Community Dialogues as a Method to Discuss and Reduce Multiple Concurrent Partnerships in Lesotho

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
C-Change	Communication for Change
FGD	Focus group discussion
HIV	Human immunodeficiency virus
HSRC	Human Sciences Research Council
IDI	In-depth interviews
IRB	Institutional Review Board
MCP	Multiple concurrent partnerships
NAC	National AIDS Council
NUL	National University of Lesotho
SBCC	Social and behavior change communication

EXECUTIVE SUMMARY

Background

HIV prevalence among adults ages 15–49 in Lesotho was estimated at 23.2 percent in 2008, the third highest in the world. That year, an estimated 270,000 people were living with HIV in the country, and 60 died each day from AIDS complications. The practice of concurrent sexual partnerships or 'concurrency' (UNAIDS 2009) is considered to be a significant driver of HIV and AIDS in Lesotho. Evidence suggests that multiple partnerships are linked to between 32 percent and 59 percent of all new HIV infections in Lesotho (Khobotlo, Tshehlo, Nkonyana, et al. 2009).

In addition, findings from a 2009 survey of 1,600 men in Lesotho by the Communication for Change (C-Change) project suggested that high levels of HIV and AIDS awareness do not necessarily affect concurrency and other sexual behaviors (C-Change 2009). Among the men surveyed, 45 percent reported having more than one sexual partner at a time, and only 13 percent reported using condoms with their regular partners.

C-Change supported the collaboration of the National AIDS Commission and Lesotho's Ministry of Health and Social Welfare to reduce the prevalence of concurrency through a series of social and behavior change communication (SBCC) initiatives. OneLove, a regional campaign of the Soul City Institute for Health & Development Communication, that addressed concurrency, was implemented in Lesotho from 2009 to 2011, in partnership with Phela Health and Development Communications. C-Change supplemented the OneLove campaign's booklets, flyers, radio PSAs, radio drama, short films, and posters with a radio talk show, billboards, and additional pamphlets and radio PSAs.

C-Change launched a community-based, outreach program in Lesotho in January 2009. It focused on promoting open dialogue about HIV and concurrency, while educating and mobilizing communities to implement further interventions to lower concurrency prevalence. The community dialogue program, *Relationships: Intimacy Without Risk* (C-Change 2010), was adapted, facilitated, and managed by Phela, and the dialogues were co-branded by C-Change and OneLove. Between mid-2009 and September 2010, dialogues were conducted in five districts: Maseru, Leribe, Butha-Buthe, Mafeteng, and Mokhotlong.

Evaluating the Community Dialogues

After obtaining ethical approval through both the Institutional Review Board (IRB) used by C-Change and the Lesotho Ethics Committee, a qualitative evaluation of the community dialogue intervention was conducted in February and March 2011 to gather and analyze participants' perspectives and assessments of the intervention in the five districts.

The primary objective of the study was to assess whether the community dialogues had been effective in improving communication on topics such as concurrency and cross-generational and transactional sex and had a positive effect—or potential effect—in reducing these risk behaviors. The evaluation also gathered suggestions from participants on how future community dialogue interventions could be improved. A secondary research objective was to explore the role of concurrency in contributing to the spread of HIV and to identify other issues seen as problematic in communities, such as poverty and substance abuse.

Methods

A convenience sample of 158 women and 107 men ages 18 and older was drawn from among the 485

women and 204 men who had participated in community dialogues between mid-2009 to September 2010 in the five districts. In-depth interviews (IDIs) were conducted with 54 individuals in this sample (28 females and 26 males), and 29 focus group discussions (FGDs) were conducted with the remaining 211 individuals in the sample. In total, 17 female FGDs and 12 male FGDs were conducted—between four and seven per study district—each with between five and seven participants.

The IDIs and FGDs were conducted by trained interviewers and facilitators from the National University of Lesotho (NUL). All interviews were tape-recorded, transcribed, and translated. Notes were inserted in the transcripts to clarify the context of some statements and statements affected by poor sound quality.

Findings

Seven major issues facing communities in the five districts were identified: substance abuse, HIV and AIDS, poverty and unemployment, physical infrastructure challenges, teenage pregnancy, crime, and community apathy.

Most study participants viewed concurrency as a driver of HIV and identified several reasons:

- the ripple effect of concurrency and its widening sexual networks
- the practice of unprotected sex
- transactional sex as a means of survival
- lack of information on HIV
- lack of knowledge of one's own HIV status and the status and sexual history of others
- the drive for self-gratification
- the perceived norm of concurrency as an acceptable common practice
- ignorance of the HIV risk of concurrency or dismissive attitudes toward this risk

Almost all participants perceived the community dialogues as an overwhelmingly positive contribution to their communities and their relationships with partners. Positive effects reported included:

- improved sexual behavior (reduction in concurrency practices, increased practice of protected sex, and reduction of transactional sex)
- more open communication about sex and other sensitive issues with sexual partners, spouses, children, parents, families, and peers and within communities
- improved relationships with sexual partners, including strengthened emotional ties, trust, and commitment, improved sexual techniques, and altered gender norms relating to women taking the initiative in sexual relationships
- increased information dissemination and knowledge about HIV and AIDS
- improved health-seeking behavior, including increased uptake of HIV testing
- increased acceptance of one's own HIV status
- increased sense of personal contribution and empowerment in the community

A minority of participants expressed critical views about the community dialogues and open discussions of sexual practices and concurrency. Some charged that this was culturally unacceptable and not of interest to some people. A few participants said the community dialogues did not lead to social and behavior change, while others said the dialogues had instigated community and interpersonal conflicts, including by undermining trust in sexual partnerships.

Conclusions

Based on perceptions and testimonies of participants, the study provides anecdotal evidence of the positive effect of the community dialogues. While behavior change is unlikely after such a short intervention and conclusions cannot be drawn about the impact of community dialogues on concurrency, the evaluation suggests that the C-Change/OneLove intervention, as implemented by Phela, is on the right path to contribute to reducing HIV transmission in hyper-epidemic countries.

Community dialogues, in combination with campaigns that promote voluntary medical male circumcision, condom use, alcohol reduction, and other targeted risk-reduction behaviors, should be more rigorously evaluated to determine the efficacy of broader prevention approaches in the response to HIV and AIDS.

Recommendations

Participants contributed suggestions relating to the future use of the community dialogue methodology to address concurrency or other drivers of HIV. The recommendations that follow are based solely on these suggestions:

- Community dialogues should target communities most in need—those with highest HIV prevalence and with high rates of concurrency and poverty—as well as specific institutions and key opinion leaders.
- Community dialogues should be linked more substantively with strategic cultural and community activities, such as dramas related to concurrency, HIV counseling and testing at local rallies, and sponsored competitions for youth.
- Ample financial, human, and material resources should be provided to support community dialogues.
- Additional feedback and consensus should be obtained from target populations about the most appropriate timing, duration, and frequency of community dialogues.
- If dialogue groups are sufficiently large, age-specific sub-groups should be organized during some parts of the dialogue process.

The C-Change community dialogue program ended in Lesotho in 2011. As part of the exit strategy and to promote sustainability, C-Change's worked with Phela to adapt the Community Conversation Toolkit (for HIV Prevention) for Lesotho, which community groups can use to continue the dialogues (see http://c-changeproject.org/resources/community-conversation-toolkit-hiv-prevention). C-Change printed 200 copies for community groups and conducted trainings for selected groups in the five implementing districts. Phela continues to work with existing groups to expand community dialogues on concurrency and HIV risk.

1. BACKGROUND AND KEY OBJECTIVES

1.1 Overview of Concurrency in Lesotho

HIV prevalence among adults ages 15–49 in Lesotho was estimated at 23.2 percent in 2008, the third highest in the world (Khobotle, Tshehlo, Nkonyana, et al. 2009). The number of people living with HIV and AIDS in the country was estimated in 2009 to be about 270,000, with 60 people dying every day from AIDS complications.

