setswana phrase which means 'check yourself'. It was adopted by the government of Botswana as the tag line for the national MCP campaign (Lillie 2010).

### 1.6.3 Perception

Perception is the organisation, identification and interpretation of sensory information in order to represent and understand environment (Schacter et al, 2011).

### 1.6.4 Knowledge

Knowledge is the capacity to acquire, retain and use information; a mixture of comprehension, experience, discernment and skill (Badran, 1995).

### 1.6.5 Attitudes

Attitude is a person's positive or negative feelings toward performing a defined behaviour (Family Health International 2004).

### 1.6.6 Drivers

An identified set of factors that have been empirically shown to influence risk for a given target group (Parkhurst, 2013). For the purpose of this study they are factors that lead people to engage in risky behaviour of practising multiple concurrent partnerships.

### 1.6.7 Effectiveness

The extent to which a project, programme or intervention produced outcomes and reached its overall objectives (UNAIDS, 2000).

## 1.7 Structure of the dissertation

In addition to **Chapter 1** which provides a background to the study including its objectives and rationale, the dissertation comprises of four additional chapters.

**Chapter 2 Literature Review**

This chapter locates the reader in the current literature related to the study. The discussion in the chapter focuses on the inter-linkages between MCP and HIV as well as plausible prevention strategies.

**Chapter 3 Research Methodology**

This chapter describes and justifies the methodology adopted and the procedures involved in the study.

**Chapter 4 Research Findings**

This chapter presents the findings that emerged from the study.

**Chapter 5 Conclusion**

This chapter summarises the study findings, provides conclusions, and offers recommendations.

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 Introduction

Sub-Saharan Africa remains the epicentre of the global HIV and AIDS epidemic with an HIV prevalence of about 4.9 percent in 2011 (UNAIDS 2012). Comparing this to the average of 0.8 percent in the rest of the world means that 23.5 million people living with HIV reside in this region (UNAIDS 2012). A growing number of studies single out multiple concurrent partnerships (MCP) in which men and women maintain two or more sexual relationships as the most powerful force propelling the killer disease in the region(Epstein 2010). Indeed, the Southern African Development Community (SADC) identified MCP by men and women, along with inconsistent condom use and low levels of male circumcision as the key drivers of the HIV epidemic in Southern Africa (UNAIDS 2009). For example, in Lesotho where 23.3 percent of adults aged 15-49 years were living with HIV in 2011 (UNAIDS, 2013), about 55 percent and 39 percent of women were found to be engaged in MCP (Goldberg, 2012). This chapter presents a brief overview of MCP, types of MCP, causes and risk factors associated with MCP and strategies to reduce MCP.

Concurrent sexual networks link people in a giant web of sexual relationships that create ideal conditions for rapid spread of HIV (Gourvenec et al 2007). The relationship between stages of infection and concurrent sexual partners particularly make MCP risky (Parker 2011). In essence, HIV is able to spread when infected people have sex with multiple partners during the acute phase. This is in contrast to individuals having one sexual partner at a time where HIV is unable to spread because there is no sexual network (Gourvenec et al 2007). In essence, as Jeffrey and Case (2009) found out, MCP increases the chance of infection by exposing partners to HIV during periods of high viraemia in primary infection and later by infecting partner in

a sexual network. This, as Parker (2011) argues, spreads HIV more rapidly in societies where MCP is common than those where serial monogamy is practised. Although serial monogamous relationships exclude partners from sexual networks (Parker, 2011), the risk of an HIV infection is related to the risk of previous sexual partners of the current partner. This is because partner concurrency increases HIV vulnerability as individuals are linked to high numbers of partners through networks that include sexual partnerships occurring within the time frame (Gourvenec et al 2007). Doherty et al (2006) point out that mixing different characteristic (for example, partners from different towns or economic groups) and concurrent partners widen sexual networks and increase HIV transmission.

Thus as the study by Jeffrey and Case (2009) also found, reducing concurrent partnerships can be a key component in reducing HIV in African countries with generalised epidemics. This is in line with modelling and empirical evidence suggests that MCP can increase the size of an HIV epidemic, the speed at which it infects a population, and its persistence within a population (Mah & Halperin 2008).

## 2.2 Types of MCP

According to Nkambule (2008), there are four forms of MCP: (1) a steady partner and other side partners; (2) intergenerational sexual relationships; (3) transactional sexual relationships; and (4) polygamy. In essence, these are sexual relationships whereby a person has overlapping sexual relationships with two or more partners. The differences between these relationships are described below.

### 2.2.1 Steady and other side partners

This is a type of MCP where a primary partner enters into one or more additional relationship or relationships (Goldberg 2012). In this relationship the other partners are kept secret and they serve to satisfy different needs.

Nkambule et al (2008) indicates that there are a number of reasons to engage in these extra relationships and these include dissatisfaction, insufficient and unsatisfactory communication, violence, and family discord.

### 2.2.2 Transactional relationships

According to Nkambule et al (2008), transactional relationships are partnerships driven by exchange of sex for social and financial gains from different partners. Goldberg (2012) points out that the relationships often highlight gender, social, and instrumental inequality as well as certain cultural norms.

### 2.2.3 Intergenerational sexual relationship

These are closely related to transactional relationships as they are both motivated by monetary value of the relationship (AIDSTAR-One 2011). Intergenerational sexual relationship is characterised by age disparity between a young partner and an older partner. The latter typically has another partner or partners in addition to the younger one. Several studies have highlighted that these relationships are associated with increased HIV risk and unsafe sexual practices.

### 2.2.4 Polygamy

Polygamy refers to the practice of having more than one spouse, and it is culturally-sanctioned in some parts of Africa (Goldberg 2012). These relationships can present risk of MCP scenarios if one member of the network compromises the link by having an extra relationship out of the network (Gourvenec et al 2007).

## 2.3 Causes of MCP

Multiple factors, including cultural practices, societal, economic and individual causes contribute to the rapid and expansive amplification of MCP.

### 2.3.1 Cultural factors

There are many customary practices which contradict the present day norms and values that play a role in mitigating the spread of HIV. In Botswana, for example, the saying "*Monna ga a agelwe losaka'* which can be roughly translated as "a man cannot be confined to a 'kraal" is often cited as one example of a cultural norm that somewhat influences and conditions people to engage in MCP. A ten country report on MCP by Nkambule et al (2008) reported several reasons that were given for the acceptance of MCP in many African countries. In Malawi, study participants said that polygamous relationships guarantee men children and allowed more wives to share domestic responsibilities. In Tanzania, respondents said that polygamous relationships guarantee a man sex all the time especially when the wife is menstruating or breastfeeding.

A respondent in Namibia stated that:

> *In our Herero culture it is accepted for a man to have many sexual partners, a man can marry ten wives and they will build their houses randomly and the husband's house will be in the middle.*

In many African societies polygamy is also supported by certain religious institutions such as African churches and Islam that allow their members to have more than one partner (Nkambule et al 2008). These and other cultural practices have placed women at greater risk of HIV infection. For example, African cultural practices such as wife inheritance of a deceased brother and the impregnation of an impotent brother's wife expose women to greater risks of HIV infection (Van Dyk 2001). Some cultural norms also make men who have multiple partners heroes while condemning women who do the same. For example, a man who has many partners is respected by his peers and regarded as a 'real' man whereas a woman who has many partners is regarded as a 'bitch' (Nkambule et al 2008).

### 2.3.2 Alcohol abuse

The use of high quantities of alcohol is associated with risk behaviours such as violence, and inconsistent and incorrect condom use (Parker 2011). This is due to the inability to think rationally after consumption of alcohol. According to several authors (for example, Shelton, 2009; Singh et al, 2010; Zabloska et al, 2010), alcohol and drug abuse is related to sexual risk and HIV infection and vulnerability. It also contributes to multiple sexual partners such that people end up picking sexual partners from drinking spots.