The practice of concurrency or concurrent sexual partnerships is considered to be a significant driver of the HIV and AIDS epidemic in Lesotho. Concurrency is defined as overlapping sexual partnerships, where sexual intercourse with one partner occurs between two acts of intercourse with another partner (UNAIDS 2009). Concurrency spreads HIV more effectively than serial relationships because the infected partner is more likely to have sex with more than one individual during the period of greatest infectivity. The Modes of Transmission study undertaken by the Lesotho National AIDS Commission (NAC) concluded that having multiple partnerships is linked to between 32 percent and 59 percent of all new HIV infections (Khobotlo, Tshehlo, Nkonyana et al. 2009).

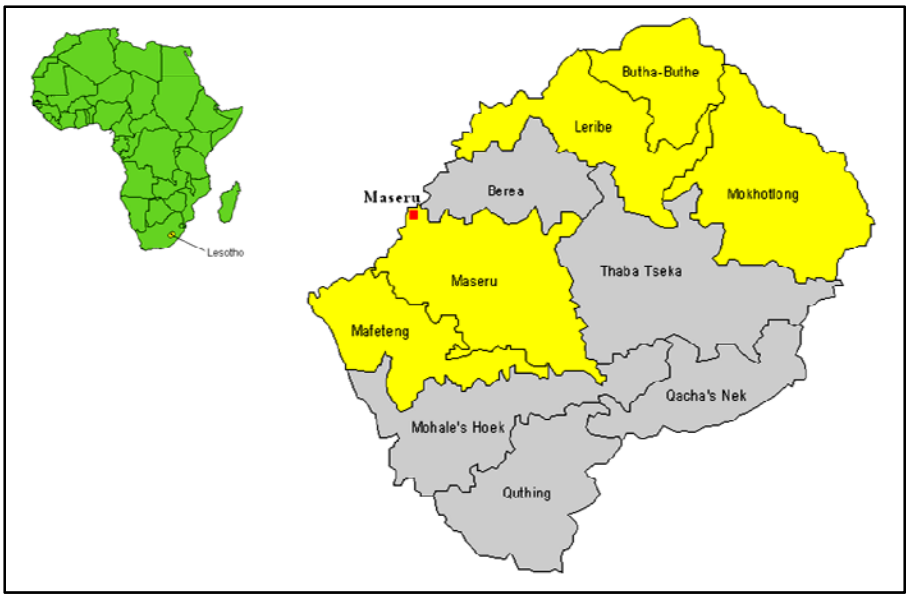
The *National HIV & AIDS Strategic Plan (2006-2011)* (Government of Lesotho 2006) identifies transactional and intergenerational sex as important drivers of the epidemic. These high-risk behaviors are, in turn, associated with underlying socio-economic factors, such as high unemployment, poverty, and food insecurity.

A 2009 survey of 1,600 men in Lesotho undertaken by the Communication for Change (C-Change) project suggests that while Basotho have high levels of HIV and AIDS awareness, this does not necessarily affect sexual behaviors such as concurrency. For example, 45 percent of men in the survey reported having more than one sexual partner. Among these men, 79 percent knew that every new partner increased HIV risk and 92 percent said that they would be concerned about their health if they knew that one of their partners had other partners. Furthermore, only 13 percent of men engaged in concurrency used a condom with regular partners (C-Change 2009).

1.2. Overview of the C-Change Program in Lesotho

C-Change supported the collaboration of the NAC and Lesotho's Ministry of Health and Social Welfare to reduce the prevalence of concurrency through a series of social and behavior change communication (SBCC) initiatives. OneLove, a regional campaign of the Soul City Institute for Health & Development Communication to address concurrency, was implemented in Lesotho from 2009 to 2011, in partnership with Phela Health and Development Communications. C-Change supplemented the OneLove campaign's booklets, flyers, radio PSAs, radio drama, short films and posters with a radio talk show, billboards, and additional pamphlets and radio PSAs.

C-Change launched a community-based intervention in January 2009 called *Relationships: Intimacy Without Risk.* A facilitator's guide, training manual, and other materials were developed that focused on promoting open dialogue about HIV and concurrency, while educating and mobilizing communities to effectively implement further interventions to lower concurrency prevalence (C-Change 2010). The series of community dialogues was adapted, facilitated, and managed by Phela and co-branded by C-Change and OneLove. Between mid-2009 and 2010, community dialogues were conducted in five districts: Maseru, Leribe, Butha-Buthe, Mafeteng, and Mokhotlong.



Local facilitators were trained to lead discussion sessions that stimulate deeper dialogue and discussion around relationship issues and HIV prevention, including how to improve relationships and sexual lives without taking on extra lovers. The sessions, spread over 11 weeks, were designed to help mobilize and engage communities in conversations that encourage and empower them to address their own concerns with the practice of concurrency.

Rather than forming new groups, members of existing community groups (those registered with community councils) were trained to conduct the dialogues within their own groups. This decision was made to promote sustainability, since these existing groups could continue the community dialogues and action around HIV prevention after the C-Change program ended.

The dialogues were conducted before HIV experts had more clearly defined concurrency (UNAIDS 2009). During the time of the dialogue implementation, the practice was generally referred to as multiple concurrent partnerships (MCP), and this term is used in rest of this report .

1.3. Objectives of the Assessment

The qualitative evaluation was conducted in February and March 2011 among men and women who had participated in the community dialogues in the five districts between mid-2009 and September 2010. The primary objective was to learn whether the community dialogues had been effective in improving communication on topics such as MCP , cross-generational and transactional sex, and whether they had a positive effect—or potential effect—in reducing these risk behaviors. The study also sought participant input on how the community dialogue intervention could be improved for future implementation.

A secondary research objective of the evaluation was to explore the role of MCP in spreading HIV in contributing to the HIV epidemic in communities and to determine what other issues were considered to be problematic issues in the community, such as substance abuse, poverty and unemployment, teenage pregnancy, and crime.

2. METHODS

2.1. Study Design, Setting, and Research Team

The qualitative evaluation was conducted in five districts—Maseru, Leribe, Butha-Buthe, Mafeteng, and Mokhotlong. The research team included C-Change staff who provided oversight; staff of the Human Sciences Research Council of South Africa (HSRC) contracted to implement the study by C-Change; and NUL field staff, who collected data and worked directly with HSRC.

2.2. Sampling

Phela, the local organization that implemented the community dialogues, contacted facilitators and participants in dialogue groups to inform them about the evaluation study and encourage their participation. The Lesotho-based evaluation fieldwork team used the list of groups to approach members individually and recruit a purposeful sample of individuals 18 or older. Those agreeing to participate were provided with information on the contact person, location, date, and time of the focus group discussions (FGDs) or in-depth interviews (IDIs). On arrival at these locations, FGD and IDI participants were taken through the voluntary informed consent process.

The intended convenience sample was expected to be 130 women and 130 men ages 18 and older, selected from among 485 women and 204 men who had participated in C-Change community dialogues in the five districts between mid-2009 and September 2010. The actual convenience sample comprised 158 women and 107 men over age 18—a total of 265 individuals.

A total of 50 IDIs were expected to be conducted, 25 with males and 25 with females. Instead, 54 IDIs were conducted, 28 with females and 26 with males who had participated in the community dialogues.

A total of 30 FGDs were expected to be conducted—15 with males and 15 with females—including five for each of three age cohorts: 18–24, 25–29, and 30 and older. At least seven participants were expected in each FGD, yielding a total sample of about 210 participants. Instead, the actual FGD sample was 211 participants in 29 FGDs, 17 with women and 12 with men. The number of FGDs per study district ranged between four and seven, and the number of participants ranged between five and twelve. The actual sample had an under-representation of males and of participants in the age cohort 18–24.

The main reason for this under-representation was that existing groups were selected for the community dialogues, including sewing and savings clubs. (These were chosen for sustainability reasons as part of the exit strategy, as noted above.) Participants in these groups were often of mixed ages and many had an 'over-sampling' of females. In addition, though both genders were invited to participate, a higher proportion of females volunteered for the FGDs and IDIs. Study researchers did not document or calculate a refusal rate.

Except in Butha-Buthe, there were problems establishing FGDs for the age cohorts 18–24 and 25–29. The fieldwork period coincided with unseasonal, heavy rainfall that washed away roads, bridges, and fields, making transport and general access to FGD venues extremely difficult. In addition, the fieldwork occurred during a period when younger participants were away from their villages attending distant educational institutions and when economically active young males were engaged in planting and harvesting.