It is evident that alcohol abuse has remains the most common form of primary substance abuse by youth in Botswana (Phorano at el 2005; Botswana Alcohol AIDS Project 2004). This was corroborated by Seloilwe et al (2013) who indicated that in Botswana youth of both sexes engage in risky sexual behaviours that put them at risk of contracting HIV, STIs and unplanned pregnancies. The study purport that risk of sexual behaviour was associated with use of alcohol and drugs especially dagga. The participants in the study indicated house parties have become common for young people to indulge in sexual activities, where they invite others through facebook and other social media (Seloilwe et al 2013). A respondent stated that:

> *When parents leave for meetings for the whole week, they will give you money to buy small things for the house but instead we use the money to organise house sessions.*

### 2.3.3 Mobility

The spread of infectious diseases that are transmitted from person to person are likely to follow the movement of people (Decosas et al 1995). The vulnerability of migrants is however not the direct results of mobility but rather the circumstances and risk related to migration process (Girdler-Brown 1998). For example, mine workers are vulnerable to HIV infection as they often engage in high-risk relationships with women near the mines or with

commercial sex workers (Jochelson et al 1991). Parker (2011), on the other hand, posits that mobility related to job-seeking and employment, which is an important element of Southern African communities, often separates couples for long periods of time, which could lead to individuals looking for additional partners. Overall, therefore, migration and mobility increase exposure to sexual networks by accentuating the possibility of having multiple and concurrent partners.

### 2.3.4 Gender inequality

The subordinate social and economic position of women in many patriarchal African societies leaves them vulnerable to HIV infection as cultural and social systems in these societies often have strict rules concerning female sexuality (Evian 1993). According to Evian, women in these societies have little control over their sexual lives, as well as those of their husbands or partners and this hampers the women's inability to protect them from HIV infection.

### 2.3.5 Sexual dissatisfaction

Sexual dissatisfaction in relationships may also result in MCP among couples. According to Nkambule et al (2008), dissatisfaction in a relationship was identified as a major reason why people engage with additional partners in a ten-country study in Southern Africa. The author further indicates that this maybe worsened by lack of communication which may lead to abuse and neglect of partners, as well as sexual deprivation due to tiredness from work or other infections that affect sexual performance. Research has also shown that men look for young women to experiment with. Nkambule et al (2008), for example, maintains that married men are less experimental with their wives and seek the pleasure with young women or enter into additional relationships. The author urges that there is a less widely accept norm that women need to satisfied sexually and will go outside of their main partnership if they need to. Ministry of Health (2012), points out that sexual dissatisfaction

and sexual variety among youth is high in Botswana. The report further states that behaviour change among youth is paramount as 60 percent of new infections occur in the under 25 year's age group. It links high HIV infection of youth with the high prevalence of MCP.

### 2.3.6 Monetary and financial gain

Literature has indicated that lack of money and the quest for material possessions influence MCP in different ways. The International Organization for Migration (2006), for example, posits that factors such as urbanisation and high unemployment in sub-Saharan countries have increased sex work. This is due to young women who come to urban areas to look for employment and better life. When this becomes elusive, in order to get food and accommodation, sex work becomes a means to survive (International Organization for Migration, 2006). In this scenario, economic status is used for sexual favours which are associated with risky sexual behaviours such as the likelihood of inconsistent condom use.

A study by Msisha et al (2008) found that in Tanzania, urban, educated and wealthier men and women are likely to have concurrent partners than rural less educated and poorer men and women. This has been partly attributed to economic status in urban areas. The concurrent partners in urban areas are linked to consumption or materialism, whereas in rural areas they are linked to survival (Lopman et al., 2007; Johnson et al., 2009).

By the same token, Hammond-Tooke (1974) argues that the expectation of gifts and economic support from men is an old custom which has been practised for years. Its benefits may include acquisition of money, jewellery, clothing, accommodation, transportation and other valuable items. Cockroft et al (2010) found that although young women were aware of the risk of HIV in transactional sex, they were willing to continue with these relationships for these benefits. It is also noteworthy that some young men also engage in

sexual relationships for financial support. The exchange of sex for social or financial gain is therefore common among both young boys and females and often lures them to be involved in MCP (Nkambule et al 2008).

## 2.4 Strategies to mitigate MCP

### 2.4.1 Media Communication

The increasing popularity of media channels such as mobile phones, computers and television sets in Africa can be a valuable assets in reaching larger audiences to provide correct information on the prevention of the spread of HIV and AIDS, including addressing engagements in MCP (NACA, 2009; Spina 2009). Singhal et al (2004) argue that entertainment-education or 'edutainment' is a particularly useful strategy that entails the process of purposely designing and implementing a media message to both entertain and educate. It also increases audiences' knowledge about educational issues, and creates favourable attitudes, shifts social norms, and changes overt behaviour (Singhal et al, 2004). Edutainment may have a particular appeal to young people and thus may present a special opportunity to affect norms before they are fully set (Singhal et al 2004).

The other modes of communication that can be effective in reaching diverse audiences include: games, electronic technologies (mobile phones and computers), street theatre, art, music and cultural activities (Singhal et al, 2004). Donovan and Vlais (2005) highlight social marketing campaigns as other popular means for engaging society in primary HIV prevention that have also been shown to produce positive changes in, for example, the attitudes and behaviour associated with men's perpetration of violence against women.

It has been argued that communication interventions should address why people have multiple partners as this is the key to behavioural change. This will entail targeting complex behavioural determinants through different

messaging strategies for men and women. Gourvenec et al (2007), for example, argue that addressing deep seated determinants such as male peer support, men's attitudes towards sex and lack of ability to decide on sex by women are more challenging than addressing knowledge and risk. Kalichman et al (2007), on the other hand, are of the view that strategies should target all including those not at risk of HIV infection because people living with HIV who are in concurrent relationships are less likely to use condoms and to disclose their status.

### 2.4.2 Understanding of MCP

BOTUSA (2007) indicated that MCP has a powerful historical, social and economic foundation and it is a very complex behaviour. Matlhare (2009) also alludes that MCP is not a single behaviour; it has many faces, different kinds of sexual partnerships and different underlying factors. Thus developing an understanding of the nature and relationship between sexual networks and MCP is a key to the development of effective behaviour change interventions in Africa (Kalichman et al, 2007). In order to structure intervention programmes strategically, HIV and AIDS prevention programmes should allocate special consideration to focal actors in the sexual network (Kalichman et al 2007). By targeting and achieving behaviour change amongst core network members, major pathways for transmission across the network may be impeded. The authors indicate that in doing so, efforts to change behaviours, and to get people off the sexual network will allow maximum risk reduction. As research indicates, MCP is embedded in many African societies and cultures and it needs to be challenged and widely discussed to adapt cultural practices to take cognisance of contemporary health issues such as HIV and AIDS (BOTUSA 2007).

### 2.4.3 Community and stakeholder consultation

Research suggests that community consultation and engagement should guide the development of MCP programmes. Lillie (2010) argues that it is vital

to involve fundamental stakeholders from the beginning to the implementation process and evaluation part given that attitude, knowledge and behaviour change takes place within a community context that can support, facilitate or discourage such behaviour change efforts (Carter et al, 2007; Gregson et al, 2002, Parker et al, 2007). In addition, given some underlying factors such as socio-cultural, political and economic factors that influence people's attitudes, values, norms and behaviour, there is need to seek the assistance and cooperation of gate keepers who can influence people to adopt desired behaviour.

The coordination of all stakeholders should ensure that they attain maximum impact. According to the Social Assessment Report (2010) linking and strengthening collaboration between government and other stakeholders is essential to enable sharing of resources and to avoid contradictions of messages from other organizations. In Botswana, for example NACA (2011) showed that some efforts have yielded positive results in areas of disbursement of resources and insufficient consultation has been identified as weaknesses. It further stated that the primary purpose was to eliminate implementation bottlenecks, help to assist in sharing of information on relevant strategic and policy issues that may influence the implementation of programmes.

### 2.4.4 Communication strategies

As Ntshebe et al (2006) argue that, HIV messages including those related to MCP should promote links to cultural values, principles and conducted in indigenous language to adopt culturally appropriate communication approaches. Additionally, MCP campaigns should engage a number of tailored communication tools and strategies ranging from interpersonal activities, mass media and community mobilization, and social media. National campaigns should also thrive to involve all key national, districts, international and local partners.