2.3. Data Collection Methods

Focus group discussions (FGDs) and in-depth interviews (IDIs) were used to collect data. An expert in qualitative research provided training on qualitative data collection and on facilitating and co-facilitating interviews. A total of 20 NUL personnel from different departments and faculties who received this training served as field workers for the FGDs and IDIs in the five study districts. Refreshments such as cold drinks and biscuits were provided as incentives for participants.

Permission was obtained to hold FGDs in venues such schools, clinics, community centers, and recreation halls. Language differences between the five districts were addressed by recruiting facilitators who were proficient in the local language. Each FGD lasted approximately 90 minutes. Two researchers worked together: one conducting the FGD and the other taking notes and operating the tape recorder. IDIs were conducted among individuals who had facilitated the community dialogues in each district. Most lasted about an hour.

2.4. Ethical Considerations

Prior to beginning the study, ethical approval was secured through both the IRB used by C-Change and the Lesotho Ethics Committee. As study participants were recruited, the research team took them individually through the informed consent process, providing an information sheet and an informed consent form in the preferred language that included information on how to contact the research team or lodge a complaint after the IDI or FGD. After signing two copies, each participant gave one copy to the fieldworkers and retained one copy. Participants were permitted to give verbal consent if they did not want to sign form. This action was witnessed by a gatekeeper or another participant, who attested to it by signing the form.

Participants' names were not used during the FGDs and IDIs or in transcriptions of recorded tapes and final reports. All study materials, including lists of participants, were kept in locked filing cabinets in the offices of the local research team and accessed only by team members. Interviewers were trained on the issue of confidentiality and its importance, and participants were briefed on the importance of not repeating what was said in the FGDs.

2.5. Data Management and Analysis

As two researchers read through their notes from the IDIs and FGDs, they clarified statements in audiotapes affected by poor sound quality, paid attention to the cultural meaning of words and phrases used, and worked to arrive at the most accurate interpretations of participant statements. The audiotapes were transcribed and notes inserted to clarify the context of statements. They also developed summaries and tables that helped to identify transcripts.

Study authors received the transcripts by email and went through all of them, analyzing qualitative data and identifying themes and sub-themes.

3. FINDINGS

Findings are organized into five broad categories that address primary and secondary research objectives. Secondary objectives are presented first: an exploration of major issues facing the community and the role of MCP in the local HIV epidemic.

Findings related to primary evaluation objectives follow: participant assessments of the effectiveness of dialogues in improving communication on related sexual topics and the effect (or potential effect) of the dialogues in reducing HIV risk behaviors, including MCP. The final section summarizes participant input on improving or enhancing community dialogues.

3.1 Major Issues Facing the Community

Participants identified seven major issues facing the community: substance abuse, HIV and AIDS, poverty and unemployment, physical infrastructure challenges, teenage pregnancy, crime, and community apathy. These issues are summarized below, with representative quotes from participants.

3.1.1 Identified community problem: Substance abuse

Almost all participants indicated that alcohol and drug use was a major problem in their communities. High, escalating levels of alcohol and drug use were attributed to unemployment, poverty, stress, and peer pressure. Participants were of the view that alcohol and drug abuse contributed to unprotected sex, MCP, reckless behavior, increased HIV risk, alcohol-induced sex, alcohol-linked aggression, specific youth indulgence in alcohol, and, finally, to the use of alcohol and drugs as coping strategies for problems encountered.

3.1.1.1 Alcohol and drug abuse contributes to unprotected sex.

Almost all participants indicated that most young people consume large amounts of alcohol, leading to a loss of self-control and engagement in high-risk activity, including unprotected sex.

> *If people drink too much, they get drunk and finally they would engage in unprotected sex, especially the youth.* Male IDI (age 37), Butha-Buthe

> *If we could do away with drugs and alcohol in the community, there could be a solution, and if we could sit and talk with these young people and show them what will happen if they engage in drugs because when they (*young people) *get drunk they lose control. They are careless about sex; they do not care anymore or think of using a condom.* Female FGD (age 30+), Maseru

3.1.1.2 Alcohol and drug abuse contributes to MCP.

Almost all participants in FGDs and IDIs indicated that alcohol and drug abuse leads to involvement in MCP that would not otherwise have occurred. Participants further mentioned that some people have sex with strangers whom they meet at an alcohol outlet each night.

> *Alcohol drinking leads to concurrent sexual relationships because a man will buy alcohol for me. After buying me alcohol, when we finally go home, maybe we will be going in the same direction and on the way he will overpower me and tell me he wants to have sex with me. He want to engage in sexual relations with you right there and then. Because you are both drunk, you do not remember to use condoms and you just do it.* Female FGD (age 30+), Mokhotlong

3.1.1.3 Alcohol and drug abuse contributes to HIV transmission.

Almost all participants felt that alcohol and drug abuse placed individuals at greater risk of HIV. It was reported that older men often made young women drunk in "shebeens" (alcohol outlets) and thereafter engaged in sex with them. "One-night" sexual acts were more prevalent during the holiday season, when people generally consume more alcohol.

> *Madam, this transmission of the disease is mainly caused by drunkenness.* Female FGD (age 30+), Mokhotlong

> *It's drunkenness which causes HIV to increase. You see people who get reckless while drunk.* Male IDI (age 48), Maseru

3.1.1.4 Alcohol and drug abuse contributes to socially unacceptable behavior.

Overall, most participants were of the view that alcohol use promotes socially unacceptable behavior and shameful deeds, such as stealing, fighting, killing, forceful sexual intercourse, and use of dangerous drugs.

> *Simply because of alcohol; these home-brewed beers are dangerous! When one is drunk he may decide to kill another one, for no apparent reason at all! At times over a minor issue which could have been cleared through a brief deliberation!* Male FGD (age unknown), Mafeteng

> *When a person is drunk, he or she tends to smoke dangerous drugs like dagga. This is the time when all the useless things come to his mind and the drugs distorts his or her mind. This is when this drugged person ends up raping or going to an extra-marital affair, and things like those. In the village, the biggest problems are liquor and unemployment or idling without anything to do.* Male IDI (age 33), Mafeteng

3.1.2 Identified community problem: HIV and AIDS

Most participants identified HIV and AIDS as the major disease affecting the community. They identified several factors they felt contributed to high HIV and AIDS prevalence: engagement in unprotected sex; a large number of AIDS orphans and vulnerable children; and HIV and AIDS stigma. Other factors mentioned by some participants included the intentional spread of HIV by infected individuals and the refusal to test for HIV.

3.1.2.1 Unprotected sex is a common practice, since many people do not like to use condoms.

Most participants indicated that the practice of engaging in sex without condoms contributes to an increase in HIV risk. They also reported several reasons people generally did not like to use condoms, including the belief that condoms lead to diseases. Unprotected sexual relations with one's wife was viewed as a right. A few reported that HIV-positive persons did not use condoms because they had the intention of infecting others.

> *One would say that they have a wife therefore they will not have sexual intercourse with paper. They want flesh on flesh.* Female IDI (age 45), Leribe

> *In the families, the men are the ones who bring HIV because they refuse to use condoms.* Female FGD (age 30+), Leribe –Pitseng

> *Oh they used to say that these plastics make them sick; they cause kidney diseases, they*

also have worms, they mentioned quite a number of things about them. Female IDI (age 49), Leribe–Pitseng

Those condoms— there is a time they would tell you "No they are smelly! Now you have brought the smelly ones today." I give them out. You will hear them saying they are smelly those that I have brought. Female FGD (age 30+), Butha-Buthe

Both sides, because sometimes there are girls that we talk to, and they'd say that their partners say they feel nothing when they use a condom during sex or that the condoms suffocate them…. Girls say things like the condom oil makes them sick or when they use it. Male IDI (age 25–29), Butha-Buthe

3.1.2.2 Orphans and vulnerable children engage in risky behavior.

Most participants stated that a high level of mortality from AIDS in their villages meant that many parents had died and left their children with no means of survival or proper caretakers. This negatively affected the upbringing of the children and their subsequent performance at school. These children were also perceived to indulge in risky, unacceptable behavior.