### 2.4.5 Promotion of community ownership and sustained engagement

Van Dyk (2001) indicates that to effectively change harmful beliefs and practices, such as MCP, initiatives should engage directly with members of communities. Michau (2007) argues that initiatives should strengthen individuals', groups' and institutions' capacity to be agents of change with programmes working to ensure that activism will be sustained long after a specific project ends. Michau (2007) indicates that community ownership can be promoted by:

- Instilling hope and excitement regarding alternatives to MCP;
- Personalizing the process by reflecting that each person can be a part of the solution;
- Engaging community members to take up the issue and become activists themselves; and
- Including men as part and parcel of community mobilization.

Seloilwe et al (2013) is of the view that special consideration should be given to parents and teachers to strengthen communication skills. This is to capacitate them and to equip them with skills necessary to guide adolescents into adulthood through education and family communication. The role of parents and teachers to provide effective communication to adolescents is crucial in guiding them. The Ministry of Education report (2006) indicates that 70 percent of youth in Botswana are enrolled at primary and secondary schools and this creates a unique opportunity for teachers and parents to promote behaviour that reduces the risk of HIV infection. Despite this, Francoeur (2004) argues that there is no formal sex education in Botswana schools and that parent are not comfortable talking about sexuality with their children.

### 2.4.6 Integration of MCP with other HIV strategies

Addressing HIV is vital along with the combination of social and medical approaches to mitigate the impact of the virus. UNAIDS (2008) states that coordinated evidence informed strategies that work in concert towards shared prevention goals in the context of a well-researched and understood local epidemic will have the best chance of success. It is also imperative for resources and efforts to be prioritized for these approaches rather than for those which evidence of impact is weak (UNAIDS 2008). These should address the drivers of the epidemic in different contexts and modes of transmission.

To the extent that the integration of programmes into the existing well developed infrastructure is vital, MCP programmes should be integrated within other HIV prevention efforts such as Voluntary Counselling and Testing and Antiretroviral Therapy (Lillie 2010). UNAIDS (2008) adds that this should be done through research, planning and delivery of campaigns, advocacy, and communication initiatives. This should also not be developed by single organizations with no effort to create synergies as they may target one level. For instance, individual behaviour change may be targeted without focusing on the social and cultural norms, beliefs and values that encourage multiple partnerships for men or women (UNAIDS 2008).

### 2.4.8 Advocacy

To scale up HIV prevention programs in Sub-Saharan Africa advocacy is necessary for resource mobilisation. In order for the programs to be rolled out, advocacy targeting public, private and international donors is necessary given that most African countries are poor. Furthermore, it is a very crucial to engage key state and civil institutions to advocate for policy interventions (NACA 2009). In Botswana, MCP ambassadors need to focus on key institutions such as *Ntlo ya Dikgosi* (House of Chiefs), parliament and faith based organisations who are the key custodians of social norms, who can stage media and community debate about MCP (NACA 2009). The focus

should be on political leadership, youth leaders, cultural and gender related issues that perpetuate MCP and HIV transmission.

## 2.5 Theoretical framework

Theories try to explain why behaviour change occurs and why diverse populations and cultures behave differently, and often cite environmental, personal, and behavioural characteristics as the major factors in behaviour determination. HIV prevention programs are mostly based on theories about why people change their behaviour and hence focus HIV prevention efforts on elements believed to be essential for individuals to act and sustain behaviour change.

The study adopts the Health Belief Model, a theoretical framework based on the premises that a person's willingness to change their health behaviours is primarily due to personal beliefs or perception about the disease (Green & Kreuter 1999). According to the model, the following serve as the most important constructs: perceived threat, perceived benefits, perceived barriers, and cues to action and self-efficacy. According to Family Health International (2004) the most important element of the model is to recognize and label one's behaviour as risky in prompting people to adopt a healthier behaviour. The greater the perceived risk, the greater the likelihood that people will engage in behaviour change to decrease the risk.

To this end, the constructs of the theory were used to explore the effectiveness of MCP campaign and identify possible gaps between the programme objectives and implementation. The construct of perceived benefits highlights the usefulness of a new behaviour in decreasing the risk behaviour (Family Health International, 2004). In essence, it is difficult for people to change their risk behaviour if they feel the new behaviour is not beneficial. For example, assessing the cost and benefit of MCP or reducing partners will lessen involvement in activities that can increase the risk of HIV

infection. In order for a new behaviour to be adopted and sustained obstacles to behaviour change have to be dealt with. The process of taking action also depends on level of self-esteem and self-efficacy to make health related changes (Family Health International, 2004). Events, media reports or media campaigns can also influence people to reduce partners.

The Health Belief Model also attempts to explain and predict health behaviour by focusing on attitudes and beliefs of individuals. It recognises internal and external factors that help individuals to adopt negative or positive behaviours or that may hinder or facilitates the labelling of one's behaviour (FHI 2004). Therefore health education campaigns may cause people to examine and change their sexual activities. This makes the Model relevant for explaining participation or lack of participation in *O Icheke* campaign because if people are not aware of their risk behaviours it becomes difficult to pay attention to MCP messages and adopt safe practices.

In sum, the Health Belief Model is relevant to this study because it can assist in evaluating the targeted population's general perceptions about the objective of the campaign in line with their perceived susceptibility to HIV infection and the perceived severity in case one contracts the disease. In line with this it is believed that the extent to which the *O Icheke* campaign meets its objectives largely depends on the individual psychological evaluation of the campaign. To a greater extent also, the perception of individuals is dependent on the level of information they receive about the proposed preventive behaviour and its benefits to them. On the other hand, people need to associate the risky behaviours with getting infected with HIV; they must also consider themselves vulnerable to HIV if they engaged in MCP. They must further believe that MCP is directly associated with HIV and must also be aware of the benefits of not engaging in MCP.

## 2.6 Conclusion

The foregoing literature review has explored previous research on MCP and HIV and the discussion includes; causes, risk factors, types of MCP and strategies to reduce MCP and HIV. It has shown that in the African context MCP is influenced by socio-economic and cultural factors. This has been highlighted as a preclude behaviour change as MCP is not a single behaviour with many facet. Finally, the chapter discussed the theoretical framework that guided the study.

# CHAPTER 3
# METHODOLOGY

## 3.1 Introduction

This chapter discusses the methodology used to examine the perceptions of young people regarding *O Icheke* MCP campaign. The chapter sets out with discussions on the research approach and design. The chapter presents the research design of the study, the study site, the study population, sampling technique and the methods used to collect data. This chapter also discusses data analysis, reliability and validity, ethical considerations and limitations of the study.

## 3.2 Research design

The study adopts a qualitative research approach which measures information based on opinions and values as opposed to statistical data (Babbie and Mouton, 2001). According to Neuman (2002) qualitative research focuses on meaning, experience, and understanding while Leedy and Ormrod (2005) argue that it is a research involving detailed verbal descriptions of characteristics, cases and settings. Leedy and Ormrod (2005) also argue that qualitative research can reveal the nature of certain situations, settings, processes, relationships, systems and people. Overall, a qualitative study enables a researcher to gain new insights about a particular phenomenon; to develop new concepts or theoretical perspectives about it; and to discover the problems that exist within the phenomenon (Neuman 2002).

According to Ambert et al (1995), in order to understand qualitative research, it is vital to outline and define its foci and its goals. The major aspect of qualitative research is that it seeks depth rather than breadth or representation in the study being carried out; hence as an alternative to

drawing from a large, representative sample of an entire population of interest, qualitative researchers seek to acquire in-depth information about relatively smaller groups of persons by concentrating on words and observations to express reality and to describe people in their natural setting. Against this background, a qualitative approach was deemed the most appropriate for exploring perceptions about the *O Icheke* campaign as it provided the researcher with an opportunity to interact with young people whose experiences on MCP campaign the researcher wanted to deeply understand.

### 3.2.1 Study site

The study was undertaken in Selebi Phikwe, a mining town in eastern Botswana. As per the 2011 population census the total population of the town was 49 724, of which 24749 were males and 24975 were females (Central Statistics Office, 2011). Data collection was undertaken at the town's District Youth Council (SPDYC), a non-governmental organization (NGO) founded in 1974 through a President Directive. The NGO is an affiliate of the Botswana National Youth Council and its main mandate is to empower young people aged 18-35 years through activities such as drama clubs; condom distribution; and HIV and AIDS outreach events such as Youth Against AIDS (YAA) and MCP campaigns. Overall, the organisation provides services to mitigate the spread of HIV as well as to address the socio-economic difficulties faced by young people. It serves about 3000 registered and non-registered young people in Selebi Phikwe.

### 3.2.2 Study population

A study population refers to the entire group of objects (including people) in which the researcher is interested (Neuman, 2004), and for this study it was males and females aged 18-35 who are registered members of the Selebi Phikwe District Youth Council. The study was limited to young people in this

age bracket and who are members of this organisation for three basic reasons:

1. The aim was to explore the perceptions of those who have knowledge of the *O Icheke* campaign and have been exposed to its activities.
2. 18-35 years is the target group of the Selebi-Phikwe District Youth Council; young people below 18 years are not eligible for membership.
3. 18-35 years also falls within the age bracket hardest hit by HIV and AIDS in Botswana as shown by the 2008 Botswana AIDS Impact Survey results (NACA, 2009).

### 3.2.3 Sampling

Babbie (2007:180) refers to the process of sampling as the selection of participants. For the purpose of this, purposive sampling was used to select the study population. As a non-probability sampling technique, purposive sampling entails selecting a sample based on certain criteria (Given 2008). For the purpose of this study age and gender were used as criteria for the sampling population and the sampling frame was registered members of SPDYC aged 18-35 years. Overall, the researcher used purposive sampling to select those young people whose experiences would permit an exploration of the phenomena in question, that is, the perceived strengths and weaknesses of the *O Icheke* campaign.

### 3.2.4 Data collection

Hancock (2002) denotes that a qualitative researcher's approach to data collection usually involves direct interaction with individuals on a one to one basis or in a group setting. Using a semi-structured interview guide (Appendix 1), data was collected through four focus group discussions with the following groups of young people:

- Males aged 18-24 years

- Females aged 18-24 years
- Males aged 25-35 years
- Females aged 25-35 years.

Focus group discussions were deemed the most appropriate method for collecting data and meeting the objectives of this study because by nature, the discussions are designed to explore perceptions, opinions, and beliefs (Taylor & Lindlof 2002). Taylor and Lindlof (2002) assert that focus groups interviews have the distinct advantage of producing data and insights that would be less accessible without group interaction.

The decision to have focus groups for males and females separately was based on the available evidence showing that "the drivers of MCP are different for men and women" (Gourvenec et al, 2007:1). It was also assumed that the perceptions of younger and older people will differ, hence the separation of the age bracket into two broad groups (18-24 and 25-35) for each gender.

The focus group discussions took place at SPDYC premises and each group discussion lasted approximately one hour thirty minutes. With the consent of all participants, all the focus group discussions were audio recorded. This was to help capture data and to enable revisiting the discussion, if necessary, during data analysis. Field notes documenting additional information that emerged during the focus group discussions and non-verbal clues for participants were also prepared.

### 3.2.5 Data analysis and interpretation

To undertake data analysis, all focus group discussions were transcribed verbatim. Transcribing is important as it enables interaction with data collected and enhances deeper understanding of material from interviews (Babbie et al 2001). After transcription data was sort out into different

categories and common themes in responses (i.e. similarities and differences) were identified and grouped together. This helped to develop descriptions from the data, to find connecting and interrelated themes, and allowed the analysis of data by observing meaningful patterns, recurring themes and drawing conclusions from the data. Ideally an independent decoder would have been appointed to verify the themes. However this was not feasible due to budgetary constraints, as discussed later in Section 3.4 (limitations).

### 3.2.6 Reliability and Validity

According to Kirk and Miller (1986) reliability is the extent to which a measurement procedure yields the same answer under different but standardised conditions. Validity on the other hand determines whether an item truly measures that which it was intended to measure the results (Joppe 2000). The researcher strived to achieve both reliability and validity through a number of measures including:

- Pre-testing the interview guide on one male and one female group before the actual data collection. The pre-test enabled the determination of the right questions to ask by allowing adjustments to the interview guide as deemed necessary. The pre-test also helped to evaluate time duration for data collection.
- Constantly reviewing data to ensure that as new patterns emerge nothing was missed out.

## 3.3 Ethical considerations

Permission and approval to conduct the study was sought from, and granted by the Higher Degree Committee (HDC) of the Department of Sociology at the University of South Africa, the Selebi Phikwe District Youth Council (the organisation where data collection took place) through Botswana National Youth Council, (See Appendix 3). In line with the HDC ethics approval, the researcher ensured that the basic principles of research were adhered top

throughout the study including during the write-up of the findings. These principles include protecting and respecting the rights, dignity, privacy, anonymity and confidentiality of all study participants. The researcher also considered ethical considerations of power relations, informed consent, voluntary participation and debriefing as the pillars of the study. All these principles are briefly described below:

### 3.3.1 Power relations

This involves the moral responsibility to guide, protect and oversee the interest of people being studied (Neuman 2004) and to avoid abuse of power and trust.

### 3.3.2 Informed consent

Informed consent entails informing the participants of the purpose of the study and any possible risks and benefits from participation (Neuman, 2004). The researcher made sure that the participants understood what the research involved, specifically the procedure to be followed, as well as demands or risks. Consent was therefore obtained from research participants to partake in the research (see Consent Form in Appendix 2). The researcher explained to the participants that data was to be collected through focus group discussions. The researcher elaborated on the use of audio tape and field notes that it will be confidential and securely stored.

### 3.9.3 Privacy, Anonymity and Confidentiality

In social research privacy of participants is respected in order to study social behaviour especially when asking about beliefs, background and private intimate details (Neuman 2004). As a result, the names of the interviews are not provided in the dissertation. That is, the participants' identifications remain anonymous. The researcher has therefore kept the details of the interview participants confidential.

### 3.3.4 Voluntary Participation

Participants were informed that participation in the study was voluntary and consent was sort before commencing with data collection. The researcher explained that failure to participate in the study or withdrawal at any stage would not result in any penalty or negative consequences for the participant.

### 3.3.5 Debriefing

At the end of the interviews the researcher shared with the participants what the focus group discussion had been like, and asked how they felt about it. The researcher also enquired on whether there was anything in particular that they wished to share with him.

## 3.4 Limitations

Time and financial constraints limited the collection of data from more young people and from those in other localities such as rural areas. In addition, the small sample size means the findings of the study cannot be generalised. However, given that qualitative data, by nature, is meant to present insights rather than statistically representative data (Mokomane & Rochat, 2012); the results are deemed valuable as a source of insights into the views of those who are actively involved in the *O Icheke* campaign.

# CHAPTER 4

# RESEARCH FINDINGS

## 4.1 Introduction

This chapter presents the key findings of the study. The chapter begins with an overview of the basic characteristics of the focus group participants. Thereafter perceptions of young people regarding MCP and the *O Icheke* MCP campaign in particular are discussed. The chapter concludes with an exploration of the young people views of the key strengths and weakness of the campaign. In interpreting the results it is noteworthy that the data analysis did not reveal any major variations in the views of young people by age or gender.

## 4.2 Basic characteristics of focus group participants

The table below presents the basic characteristics of the 27 focus group participants.

**Table 4.1 Basic Characteristics of focus group participants**

| Group | Number in group | Average Age | Marital status | Highest Educational attainment | Any additional qualifications |
|---|---|---|---|---|---|
| (1) Males aged 18-24 | 8 | 20.9 | All single | All Senior Secondary Qualification | 4 lay counsellors |
| (2) Females aged 18-24 years | 6 | 22.5 | All single | All Senior Secondary Qualification | None |
| (3) Males aged 25-35 years | 6 | 30.0 | All single | All Senior Secondary Qualification | All Peer educators |
| (4) Females aged 25-35 years. | 7 | 27.0 | 3 married<br>4 single | 3Senior Secondary Qualification<br><br>4 Junior Secondary Certificate | None |

It is noteworthy that the above table is not meant to reflect the actual volume of data collected but only to shown the number and characteristics of participants who took part in the focus group discussions.