I will talk about the problems I face with the children I live with. They are orphans. They are not controllable. They are attracted by men offering them gifts. Sometimes, I don't even get to see these gifts. Female FGD (age 23), Mokhotlong

3.1.2.3 HIV and AIDS stigma is a problem.

Stigma and self-stigma were mentioned by most of the participants as a problem contributing to non-disclosure of one's HIV status.

After testing, if you disclose your status, they start pointing fingers, saying so many things. Showing some form of discrimination, like avoiding to sit next to you or to eat with you, even in settings like funerals. Female FGD (age unknown), Maseru

3.1.2.4 Intentional transmission of HIV is a problem.

Some participants were of the opinion that a small proportion of HIV transmission occurred due to malicious intent of infected individuals. They intentionally planned to infect others, sometimes by raping them. They were bitter and sought revenge because they did not know who infected them or they did not want to die alone.

These rapes happen because if one knows that he has the infection, he chooses to take it to other people, because what is commonly said is that we should all have it. They intentionally rape others to infect them. Female FGD (age unknown), Maseru

These are types that will go around, telling themselves that "I will not die alone, because I do not know who infected me; I want to die when I also have spread it." This is why you find a long chain of contacts. The concurrent sexual partnership spreads the infection. Female IDI (age 55), Mafeteng

3.1.2.5 Many people avoid being tested for HIV.

Some participants indicated that lack of testing was a problem in their communities. Some people were driven by the fear that if they tested positive they would view this as the end of their lives and feel stressed and hopeless. Some participants also mentioned that avoidance of testing was driven by a

negative attitude. The general view was that men had a negative attitude towards testing and believed that women were the ones who needed to be tested.

> *I will not test. I will not go there because when I hear them saying that I have HIV/AIDS I'm going to stress out and end up dying immediately.* Female FGD (age 30+), Butha-Buthe

> *The problem with men is to know his status; men are the ones who face a main challenge when it comes to HIV and they do not want to believe that they have it. They want to believe that a woman might bring it in the family from elsewhere.*
> Female FGD (age 30+), Butha-Buthe

3.1.3 Identified community problem: Poverty and unemployment

The issues of poverty and unemployment were raised as a serious concern by most participants. They highlighted the link between poverty and MCP and the disruptive effect of poverty on schooling. They also referred to pervasive food insecurity and the apathy of community members in taking action to change these conditions directly.

> *If you could help us with jobs, we could maybe grouped and be given means of farming; be given seedlings and see what we could do. I may not be able to express myself clearly, but all I am saying is that we are poor and in need of money.* Female FGD (age 30+), Mafeteng

> *Other disadvantaged children do not go to school because of the unavailability of the fees.*
> Female IDI (age 20), Butha-Buthe

3.1.4 Identified community problem: Physical infrastructure challenges

Most participants were very vocal about the absence or poor condition of physical infrastructure and services in the five study districts, including health, transport, water, electricity, and recreational facilities. The lack of nearby clinic services was highlighted, along with poor road conditions and transport problems that affected access and utilization of HIV testing and other essential services. Another problem was the unavailability of safe drinking water and the irregular water supply in the villages. Participants indicated that they were given water for short periods of time and told that this was because of a lack of money. They could not grow plants, as they did not have wells or donkeys to fetch distant water. Electricity was not available in some communities, and external communication was difficult. A lack of cinemas, libraries, tennis courts, and sports and recreational centers for the youth was also cited.

> *I think a big problem in my village is the lack of clinics. The ones we do have are far away and people who need immediate medical attention cannot find help.* Male FGD (age 25–29), Butha-Buthe

> *Now sometimes you find that you do not have transport to go to Morija. You have no chance to go to Matukeng to test.* Female FGD (age unknown), Maseru

> *Yes ma'am, we have a problem. We have taps but they have no water.* Female FGD (age 30+), Maseru

> *The other thing is that there is no electricity in my community; there is no electricity and getting telephone signal is equally problematic!* Male FGD (age unknown), Mafeteng

3.1.5 Identified community problem: Teenage pregnancy

Some participants were vocal about the effect of teenage pregnancy on their community.

> *The most prevailing problem that we encounter is teenage pregnancy. Our young girls and boys are really getting into this problem quite a lot. They do not listen to their parents and therefore this is getting out of hand. We have grandchildren who do not have their fathers, born out of the wedlock.* Female FGD (age 23), Mokhotlong

3.1.6 Identified community problem: Crime

Most participants raised concerns about crime in their communities. Rape was the main issue; general theft and child abuse were also mentioned. Participants said that most young women were victims of rape, and some believed that this was due to the way they dress. Herd boys were identified as being notorious for rape. Participants also indicated that married women were sometimes forced by their husbands to have sex. Most participants also reported that theft was rampant due to widespread unemployment in their villages. Only a few mentioned child abuse as a problem.

> *Youth are the ones who are mostly raped, given the way they dress up.* Female FGD (age unknown), Maseru

> *When you and your husband have had a fight, you do not become open. At that time he will demand sex. To a woman that appears as rape.* Female IDI (age 45), Leribe

> *My contribution will be based on herd boys who are notorious for rape, which they do without knowing their status and end up transmitting the virus unknowingly.* Female FGD (age 25–29), Butha-Buthe

> *They break people's houses, they steal; one can say in general our youth end up being loose mannered as a result of lack of jobs. They have nothing to keep them busy the whole day and their idle becomes the devil's factor.* Female IDI (age 54), Mafeteng

> *Yes, the people who are confronted with them mostly are the children due to abuse. The parents abuse children.* Female IDI (age 21), Butha-Buthe

3.1.7 Identified community problem: Community apathy toward HIV and AIDS

Some participants expressed concern about a lack of interest in community issues, especially HIV and AIDS.

> *In my village, when we invite them (young people) to public gatherings as support group members, they refuse to come, saying we are going to talk about this HIV and AIDS thing, and they don't want to hear about it anymore. So, we end up talking to these adults who want to talk to us. These young people are really refusing.* Female FGD (age 23), Mokhotlong

> *The problem that we have is that the people in our villages refuse to attend rallies. They never participate in gatherings where they would get the right information.* Female FGD (age 30+), Mafeteng

3.2 The Role of MCP in the Spread of HIV in the Community

Most participants viewed MCP as a driver of the HIV epidemic in their communities. They identified several reasons why, including the ripple effect of MCP; unprotected sex; transactional sex as a means of

survival; lack of information about HIV; lack of knowledge of one's own HIV status and the status and sexual history of others; self-gratification; MCP as an acceptable common practice; and generally apathetic attitudes.

3.2.1 MCP as the driver of the epidemic

Almost all participants referenced MCP as an efficient driver of the HIV epidemic.

> *In my community, MCP has a major role. How can I put it? Suppose a man has a concubine in town, while he lives in the village and has a wife. The concubine may also have a husband or other sexual partners. This scenario can spread HIV/AIDS, if one of the partners is infected and this man can easily pass the infection to his wife….* Female IDI (age 24), Butha-Buthe

> *It spreads the disease in a sense that when one gets into sexual relationships with many people; people are different and have different kinds of diseases.* Male IDI (age 25–29), Butha-Buthe

> *Yes sir, really that is so. I am saying sex networks with many partners really causes this transmission, and in the absence of a way to have people practice safer sex. It really causes the disease of HIV and AIDS.* Male FGD (age 30+), Mokhotlong

3.2.1.1 MCP has a ripple effect.

The widening network of MCP was noted by most participants. MCP was said to be highly prevalent and responsible for undermining the integrity of family and couple units within the community. This ripple was perceived as an ever-widening ring of influence marked by sexually transmitted infection.

> *It will spread widely, because if I am one and engaging with these multiple partners, I will end up giving it to a hundred people, as will be engaging in one chain. I deceive myself if I think I am the only partner in a relationship; he/she has the other partner. If he happens to find ten of us in a day maybe, then we will be too many.* Female FGD (age 30+), Mafeteng

> *I agree with what he says— that having multiple partners is dangerous. For example, if I have the virus and I pass it on to my lover who also has another lover, they will pass it on to that other person. And that person might pass it on and on it goes. Therefore it is dangerous to do this.* Male FGD (age 25–29), Butha-Buthe

3.2.1.2 Unprotected sex often occurs within MCP networks.

Most participants reported that unprotected sex within MCP networks was highly prevalent.