## 4.3 Knowledge of, and views on, MCP

Participants in the study indicated that they understood MCP and described it as an act of having more partners in a relationship at a time. This act of behaviour was seen to be a very risky behaviour that fuels HIV transmission in Selebi Phikwe. It was also indicated that the behaviour is a dangerous relationship that occur between men and women who maintain more than one sexual relationship for a longer period. In addition, it was also mentioned that the relationships could be long lasting or casual sex, where most couples eventually stop using condoms. Furthermore, all research participants knew that transmission will occur, if one partner is HIV positive and have sex without the use of condoms. The literature has shown that there is high level of knowledge on HIV and MCP. However, such knowledge has not led to low risk behaviour. This affirms the Health Belief Model (HBM) that changes of risky behaviour is a process that one has to assess and deem it necessary to change or adopt safe behaviour.

## 4.4 Reasons for taking part in partnerships

Participants were of the view that that there are a number of factors that influence people to take part in MCP. These include financial reasons; the quest for material possessions; need for sexual variety; migration and unemployment; alcohol abuse; and perceptions of drivers of MCP.

### 4.4.1 Financial reasons

Lack of, or a financial constraint was cited as one reason why most people end up in MCP. Some of the respondents from the male group of 18-24, for example, argued that young males who do not have lots of money lose out to older ones due to the cash that the latter flash out to young females. For

example, a study in Botswana found out that young women are willing to enter into intergenerational relationships due to benefits of financial gain (Cockroft et al 2010). One of the participants said:

> *It is older guys who have money; they take our girls who are attracted to their monies and cars. Our older brothers spoil these girls (Male participant, 18-24 age group)*

> *Young girls are spoilt they like money and want money for cell phones and airtime, for example, senior secondary school girls like taxi drivers (combi conductors) because they give them money every day and they do not pay to and from school. Sometimes they love you because you drive fancy car or something like that (female participant 18-24 age group).*

The above statement support the literature as Social Assessment survey (2010) indicates that Selebi Phikwe has the highest number of women receiving money or gifts in exchange for sexual favours in Botswana. It was generally argued that due to financial needs for paying basic commodities, most unemployed or underemployed women end up being engaged in MCP to make extra money so as to afford to pay their bills. International Organisation for Migration (2006) points out that lack of employment and economic disparities contribute to high prevalence of MCP among women. This supports respondent claim as they urge that lack of employment opportunities for women results in women seeking more partners in exchange for financial assistance. For example, one of the participants from the female 25-35 age group stated that:

> *Women have tight budget therefore, the men fit in there to assist but in exchange for something.*

The respondents further mentioned that older women, especially single mothers, are also involved in MCP. They argued that many single headed

families exist today and women bear the burden of those families. However, it was argued that for older women it was more about survival while it is about fashion for younger women. As the HBM theory posits that people weigh cost of MCP, the study concludes that people who are involved in MCP have weighed rewards of MCP such as financial gain. Another female participant from the 24-35 age group said:

> *Most women are not working and life is expensive so the only option is to have boyfriends that will give you money. We need money for many things and only few jobs exist for us unlike men who can work any job.*

The respondents indicated that cultural norms and expectations that a man has to provide financial for a woman exacerbate the situation. They argue that this creates dependency of women on men and such behaviour will encourage women to have couple of partners to take care of them. As one participant mentioned that:

> *Women who like money target every man who comes and flashes money before them and they like being spoilt because they believe man are there to provide for them (female participant age group 24-35).*

### 4.4.2 Quest for material possessions

Respondents indicated that the quest for material possession is also an influencing factor to MCP in a number of ways. They indicated that most of the younger women who get involved in MCP are interested in material benefits such as expensive mobile phones, clothes and jewellery, which they easily obtain from older men. One of the participants from the female 25-35 age group had this to say:

> *Young girls get a sense of pride and happiness to get anything they need or want while others do not have the privilege of getting it.*

Another participant indicated that:

> *At times your friends will brag about things they get from their boyfriends and you will be compelled to join. We compete as women and become jealous that someone is getting better presents than you. There is high completion for boyfriends who gives lots of money and presents and we go to the extreme of getting them (female participant from 18-24 age group).*

The participants stated that young people who cannot afford fashionable designer labels often resort to having many partners. However, material benefits were typically related to women whereas for men, sexual favours are the main factors contributing to MCP.

### 4.4.3 Quest for sexual variety

This was identified as a mainly male phenomenon and another reason why men are more engaged in MCP. It was the view of most female participants that concurrency starts from young age as boys learn about sex on the streets from older boys or those who are sexually experienced. The females argued that to the extent that males like competition among themselves they will often compete to have many girlfriends and boast of being able to attract women. This is consistent with literature as Gourvenec et al (2007) indicated that concurrency is common among youth in Botswana and also associated norms supporting MCP. One female participant in the 18-24 female age group mentioned, for example, that:

> *Men are selfish and they want to sleep with many girls, sometimes they boast that girls are weak and cannot resist them.*

> *Sometimes you just like something about girl and you will want to sleep with her, that's men they will want to experience with many girls of*

*different types, you cannot change it (male participants from the 18-24 age group)*

The HBM stresses the importance of internal and external factors in adopting negative or positive behaviour. It is clear from the study findings that from young age competition and boosting among boys is taken negatively to have many partners. The participants pointed out that men and women like to boost about their sexual experiences or encounters. This concurs with Nkambule et al (2008) who reported sexual dissatisfaction by men and women as one of the major reason why people engage in MCP. It further, states that additional sexual partners are need to have change from regular partners. MCP surfaces in an attempt to have sexual experience with different partners. This will entice others to seek more partners with the hope that they will meet a partner with that experience or that skill. One of the participants from the male group aged 24-35 years old mentioned that:

*Your friends will be boosting about how they met a virgin or ladies commenting that someone is good in bed others will like to try out also. For example, some women like guys who are players because they want to experience why other girls like them. Sometimes they like a guy who has a big manhood.*

Another participant mentioned that,

*Males end up doing this because it has come much easier for them to get sex whenever they want from different girls who are mostly in their early 20s (Female participant, 18-24 age group)*

Another participant from the female group 25-35 years old stated that:

*There are girls who are known to be 'sluts' who will sleep with any new come in town and any guy who interested will sleep with them. There are*

*people who like sex and it's like a disease to them, they have to sleep with different girls or men every day.*

Sexual variety was point out to be common among people who stay in camps such as mine workers, police and military personnel. They argue that these people do this to relieve boredom and take it as an entrainment for them. A female participant from 18-24 age group mentioned that:

*If you go to BDF (Botswana Defence Force) barracks they change women every day, women like soldiers a lot because they believe they have money. Even if the guy knows you date his friend or housemate, he will propose you and it's a common thing to see them changing and sleeping with their friend's partners. They behave like school boys and girls; there is no age difference because they all behave alike.*

### 4.4.4 Migration and unemployment

People's movement from one place to the other in search for jobs was identified as one contributory factor to MCP. Focus group participants argued that in cases where they do not know anybody and are, unemployed, job-seekers—especially women—often enter into relationships so as to get accommodation, and to be taken care of by men who are employed. This is consistent with the literature where moving to other areas in search of work has been described as a catalyst for HIV spread (International Labour Organization 2002). The focus group participants described the population of Selebi Phikwe as female dominant, meaning that there are more women in Selebi Phikwe than males:

*It [the town] is full of people from other areas who came to look for jobs, which most of them are women who came to work in China Shops (Female participant, 25-35 age group).*

The few males available in Selebi Phikwe are said to be those working in the army and the copper-nickel mine. The respondents argued that this has resulted in high partner exchange in Selebi Phikwe due to many women who are unemployed or underpaid competing for the few available men.