> *I was saying that it (MCP) does have a role in that, as one of the ways of transmitting HIV is unprotected sex, when one has unprotected sex with many people it may happen that he/she may pass it to those people or they may pass it onto him/her!* Male FGD (age unknown), Mafeteng

> *Myself, I see it causing the spread of the infection, this multiple concurrent partners, because if one person has the infection, then she or he has unprotected sex with many people, she or he would have infected many people alone at the same time.* Female FGD (age 30+), Leribe–Pitseng

3.2.1.3 Transactional sex and MCP are survival mechanisms.

Transactional sex was intertwined with the issue of intergenerational sex, clearly reflecting poor socio-economic circumstances that increase the vulnerability of people engaged in MCP.

> *Certain circumstances in the house may drive me to have MCP, which would help me raise my kids, without realizing that I may be getting myself into a problem that would affect my children in future, or if my husband had already infected me, I should worsen it.* Female IDI (age 53), Maseru

> *I have one example from my village. There are some men who work in the mines, and I've noticed that they are with different kinds of women all the time, this shows that rich men also help the spread HIV.* Male FGD (age 25–29), Butha-Buthe

> *Not that they need sex, they say that what they really need is for the hunger, now they try to get (support), this one and that one.* Male FGD (age 30+), Mokhotlong

3.2.1.4 There is insufficient awareness of and information about HIV and MCP.

Most participants mentioned the general lack of information on HIV as a significant factor in promoting MCP.

> *We refuse to attend the training sessions and learn about these things (MCP). Now this is the thing that encourages the spread of these many sicknesses. It is because we are afraid to come to school to be taught these things.* Female FGD (age unknown), Maseru

> *Because it seems as though HIV is spreading because people are clueless. They are not aware that in this day and age they have to practice one love.* Female IDI (age 45), Leribe

> *That one has knowledge that he has AIDS, but has no knowledge of how to protect himself so that he does not spread it to other people. He just feels that he is a man because he has many concubines.* Male FGD (age 18–24), Butha-Buthe

3.2.1.5 The MCP risk is increased by a lack of knowledge of a partner's HIV status.

Widespread ignorance of HIV status was recognized by most participants as increasing the risk of HIV transmission in MCP networks, along with not knowing the sexual history of individuals in the network.

> *People engage in sex with multiple people whom they do not know their status.* Female FGD (age 25–29), Butha-Buthe

> *I think it is sleeping with many people not knowing their HIV status, and one day being with one person and the following day moving on to the next person. I do not even know which one will give me the infection.* Male FGD (age 25–29), Butha-Buthe

> *This issue of one having sex with multiple partners enhances the risk of contracting HIV because I would not know what the partner had been doing and what he would be bringing to me, and all those sicknesses would be transmitted to only me.* Female IDI (age 49), Leribe–Pitseng

3.2.1.6 People engaged in MCP focus on self gratification, rather than risk.

Most participants noted that people engaging in MCP were mostly consumed by a focus on their own gratification, rather than considering the potential risk of infection to themselves and their partners.

As people we have multiple love affairs; we refuse to engage in one love; we seem not to be satisfied. Like I would be having a love affair with a particular person, not knowing that he also has someone on the other hand, yet I would be trying so much to satisfy him. Female FGD (age unknown), Maseru

3.2.1.7 MCP is an acceptable, common practice.
Some participants referred to the high prevailing rate of MCP as evidence of the "acceptance" of the practice by the community.

The sex issue in our village is due to this issue of extra-marital affairs. It is a common thing, and it is the one that causes HIV to affect many people. Because it could happen that I have sex with someone, whom I do not know of his/her background, and that is where it increases. Female FGD (age 25–29), Butha-Buthe

3.2.1.8 MCP ignorance or apathy is a problem.
Some participants expressed concern about unresponsiveness to information on MCP risks.

They do not listen when we advise them that having sex with many partners leads to diseases. They do not understand. We tell them to stop such practices, but they continue as if nothing is happening. Female IDI (age 63), Maseru

3.3 Views on Participation in the Community Dialogues and Their Effect (or Potential Effect)
Most participants viewed their involvement in the community dialogues positively, along with their. effect or potential effect on their communities.

3.3.1 Positive views and effects of community dialogues on the community
Almost all participants perceived the community dialogues as making an overwhelming positive contribution to their communities. One effect reported was improved sexual behavior, or the perceived potential of individuals to improve their sexual behaviors, including by engaging in safe sex and reducing MCP practices, transactional sex, and alcohol use.

Testimony that community members were no longer engaging in MCP is cautiously reported here. The intervention lasted about a year, and generally more time is needed to produce such a change. This is especially true in Lesotho, where MCP has been shown to be a long-time, common practice.

Other reported positive contributions of the community dialogues included: 1) increased positive attitude towards discussion of MCP with others; 2) more open communication about sex and other sensitive issues with spouses, children, parents, families, peers, and within communities; 3) increased information dissemination and knowledge about HIV and AIDS prevention; 4) improved health-seeking behavior, including increased HIV testing; 5) increased acceptance of one's HIV-positive status; 6) increased sense of personal contribution and empowerment in the community; and 7) reduced spread of HIV and a reduction in sexual crimes, sickness, and death.

3.3.1.1 Community dialogues contributed to improved sexual behavior.
Most participants reported that the community dialogues had the effect of bringing about improved sexual behavior. These improvements were described in various ways, including reduced MCP practices, increased safe sex, and reduced transactional sex and alcohol abuse.

3.3.1.1.1 Positive effect of community dialogues: Reduction in MCP practices among men and women

Almost all participants agreed that the dialogues were capable of empowering them to discuss and even reduce MCP practices. They underscored the value of community dialogues in reducing MCP practices in their communities.

> *That I should be a one-woman man, and that I should protect myself by using a condom. I saw myself managing and succeeding since then, and I saw myself changing.* Male IDI (age 48), Maseru

> *Yes, there are many people who used to have extramarital relationships and sleep around a lot. But after the discussions they changed their ways and stopped doing that.* Male FGD (age 25–29), Butha-Buthe

> *I am saying that I used to have two partners, one in Lesotho, the other in Gauteng. Currently, I no longer go to South Africa. I have told myself that I will remain with the one in Lesotho. I am now settled; I no longer move about.* Male FGD (age 18–24), Butha-Buthe

> *I am one of those who had more than one partner, but after I attended the workshop I understood that I've got to have just one partner and be faithful.* Female FGD (age 30+), Butha-Buthe

> *We used to like engaging in multiple sexual activities, everywhere with many people, but now we like practicing what is right, like we were told or shown, that we should have one partner. And we are spreading these message that each person should stick to one partner.* Female FGD (age 30+), Mafeteng

> *They have actually reduced them, the community dialogues have reduced these embarrassing sexual encounters;; they have indeed reduced that chaos.* Female IDI (age 52), Mokhotlong

3.3.1.1.2. Positive effect of community dialogues: Increased use of condoms

Most participants indicated that they used to be ignorant of the need for condoms. However, after attending community dialogues, they reported that they were using them and were also encouraging others to do the same.

> *It has really changed my life, because I was a really naughty person, but since we learned about protective sex I found it very important to always protect myself to avoid many diseases, and my partner too is satisfied.* Female FGD (age 30+), Maseru

> *When I take a box of condoms home, by the time I get there they would be finished.* Female IDI (age 49), Leribe–Pitseng

> *Yes, sir, I was not using condoms, but once I came to this place, I soon realized that I have to protect myself. Besides when I go back home I may be able to advise my friends to protect themselves too.* Male FGD (age unknown), Mafeteng

> *Like at my village, we often see people like herdboys. They sometime come to us to ask us to go to the clinics to get them condoms. So yes, they seem to have understood.* Female FGD (age 25–29), Butha-Buthe

3.3.1.1.3 Positive effect of community dialogues: Reduction in transactional sex and alcohol abuse
Most participants indicated that community dialogues contributed to a reduction in transactional sex and alcohol abuse.