The respondents further identified the relatively high unemployment rate of women as another reason why they engage in extra relationships. The overall suggestion was that the women enter these partnerships in an effort to cope with demands of life and support family members back home in the rural areas. As stated by one participant:

> *Women are not working, what should they do except to have many partners? (Male participant, 18-24 age group)*

> *Money is the root cause of all evil, things have changed and you cannot survive without money, women here cannot get jobs and have families to feed, take care of siblings and other needs. You come here with expectation that you will get a job and what do you do when you don't get one? (female participant from 25-35 age group)*

All in all, the participants mentioned that survival of most women who are unemployed in Selebi Phikwe is by having many partners who will support them financially or materially. This is especially true for single mothers, even though married people are not excluded from such behaviour.

### 4.4.5 Alcohol abuse

The respondents felt that alcohol consumption is high in Selebi Phikwe and, consistent with the literature there was an apparent close link between people who frequent clubs and bars for drinking and having one-night stand partners. Seloilwe et al (2013) agree with Botswana Alcohol AIDS Project report (2003) that alcohol remains a major contributing factor to the spread of HIV in Botswana. The authors maintains that alcohol abuse during house

parties or going out on drinking spree by youth are occasions to engaging in sex especially when girls are under the influence of alcohol. They urge that there is a close link between alcohol abuse and perilous sexual behaviours like unprotected sex, engaging in sex for money or exchange for alcohol.

Focus group participants argued that while entertainment is a way of relieving stress and boredom, it can be expensive. In this regard, they indicated that women (mostly those who are unemployed) who go to clubs and bars, can barely afford alcohol. As such, men buy them drinks in exchange for sex. It was reported that it has indeed become a habit for men to offer alcohol for sex in Selebi Phikwe. Parker (2011) found that in Botswana 31 percent of men and 17 percent of women were heavy drinkers and women who drank heavily being more likely to have unprotected sex, multiple partners and exchange sex for money. One of the participants, for example, stated that:

> *Girls offer them sex afterwards and also with the expectation of getting some money in the morning (Female participant, 18-24 age group).*

Another participant from the female 25-35 age group indicated that:

> *Men have a habit of getting women drunk so that they will go sleep with them. Some girls become 'lose' (irresponsible) when they are drink and they will say no to a man who want sex especially they have been drinking together and some people like sex after drinking, it get down to their waist (expressed in Setswana; bojalwa bo a tshetlha).*

## 4.5 Knowledge on *O Icheke* campaign

The study found out that as members of the Selebi Phikwe District Youth Council the participants had good understanding of *O Icheke* MCP campaign and they had all participated in various activities of the campaign

including volunteering to mobilise the community during HIV prevention campaigns and youth rallies. The following statement by one participant from female 25-35 age group illustrates:

> *We do assist in house to house HIV prevention education, help our peers in seeking options and solutions for their problems and it is about listening to the challenges of young people and encourage behaviour change in them*.

The participants indicated that although they are not employed by the organisation, they are orientated and provided with training on the *O Icheke* campaign and on the implementation of community projects relating to HIV and AIDS prevention. The following are areas they indicated that they are trained in: strategic focus of the campaign; campaign principles; and campaign messages.

## 4.6 The strengths of *O Icheke* campaign

All focus group participants were asked about the key strengths of the *O Icheke* campaign. They identified these as the campaign's attempt to close the knowledge gap in relation to MCP; the campaign's target population; government funding; multiple stakeholders; and the campaign's delivery mode.

### 4.6.1 Closing of the knowledge gap

The participants indicated that the campaign addresses knowledge gap and change people's attitude towards MCP. They also indicated that there was a lot of valuable information provided by the campaign that encourages behaviour change, as one participant stated:

> *Some people already know the danger but do it anyway but with the campaign they have done introspection and decided to do the right*

*thing and not to be involved in MCP (Female participant, 25-35 age group).*

They further mentioned that the campaign discourages sexual networks which exposes people to unsafe sexual practice and puts them at risk of HIV infection. One participant mentioned that:

*We try to educate them, you know people are difficult to change but we try to give them knowledge and again this kind of information is everywhere this days, it's just that people are stubborn (female participant, 25-35 age group).*

### 4.6.2 Target population

The *O Icheke* MCP campaign targets 15-49 years old (Matlhare 2009). Within this age bracket the three main groups that the campaign specifically focuses on are young women aged 18 to 24 years engaged in MCP for personal or material gain; men aged 25 to 35 years engaged in MCP for sexual variety, and older men aged 36-49 years engaged in cross-generational sexual partnerships with younger girls (Lillie 2010). The focus group discussions further revealed that the campaign engages school going and out-of-school youth in discussions related to HIV and MCP. The campaign's target group was therefore seen as relevant as it is mostly those involved in MCP. In general, the participants viewed the focus on this age group as one way of reducing HIV from a highly infected age band. As one participated stated that:

*It is youth and young adults that are dying in numbers and they are the ones mostly infected. If you don't save this group the country has no future (male participant, 25-35 age group).*

### 4.6.2 Government funding

According to the focus group participants, government funding of the O *Icheke* campaign enables it to effectively address MCP as part of HIV prevention and thus contributes to the overall mandate of the National AIDS Coordinating Agency (NACA). Research has indicated that advocacy for funding is necessary especially from leadership and international donors to support the rollout of the campaign. Participants also highlighted that the campaign has strong national leadership commitment through NACA, business owners, politicians and traditional leaders who sometimes pledge or contribute some funding to undertake some specific activities of the campaign.

> *We do get funds through local District AIDS Coordinating office because they get money from United States Presidential Emergency Plan for AIDS Relief (PEPFAR). They have been supporting these programmes for long time now.*

### 4.6.3 Stakeholders

Research has shown that for effective program implementation different players have to be involved supporting community structures (Lillie 2010). The *O Icheke* campaign was described as having multiple stakeholders with partners at all levels especially locally. The participants mentioned that to ensure the success of the campaign many non-governmental organisations (NGOs) in Selebi Phikwe work closely as collaborators and/or encourage partnerships with other stakeholders including national leaders. NACA (2011) maintains that different stakeholders bring different skills and expertise which yields good results. One of the participants stated that:

> *We work with the district commissioner, police, health departments and other civil organizations (Male participant, 25-35 age group)".*

*The fact that there is support from the Office of the President means a lot to this project. People want to see our leaders involved that is how people can change (Female participant, 25-35 age group)*.

This was seen as creating a good working atmosphere with other organizations as they have the same aim of reducing MCP prevalence. The participants felt that this further increases visibility of the campaign as there is always activities offered by other stakeholders.

### 4.6.4 Delivery mode

According to Lillie (2010), media communication reaches many audiences and forms a platform for widespread public exchange on information. Consistent with this, the participants asserted that the campaign's use of entertainment-education has been a useful and the most appropriate form of mode to reach many people. As one male participant in the 25-35 age group said,

*Drama and local artists' performance boost the campaign and targets everyone or people passing by*.

This was generally attributed to the fact that young people like entertainment and as such public places where many people interact like shopping malls and field events are good for targeting audiences. As one participated mentioned that:

*If you want youth to attend you have to use entertainment and their favourite artists. Today it's not like those days, posters don't work but music is the in thing (female participant, 18-24 age group).*

Another delivery mode of the campaign (house-to-house mobilisation) was seen as important in that it creates interaction on one-to-one basis. It was however noted that the majority of people met during the house-to-house

mobilisation were housewives, meaning that many men miss the opportunity of vital information through this delivery mode.

## 4.7 Weakness of the O Icheke campaign

The key weakness of the campaign was seen as poor consultation between the funding office and programme implementers; poor coverage in rural areas; language of delivery; and competition for funding among the increasing number of NGOs.

### 4.7.1 Consultation between the funding office and programme implementers.

Some participants decried poor consultation between NACA (the main funder or funding office) and programme implementers. It was revealed, for example, that the campaign was designed by NACA without the input of the Selebi Phikwe District Youth Council (an implementing partner). According to the participants, implementing partners are typically just given funds to run the activities or implement the *O Icheke* campaign without being part of the planning and conceptualisation phases with NACA. One participant lamented that:

> *No consultation with our office and feedback from the campaign is not provided; NACA designs tools* (Female participant, 25-35 age group).

Participants reported that while their role seemed to be just implementation without any say on the project conceptualisation, they often experienced different challenges that could be easily resolved had they been part of the planning phases.

### 4.7.2 Coverage in remote areas

The study found out that there are several MCP activities in Selebi Phikwe. However, remote areas are not adequately covered. The participants

therefore expressed the importance of rolling-out the campaign to surrounding areas so as to achieve more impact. In particular participants underscored the need for the campaign to target rural dwellers especially those who are illiterate, one male participant in the 25-35 age group indicated that:

> *Lots of people around are from small settlements around Phikwe; the campaign rarely goes to rural areas unlike in town*.

### 4.7.3 Language of delivery

To the extent that the aspect of language is considered imperative in HIV prevention strategies (Chimbutane, 2012), participants also lamented the fact that people who do not understand Setswana and English (the only two languages used in the campaign) are excluded by the campaign. In the same vein, one male participant in the 18-24 age group stated that:

> *We have difficulties with communicating with people who are deaf or visually impaired*.

### 4.7.4 Increasing number of non-governmental organisations

The study revealed that there are numerous organisations that come forward to take part in HIV prevention campaigns. Many of these organisations depend entirely upon government funding. This is however often given for a certain period before being stopped and a new funding phase in which organisations have to apply for funding is advertised. Participants raised concerns that this competition for funding among NGOs has the potential to result in the closure or downsizing of organisations including those active in the area of MCP.

## 4.8 Conclusion

Overall, all groups mentioned that young males and older males are involved in MCP because of sexual variety, pride and competition. It was also

revealed that alcohol abuse contributes to MCP especially among women and men who frequent bars and other drinking places. From the study it can be argued that the above factors indicates that high levels of MCP are associated with the benefits people perceive it carries than lack of knowledge about the danger it carries. The study further revealed the strengths of the programme as it addresses the knowledge gap; it changes people's attitudes towards MCP and discourages sexual networks. It further revealed that the programme engages school-going and out-of-school youth. The other strength of the programme identified is the strong national leadership and government commitment to funding of the campaign. Despite the strengths of the programme, there were other weaknesses including the poor coverage of the programme and the emerging organisations which have similar activities.

# CHAPTER 5

# SUMMARY AND RECOMMENDATIONS

## 5.1 Introduction

This chapter presents the summary of findings and makes recommendations for improving the effectiveness of the *O Icheke* campaign.

## 5.2 Summary of Findings

The study has revealed that there are several reasons why people engage in Multiple Concurrent Partnerships (MCP). It was revealed that many people engage in MCP because of financial gains, material possession, sexual variety, alcohol abuse, migration and unemployment. To address the quest for financial gain and material possession women engage in risky partnerships as a strategy to meet their demands. In most cases, money was revealed as the root cause of MCP as it is needed for acquiring material possession and maintaining good living. Material possession was perceived to promote stature and many would like to be seen having such. Another reason which was revealed in the study as to why people engage in MCP is the search for sexual variety. In trying to fulfil their search for sexual variety, sexual partnerships are formed to satisfy the gratification. The study indicated that financial gain is related to most women whereas men benefited from sexual favours which contributed the issue of many men seeking sexual variety.

Migration and unemployment were identified as the other contributory factors to MCP in that many people leave their families in search for greener pastures and the unmet expectations of employment contribute to engagement in risky sexual relationships. Alcohol abuse was also suggested as a contributing factor. It was argued that when women go to bars without money, men who pay for their drinks in turn often benefit from sexual favours.

The participants were of the view that the key strengthens of the *O Icheke* campaign were that it addresses people's knowledge gap about HIV and MCP; it changes people's attitudes towards MCP through vigorous campaigns; it discourages sexual networks among people; and it engages school-going children, as well as out of school youth into discussions on HIV and MCP. The programme also has a financial support from government. This enables it to continue and reach its set objectives and to contribute to the overall mandate of the National AIDS Coordinating Agency (NACA).

Even though there are strengths about the campaign, the study also revealed some factors that hamper its effectiveness. It has been indicated that the campaign focuses only in Selebi Phikwe and fails to reach surrounding settlements. The participants also felt that the campaign has left out some of target population being people with disability (hearing, visual impaired) and language barrier in other instances. In addition, the emerging organisations which come with similar strategies do compete for the same meagre funding from government.

### 5.2.1 Key terms

multiple concurrent partnerships; *O Icheke* campaign; perception; drivers; knowledge; cultural factors; attitudes; young people; socio-economic factors and effectiveness.

## 5.3 Recommendations

Based on the overall findings of the study, the following recommendations to improve the effectiveness of the campaign are made for consideration by all the multi-sectoral stakeholders of the national HIV and AIDS response:

### 5.3.1 Partnerships

The funding office (NACA) should engage more closely and improve consultation with programme implementers. The campaign volunteers should

be more involved as they do most of the ground work and come across challenging issues. Efforts should be made to involve them in future reviews of the campaign. Their input and feedback would be vital to the funder and other stakeholders as the campaign continues to be rolled-out.

### 5.3.2 Practice

- Rural and remote areas should be included in the rollout of the campaign.

As the study reveals, while there are several activities in Selebi Phikwe, some of these activities are not adequately implemented in surrounding rural areas. Thus organisations that come forward to take part in HIV prevention initiatives, particularly MCP, should be urged to focus on these otherwise neglected areas.

- The campaign should be designed to target non-English and Setswana-speaking people. The campaign should be rolled out in different languages and should also target people with disability. There is, in particular, a need to for the campaign design to include sign language interpretation and to cater for the visually impaired.
- The partnership between government and non-government organisations is vital for the implementation of HIV prevention programmes and addressing other social ills. Therefore, increased and continuous government funding for organisations dealing with MCP will enable consistent implementation of the campaign's programmes and activities.

### 5.3.3 Further studies

Given that the study was undertaken in just one town in Botswana using a small sample size which limits generalibility to the national population, there is a need to reaffirm the conclusions of the study through a larger national study.

## 5.4 Conclusion

The study was conducted within the framework of the Health Belief Model which, according to Green & Kreuter (1999), explains people's willingness to adopt safe behaviour methods based on the perceived threat and labelling of behaviour as risky. In general, the risk perception of individuals is dependent on the level of information they receive about a proposed preventive behaviour intervention and its benefits to them. That is, people need to associate risky sexual behaviour with HIV infection. They must, for example, consider themselves vulnerable to HIV if they engage in MCP. They must further be aware of the benefits of not engaging in risky behaviour.

The theory was deemed appropriate as this study essentially explored views and perceptions of a campaign aimed at behaviour change by addressing HIV transmission knowledge gap and changing people's attitudes towards MCP. Overall, the study participants were of the view that while people in Botswana are aware of the dangers of MCP and the possibility of HIV infection through these partnerships, some are reluctant to change their risky behaviour due to factors such as unemployment, migration, alcohol abuse as well as the quest for financial gain, sexual variety, and material possession.

The participants were also of the view that through its target population, main funder, stakeholders and delivery mode, the *O Icheke* campaign ensures that people should constantly assess their risky behaviour. However, improved consultation between the funding office and implementing organisations and wider coverage of the programme in remote rural areas were identified as some avenues through which the *O Icheke* MCP campaign could be further strengthened to achieve its goals.

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**Appendix 1: Interview Schedule for focus group discussions**

**DEMOGRAPHIC INFORMATION (To be collected for all participants)**

1. Gender a) Male b) Female
2. How old are you?
3. What is your marital status?
4. What is your highest level of education?
5. What is your occupation?

**VIEWS ON MCP AND *O ICHEKE* CAMPAIGN**

1. Please tell me what you know about multiple concurrent partnerships.
2. Why do you think people take part in such partnerships?
3. To what extent to you think these partnerships increase HIV infections in Botswana?
4. What do you know about the *O Icheke* MCP campaign? Probes: What are the objectives of the *O Icheke* MCP campaign? How is the campaign run?
5. How have you participated in the activities of the campaign?