> *They affect us because they have stopped concurrent sexual practices with many people. People (youth) no longer accept gifts in exchange for sex; they no longer drink alcohol, which would get them into multiple concurrent sex. Female FGD (age 25–29), Mokhotlong*

3.3.1.2 Community dialogues contributed to open communication about sex and other sensitive issues.
Most participants said the dialogues enabled them to open up on HIV issues, which were traditionally perceived as secretive. They reported more open discussions on these issues in the community at large and with parents, children, spouses, families, and peers. The dialogues broke the cultural barriers in communication at all levels. They contributed to open communication about sex and other sensitive issues, and this resulted in improved relationships with sexual partners and a better informed community on HIV and MCP issues. Almost all participants indicated that they were now more receptive to the community dialogue messages.

3.3.1.2.1 Positive effect of community dialogues: More open communication with spouses
Most participants expressed the view that the dialogues encouraged them to talk more openly about sexual matters with their partners. This view was expressed by both genders, across FGDs and IDIs and age groups, and in all districts.

> *…At home there was never a time I enjoyed sleeping with my husband because he sometimes would make me angry during the day. But since I met with the ladies at the group they told me that before sex there must be communication between me and my husband because sometimes he would complain that I am always facing up (laughter). The ladies told me what to do and how to touch my husband. This group has really brought love in my family. Thank you.* Female FGD(age 40), Butha-Buthe

> *Yes, to tell the husband that I need you, then he appreciates and understands. We become free with each other. Likewise, my husband tells me when he needs me, which stops him from going outside.* Female IDI (age 42), Leribe

> *It has helped, because before a husband would never tell if he fails to be sexual active with the partner or wife, but it has now helped because we are now able to discuss. If he is tired, he just open up and tell his wife.* Female IDI (age 42), Leribe

> *The dialogue promotes openness and transparency and assists people to know their status.* Male IDI (age 19), Butha-Buthe

3.***3.1.2.2 Positive effect of community dialogues: More open communication with older adults and between children and parents***
The dialogues were seen by most participants as a culturally acceptable way to encourage discussion on sensitive topics between children and parents and with older adults. While most participants noted that young and old people are uneasy when discussions on sex are broached, they acknowledged that dialogue discussions were generally respectful.

> *We were not free to talk to our children about sex. The training has helped us to talk to them*

without any fear. Female IDI (age 63), Maseru

The dialogues have brought changes. Families today are able to discuss issues with their children, especially those entering the teenage stage (12 years, once they show maturely, e.g. enlargement of breast). Previously these issues were only discussed at the health centers, and we were not free to discuss them. Female IDI (age 55), Mafeteng

These discussions are very good because when we look at our families and talk to our matured children, they understand. You'll find that they would even go for testing without making me aware; they will just let me know afterwards, telling me that they did go to be tested and how their status is. So, in most families this is a good thing. Yes, ma'am! Female FGD (age 23), Mokhotlong

Even to my parents I explain everything about sex. In the past it was embarrassing. But now I know that to keep it a secret will lead to our death. We shall all die. We have to talk. Some people will listen. Others will not. Male IDI (age 24), Mafeteng

3.3.1.2.3 Positive effect of community dialogues: More open communication between peers and within the community

Some participants said the community dialogues contributed to more open communication about issues previously seen as taboo, both with peers and within the community at large.

From my point of view, the discussions have had a positive impact. They have encouraged people to speak more freely about topics a typical Mosotho would not have engaged in before. Male IDI (age 25–29), Butha-Buthe

... It was still a little embarrassing to stand in front of the people I was trained with… It wasn't an easy thing to talk to them. I was afraid because it was something I wasn't used to from the beginning… We continued with these issues and I began to understand more… I ended up talking it easy. Male IDI (age 25–29), Butha-Buthe

3.3.1.3 Community dialogues contribute d to information dissemination and increased knowledge about HIV and MCP.

Most participants indicated that they gained more insight on HIV/AIDS and MCP issues, including HIV transmission and protection. These participants considered the community dialogues to be an important vehicle for sharing sensitive information. They expressed a need and passion to share the information they had acquired with members of their own communities and with other communities.

3.3.1.3.1 Positive effect of community dialogues: Knowledge empowers individuals to fight HIV and AIDS and make their own decisions

Some participants felt that the dialogues had empowered them to take a stand in fighting HIV and AIDS and making their own decisions.

You are afraid to talk about it. I started to open my eyes wide after the … training program—very, very wide. During this short time I added some knowledge to what I had already seen although I did not understand very well. I then started to cover up for the wasted time of not listening to the HIV and AIDS issues. Male IDI (age 24), Mafeteng

They are very much important. I personally found them important. I did not know anything,

yet I thought I knew and that I was doing what's right, but talking to other people helped me realize the good and the bad that I had been doing, and the bad that I never knew was bad. Female IDI (age 42), Leribe

It has taught me that I have to have a strong backbone—to be able to make my own decisions and stick to them. If you are not a strong person, every person can easily influence you and lead you astray. Male IDI (age 25–29), Butha-Buthe

The influence from friends does come along, and even in our case, as adult people, we do experience such challenges, whereby a rich man would be disregarding the use of condoms, which becomes a challenge to a woman who is so much after money, and ends up being tempted…. But if you are resistant on a basis of the information you acquired you can resist friends and take a stand, if you are strong enough. Female IDI (age 42), Leribe

3.3.1.3.2 Positive effect of community dialogues: Knowledge obtained and disseminated on health risks of MCP, HIV transmission and prevention, and HIV self-care

Some participants felt that as a result of the dialogues they obtained knowledge on health risks created by MCP and on routes of HIV transmission (i.e., infection via used syringes, poor infection control, and mother-to-child transmission). They obtained knowledge on preventing HIV transmission (i.e., from mother to child and through condom use) and better HIV self-care. Some participants also reported that they now understood some commonly held myths in their communities related to condom use and that they had disseminated the knowledge and information in their communities.

The discussion has taught us a lot. We have learned that having multiple partners brings diseases, but having one partner and using protection all the time keeps you free from diseases. Even if you and your partner have other partners, you will not infect each other. Male FGD (age 25–29), Butha-Buthe

Some of our brothers and sisters have realized that this long chain of secret lovers will result in high rate of infection. Female IDI (age 41), Mafeteng

I learned also that using the same needle to inject me, and then the gentleman over there, while one of us has the virus might lead to one of us passing the virus onto the other person. Male FGD (age 25–29), Butha-Buthe

The dialogues have been a success because now people understand that you do not only get infected through sexual activity. They know that handling other people's wounds without using protection can be dangerous. Female FGD (age 30+), Mokhotlong

We also learned that it is not transferred by sharing of one toothbrush by many people but they should know about all possible ways in which HIV can be transmitted because other families are disadvantaged; people still share toothbrushes. Male IDI (age 58), Leribe

When a mother is expectant even if the child can be born HIV positive, it is given medication to stop the infection. Furthermore we were also taught about infection during delivery of a child. Male IDI (age 58), Leribe

This is to say, we really see a big change, it is there in the village. This means people have

knowledge that if maybe a mother gets an accident, I would have to go ask for gloves so that I can help her. Female IDI (age 28), Mokhotlong

People know about the use of condoms, and they do not believe in the myths about condoms: that they cause kidney disease and that the lubricant used in condoms transmits HIV. Male IDI (age 58), Leribe

*It was said that the lubricant remains in us and breeds worms, yet it was a lie, what we have now learned about the disease. F*emale IDI (age 42), Leribe

At one time I talked about these things with my friends when they visited me. I brought the booklets I had and we had a discussion about the topics. There were some disagreements but I let them take the booklets and read for themselves. Male FGD (age 25–29), Butha-Buthe

It is a matter of not being selfish, I have to spread the message to others by various means, such as providing people with books we got from Phela, since the information they contain cannot easily get lost. Male IDI (age 27), Mafeteng

3.3.1.4 Community dialogues contributed to improved health-seeking behavior.
Most participants were able to improve their health-seeking behavior based on the information taught in the dialogues. They reported that they visited health facilities, especially if they were engaged in MCP.