**STRENGTHS OF THE *O ICHEKE* CAMPAIGN**

1. How do you think this campaign helped others?
2. What do you perceive as the major strengths of the campaign? Why do you say so?

**WEAKNESSES OF THE *O ICHEKE* CAMPAIGN**

1. What do you perceive as the major weaknesses of the campaign? Why do you say so?
2. How do you think this could be addressed?

**RECOMMENDATIONS FOR IMPROVEMENT OF THE CAMPAIGN**

1. How do you view the relevancy of the programme?

2. What do you perceive as the current problems of the campaign?
3. What is your role in supporting the *O Icheke* (MCP) campaign?
4. What do you think could improve the delivery of *O Icheke* campaign?
5. What can be done to strengthen the campaign and improve its effectiveness?

***Thank you for your time.***

**Appendix 2: Consent form for focus group participation**

Dear Participant

My name is Kgosiekae Maxwell Matlapeng. I am a student in the Department of Sociology at the University of South Africa. As part of my studies I am conducting a research titled "Perception of the *O Icheke* Multiple Concurrent Partnerships Campaign: Insights from the Selebi Phikwe District Youth Council, Botswana". The study will examine young people's view of the effectiveness of the MCP campaign in Selebi Phikwe in order to contribute to the understanding of the strength and weakness of *O Icheke* campaign. The study will also explore possible gaps between the programme and implementation to see if it is target specific.

I am requesting you to take part in the study. Your participation will involve taking part in a group discussion with other males/females of your age group for one and two hours. If you agree to take part, I will also request your permission to audio-tape the discussion. However, any information you provide will be kept strictly confidential. The information gathered is going to be used only for purposes of writing the dissertation. The research report will not link any data or discussion to research participants.

Please note that your participation is completely voluntary. You may withdraw from the discussion at any time if you so wish, and there will be no negative consequences.

There are no anticipated personal risks attached to participate in this discussion. There will be no compensation provided for participation. However, scheduled follow up may be provided should the need arise to follow on any issue by the research respondents.

**DECLARATION BY PARTICIPANT:**

I have familiarized myself with the contents of this document and I am willing to take part in the study. I also give permission for the discussion to be audio-taped.

Participant's Name:
Participant's Signature:
Date:

Interviewer's Name:
Interviewer's Signature:
Date:

**Appendix 3 Access letter to the organisation**

Box 10775
Selebi Phikwe

Cell: 71299791/3655322
marxgaborone@gmail.com

10/04/2013

Botswana National Youth Council
Gaborone

**Ref: APPLICATION TO CARRY RESEARCH AT YOUR FACILITY IN SELEBI PHIKWE**

This letter serves as a request to conduct Focus group discussions with youth at BNYC in Selebi Phikwe. I am a student in the Department of Sociology at the University of South Africa. As part of my studies I am conducting a research titled "Youth Perception regarding *O Icheke* Multiple Concurrent Partnerships Campaign: Insights from youth, Selebi Phikwe District Youth Council, Botswana". The study will examine youth's views on the effectiveness of the MCP campaign in Selebi Phikwe in order to contribute to the understanding of the strength and weakness of *O Icheke* campaign. The study will also explore possible gaps between the programme and implementation to see if it is target specific. The main objectives of the study are as follows;

1. To explore Selebi-Phikwe youth about their views on MCP
2. To explore youth's views on the key strength of the campaign
3. To explore youth's views of the key weakness of the campaign
4. To make recommendations to further strengthen the campaign and improve its effectiveness.

There are no anticipated personal risks attached to participating in the data collection and collected data is purely for academic purposes. The research will be guided by UNISA research ethics and policy. The research will be based on voluntary participation of research respondents. As a result, the names of the interviews will not be provided in the study. The researcher will therefore keep the details of the interview confidential. Although, anonymity is difficult to maintain as there will be interaction with participants, identity of participants will not be disclosed after data collection.

The study will obtain data through four focus group discussions with groups of young people:

- Males aged 18-24 years
- Females aged 18-24 years
- Males aged 25-35 years
- Females aged 25-35 years

Kind regards

Kgosiekae Matlapeng
Student no: 34050205
Masters of Arts in Social Behavior Studies (HIV)
Sociology department
University of South Africa


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Tel: +267 393 9735, Fax: -1-267318 0898
E-mail: bnyc@bnyc.org.bw
Web: www.bnvc.oro.ow

*AN correspondence should be addressed to the office of "The Executive Director"*

12 April 2013

PO Box 10775
Selebi Phikwe
Botswana

Mr Kgosiekae Matlapeng

**REF: Permission Granted to Yourself: to Conduct Academic Research at the BNYC Youth Centre in Selibe Phikwe**

Dear Sir

This letter serves as a response to your letter dated 10 April 2013 addressed to the Botswana National Youth Council (BNYC). In the said letter, you request perm mission to conduct a focus group study/discussions with the youth at the BNYC Youth Centre in Selibe Phikwe. I understand the planned research is part of your Masters of Arts in Social Behaviour Studies (HIV) with the University of South Africa. You indicate that your research title is "youth Perception regarding O *Icheke* Multiple Concurrent Partnerships Campaign: Insights from youth, Selebi Phikwe District youth Council, Botswana".

I have closely looked at your request. I therefore, grant you the sought permission to carry out the planned research. From my view, the study will play a critical role in the development of the youth in Botswana. Furthermore, it will largely contribute to the dearth of literature on the perceptions of the youth on HIV and AIDS matters.

However, I expect you to work closely and or liaise with our youth Coordinator in Selibe Phikwe, Ms Reetumetse Choene. I further expect you to share with us your research findings as these would help us improve our programs. I also advise you to show this letter to our youth coordinator upon your arrival in Phikwe.

Yours in Youth Development

Boga Thura Manatsha, PhD
Director of Research & Resource Mobilisation

## Summary of Findings

The study has revealed that there are several reasons why people engage in Multiple Concurrent Partnerships (MCP). It was revealed that many people engage in MCP because of financial gains, material possession, sexual variety, alcohol abuse, migration and unemployment. To address the quest for financial gain and material possession women engage in risky partnerships as a strategy to meet their demands. In most cases, money was revealed as the root cause of MCP as it is needed for acquiring material possession and maintaining good living. Material possession was perceived to promote stature and many would like to be seen having such. Another reason which was revealed in the study as to why people engage in MCP is the search for sexual variety. In trying to fulfil their search for sexual variety, sexual partnerships are formed to satisfy the gratification. The study indicated that financial gain is related to most women whereas men benefited from sexual favours which contributed the issue of many men seeking sexual variety.

Migration and unemployment were identified as the other contributory factors to MCP in that many people leave their families in search for greener pastures and the unmet expectations of employment contribute to engagement in risky sexual relationships. Alcohol abuse was also suggested as a contributing factor. It was argued that when women go to bars without money, men who pay for their drinks in turn often benefit from sexual favours.

The participants were of the view that the key strengthens of the *O Icheke* campaign were that it addresses people's knowledge gap about HIV and MCP; it changes people's attitudes towards MCP through vigorous campaigns; it discourages sexual networks among people; and it engages school-going children, as well as out of school youth into discussions on HIV and MCP. The programme also has a financial support from government. This enables it to continue and reach its set objectives and to contribute to the overall mandate of the National AIDS Coordinating Agency (NACA).

Even though there are strengths about the campaign, the study also revealed some factors that hamper its effectiveness. It has been indicated that the campaign focuses only in Selebi Phikwe and fails to reach surrounding settlements. The participants also felt that the campaign has left out some of target population being people with disability (hearing, visual impaired) and language barrier in other instances. In addition, the emerging organisations which come with similar strategies do compete for the same meagre funding from government.

**Key terms**

multiple concurrent partnerships; *O Icheke* campaign; perception; drivers; knowledge; cultural factors; attitudes; young people; socio-economic factors and effectiveness.