Most people know about their multiple concurrent sexual practices and going to the health centre when they are sick. Female FGD (age 25–29), Mokhotlong

I see a great impact in my community because now, once a person gets sick, she or he goes to the health centre to check if it's just a minor cold or if she or he has been infected. It's only a few who are still not convinced. Female FGD (age 25–29), Mokhotlong

3.3.1.5 Community dialogues helped to overcome fear of HIV testing and increase uptake.
As a result of participating in the community dialogues, most participants indicated that they overcame their fear of HIV testing. They reported that they and others in the community had been tested.

I thank the dialogues because in my house we all know our status, so I am really thankful. Female FGD (age 30+), Butha-Buthe

I got very relieved because we were afraid to get tested, but now I go to the health centre with my head high because I am not afraid of HIV anymore. Female FGD (age 30+), Butha-Buthe

…I can also say that I observe great change because many people go to the testing stations. I think going to the testing station is an important issue in that when one knows his status will be in a position to take care of himself. Male FGD (age 18–24), Butha-Buthe

My partner never liked testing; even my child was not tested. After getting this training, I managed to convince him to go for testing. He went; we now both know our status, unlike before, when I was the only one knowing. Female FGD (age unknown), Maseru

This training has helped me lay down the fear that I used to have during counseling and testing which I was already doing with New Start. So Phela helped me, because I know that if I do HIV test after three months I can survive because the body is still strong. Male IDI (age 58), Leribe

After that I was bold enough to go and test in order to check whether the current disease has affected me or not. I was pleased to an extent that I even invited nine of friends to go to the hospitals to check our status. Male FGD (age 18–24), Butha-Buthe

But after the workshop I felt compelled to go and test and even encouraged others to test. Male FGD (age 25–29), Butha-Buthe

3.3.1.6 Community dialogues encouraged acceptance of one's own HIV status.

Some HIV-positive participants indicated that the community dialogues helped them to accept their status.

….I have observed that it has brought great change. I also observed that even those people who after testing discover that they have it, they seem to understand and accept their status, and do take their medication according to the prescription.
Male FGD (age 18–24), Butha-Buthe

The response was quite good because most of the people were those that did not understand that HIV is there and in the blood, so after the visits (to the dialogue groups) they understand and accepted what they are. Female FGD (age 30+), Butha-Buthe

3.3.1.7 Community dialogues contributed to attitude and cultural change relating to MCP.

Some participants felt that community dialogues contributed to an attitude change toward MCP. There was a reported attitude-shift among some men involved in the community dialogues, and some of them became interested in disseminating the information to other men.

Men were stubborn, but here we managed to win over a few men, and they are now interested to talk to other men. So sometimes you find that some men are shy to come here, and these men who are part of us would say that's how we are build up as men. Male IDI (age unknown), Leribe–Pitseng

There is another thing about culture and sex that used to happen a long time ago. When a girl was married, another man other than her husband would come to her to sleep with her to make sure she was still a virgin. This does not happen anymore because of the dialogues. Female FGD (age 30+), Mokhotlong

*I liked everything because we were made aware of having too many partners whereby in Sesotho it is commonly said that '*monna ke mokopu oa naba' *which means that it is right for a man to have many partners, not realizing that it's dangerous.* Male IDI (age 58), Leribe

But we have been taught that to have more than one woman, even if it is culture, it is not acceptable nowadays. One must have one sexual partner. Male IDI (age unknown), Maseru.

They are not going to divide our beliefs and cultures. They are just going to teach us about today's life and to help us to take care of our life so that we are not affected by the current

pandemic. Male IDI (age unknown), Maseru

3.3.1.8 Community dialogues contributed to perceived reduction in the spread of HIV and reduced sickness and mortality.

As a result of the dialogues, some participants perceived that there was a reduction in the rate of HIV infection in their communities and less AIDS-related sickness and mortality.

> *It looks like HIV/AIDS problem in my community is low since we had C-Change communication.* Male IDI (age unknown), Mafeteng

> *Truly, actually I can see that HIV/AIDS has gone down, and that people benefited from such talks, and you can see benefits maybe from how each family behave. This problem or its HIV/AIDS consequences is no more a "dilemma," as compared to the previous time.* Male IDI (age unknown), Mafeteng

> *But now the rate has decreased, to some extent such still exists as a result of humanity, but not as before, and the sickness as well seems to be decreasing.* Female FGD (age 30+), Mokhotlong

> *At least in two months we at least bury one or two person when before the number would be four or five or up to ten people we buried.* Female IDI (age 65), Maseru

3.3.1.9 Community dialogues contributed to reduction in sexual crimes.

Some participants held the view that the incidence of rape had decreased.

> *I have noticed that the discussions have also alleviated rapes. It's in rare case now to hear about rapes; I hardly ever hear where a person was said to have been forced to have sex with anyone. Like I said, they have decreased a lot.* Male IDI (age 48), Maseru

3.3.1.10 Community dialogues resulted in a sense of personal contribution and the ability to challenge partners about behaviors.

A few participants expressed a fulfilling sense of having contributed in someone else's life or to their community's after participating in the dialogues and sharing information gained. A few also felt that the acquired knowledge empowered them to challenge their partners to change their behaviors.

> *But involvement in the dialogue has benefitted me in that I have had a contribution in other people's lives.* Female IDI (age 43), Leribe

> *I felt very lucky to have participated. Above it all, I felt privileged to have imparted the information to the people of my village, so that they could also have information, even though they perceived it otherwise.* Female FGD (age 30+), Mafeteng

> *I felt very good to have been able to carry the message forward, the message that I got from Phela, especially to these youngsters, whom we expect their lives to be prolonged. I really felt happy to give them light, still bearing in mind that not all of them will accept, but still will patiently teach them.* Female FGD (age 30+), Mafeteng

> *Now you can challenge the husband and put him to a test, and this changes our lives. Female FGD* (age 30+), Butha-Buthe

3.3.2 Critical views of the community dialogues and their effects on the community

While the vast majority of participants in community dialogues had positive views about community dialogue activities, various critical views were expressed about the dialogues and the discussions of MCP: they were overall culturally unacceptable; they were a catalyst for community conflict; they did not generate interest among some community members; and they were unable to change behavior.

3.3.2.1 Community dialogues were culturally unacceptable.

Some participants felt the community dialogues were culturally unacceptable and taboo. Participants were said to have used inappropriate language and been disrespectful. A few said the dialogues were age-inappropriate and unacceptable to local religious institutions.

3.3.2.1.1 Critical view of community dialogues: Cultural taboo

Some participants emphasized that community dialogue messages were culturally unacceptable because they opposed the traditional belief system on how men should be perceived.

> *In our culture they are not acceptable because, if you look closely this multiple concurrent partnership* [bonyatsi]*, it is like it's a very big thing. If you do not have multiple partners, it's like you are not a man. The practice of multiple concurrent partnerships is a real big issue; that is why these dialogues are not acceptable. We have been living this way to the extent that sometimes it is even accepted in the family. These partners are seen as family friends. They laugh.* Female FGD (age 30+), Leribe–Pitseng.

> *It affected our culture in this way. In the past we were too shy to talk about this thing. And now we talk. In the past when a man talked in his home, he used to do as he pleased. When she says: "My husband you are turning yourself into a husband of every woman in the village? There used be a Sesotho saying that "A man is like a pumpkin; he has a tendency to spread. A woman is like a cabbage, she collects herself." But these days that thing is no longer acceptable. This is why this thing appears to have affected some men negatively* Female FGD (age unknown), Maseru

> *It is against the norms and values, to some extent, for those people who do not understand gender equality, because men consider themselves as heads of families who do not take advice from the wives.* Male IDI (age 58), Leribe

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3.3.2.1.2 Critical view of community dialogues: Participants disrespected.

Some participants felt that community members were disrespectful about their work with the dialogues, labeling them "AIDS people" and passing negative remarks.

> *If you happen to call them again, they respond and come, but if they could take a long time and never come. The next time they are called, they just say- ' OK! It's those people of AIDS again, they have come to bother us with this AIDS of theirs.'* Female FGD (age 30+), Butha-Buthe

> *My opinion is that [pause] we should talk to people, encourage those who do not understand… But I am discouraged by some people who say abusive words at us until one gets irritated. We should not get discouraged.* Female IDI (age 54), Mokhotlong.

> *Sometimes this is discouraging, as I think even when they see me in Maseru or Mafeteng,*

they say "this one is the one who talks about sex." Male IDI (age 38), Maseru

Even us, whenever we appear with bags and luggages with books, they starting mocking us; giving us names, making statements such as "There they come AIDS ladies, we now have names." Female FGD (age 30+), Mafeteng

3.3.2.1.3 Critical view of community dialogues: Inappropriate use of language

Some of the participants raised concerns about the language used in community dialogues. They indicated that they felt ashamed and embarrassed to speak about the sexual issues discussed at community dialogue meetings.

Sometimes it makes me feel ashamed because some things when said in Sesotho sound bad. Male IDI (age 38), Maseru.

Yes, I think that maybe one thing they did not feel comfortable talking about, in relation to having sex, is that you can touch their clitoris and other body parts. I think they did not like the use of such words. Male FGD (age 25–29), Butha-Buthe.

This was very difficult for me in the beginning, speaking of sexual issues in public, in front of other women. There were other words that were quite embarrassing to say out. Female FGD (age 30+), Butha-Buthe.

3.3.2.1.4 Critical view of community dialogues: Age-inappropriate

Some of the participants mentioned that some elderly people perceived the community dialogues as inappropriate and negatively influencing children. Further, some participants were uncomfortable discussing sensitive issues with elderly women.

My experience is that it is the very elderly people who criticize us on these issues. They say that we have turned the world upside down by talking about sexual practices and we are responsible for corrupting children, causing them fall pregnant because we are too open, while they treated issues like these with the confidentiality they deserve. On the other hand, we have ruined the world. Female FGD (age 25–29), Mokhotlong

They were elderly women, probably older than me, so it was kind of sensitive and it appeared as though I was taking advantage of them. Female FGD (age 30+), Mafeteng

3.3.2.1.5 Critical view of community dialogues: Anti-religion

A few participants mentioned that community dialogues and topics discussed in the broader community were not acceptable to the local religious institutions.

They say it cannot be discussed there, in church where there are children present. Male IDI (age unknown), Leribe–Pitseng

When you talk about sexual matters in the community, you just state fact. Like for example you just say, if you reduce sex, you reduce extra marital affairs and the risk of the virus—but in church we can't say that. Male IDI (age unknown), Leribe – Pitseng

3.3.2.2 Community dialogues instigate community and interpersonal conflicts.

A few participants mentioned that the dialogues and subsequent outreach to the larger community

caused conflicts and were a source of ridicule, squabbles, and stigmatization, especially for those living with HIV.

Yes ma'am, they cause community conflict. Female IDI (age 20), Butha-Buthe

I have realized that sometimes the people we group with are different people. They sometimes have friends elsewhere so when they get to understand the discussion they practice what we talked about. Let's say we are four friends. Out of the four, I will be the one who goes out of the way to show them the importance of this thing, so they bit by bit start to neglect me and end up calling me names every time. When I see them and want to join them they start calling me by those names as I approach them. Male IDI (age 25–29), Butha-Buthe

When one has these signs of AIDS they are afraid to meet with people, because now of late we are able to see when one is HIV positive. Now these days people are afraid of themselves when they are HIV positive. This is why I think they become afraid of meeting with other people when they become really sick. Female IDI (age 18), Butha-Buthe

Sometimes the dialogue brings about suspicions in the group. Male IDI (age 19), Butha-Buthe

I had too much stress when I first started. I did not know how I was going to communicate; it really made me sick. Female FGD (age 30+), Mafeteng

That did not happen to me but that is typical of men. They would even encourage others to beat up their wives before they become wise. And that no man can get instruction from a woman, while in actual fact there should be communication. Male IDI (age 63), Maseru

3.3.2.3 Mixed age groups for the dialogues was a problem, along with lack of interest.

Some participants offered negative views on training sessions conducted with mixed groups of participants (male, female, young, and old). A few participants also mentioned the overall lack of commitment by some, including youth and men.

3.3.2.3.1 Critical view of community dialogues: Dissatisfaction with mixed age groups

I did not like it because we had children in there. We were never free in our discussions as a result, but here we are as ladies only, and we are able to express ourselves freely. Female FGD (age 30+), Mafeteng

…Those who attended were people of all ages, and some of the items that were being discussed there were rather sensitive issues. Well, I don't know what I can say, but some issues were not supposed to be discussed in the presence of youngsters who were there! Male FGD (age unknown), Mafeteng

3.3.2.3.2 Critical view of community dialogues: Fatigue and non-commitment relating to the response to HIV and AIDS

Where I come from, whenever we support groups make public gatherings and invite young people they always refuse to come, saying we are calling them for this AIDS of ours and we are disturbing them. They don't attend public gatherings at all. Usually we only talk with grownups who attended; as for youths, we cannot get through them. Female FGD (age 30+),

Mokhotlong

I have heard men talking about it in the taxis, one saying he doesn't believe that such a thing exists, therefore cannot go there even if his wife insists that he goes. The other commented by warning him that he will die if he seriously doesn't believe. Female FGD (age 30+), Mafeteng

Yes, saying, "Oohh, those AIDS story tellers have started, and as usual they are going to talk about AIDS; we will not attend." Then they will keep themselves busy with work. Female FGD (age 30+), Mokhotlong

I talk about depth because I work with the people. The general perception amongst the people appears to be that: "We will not attend those silly things." Female FGD (age unknown), Maseru

Some do go to these discussions, but leave before the sessions come to an end. And these are the people who would say those (meaning us) are wasting our time about these AIDS issues. Male IDI (age unknown), Mokhotlong

3.3.2.4 Some believe that community dialogues do not lead to attitude or behavior change.

A few participants felt that there was no change in behavior due to dialogues, but rather a resistance to reduce MCP or even a reinforcement of the practice. A few also thought that there were no universal effects of the dialogues or the effect was partial.

3.3.2.4.1 Critical view of community dialogues: No change or partial change in attitudes or behavior

Yes, madam, there is a change. For instance, among 10 people attending the workshop, five out of 10 do understand and change their attitudes while the other five may not change. Male IDI (age 27), Mafeteng

I don't see multiple concurrent partnerships decreasing. Female FGD (age 30+), Butha-Buthe

I also had talked to some people, encouraging and telling them about these issues. Well, they were some girls and they swore never to stop the extra-marital affairs. Female FGD (age 25–29), Butha-Buthe

3.3.2.4.2 Critical view of community dialogues: Reinforces or introduces the practice of MCP

As an unintended consequence of the dialogues, a few felt that it actually introduced the idea and practice of MCP to participants.

That person will engage in early sex! Why? Because of adventure. All he just feels is that he wants to witness with his own eyes whether he can contract it! Male FGD (age unknown), Mafeteng

You know there has been one person who tried to argue that his wife must not attend these things, as suspected that these meetings promote extra-marital sexual relationships. Male IDI (age unknown), Maseru

3.4 Effect of Community Dialogues on Participants' Relationships with Partners

Almost all participants reported that participation in community dialogues generally resulted in a significant positive effect on their relationships with their own sexual partners and on family and community relationships. Only a few reported that they experienced negative effects.

3.4.1 Positive effects of community dialogues on partnerships

Participants perceived that the dialogues had been a positive influence on their sexual partnerships through strengthened communication and trust, as well as improved sexual techniques. Participants also felt the dialogues had a positive effect on family wellbeing and helped create a supportive community environment.

3.4.1.1 The community dialogues served to improve marital and sexual partnerships.

Almost all participants—of both genders, all age groups, and across FGDs and IDIs and districts—believed that participation in community dialogues improved their relationships with their own spouses or sexual partners. They reported great improvements in communication, including sexual communication, as along with strengthened emotional ties and improved trust. In addition, some reported an improvement in their sexual technique, ability to address gender norms, and increased self-confidence.

3.4.1.1.1 Community dialogues strengthened communication with spouses and sexual partners.

Almost all participants agreed that the improvement in communication allowed them to discuss sensitive concerns with their partners and led to a strengthening of their relationships.

> *I have realized that, more often than not, since I worked with these C-Change discussions, we honestly manage to talk until things get easy. We talk, maybe he is angry. I show him and try to calm him down, and talk in a calm manner, we discuss. Actually my partner and I now manage to sit down and talk about anything. Be it sex, family matters, our love, I have truly seen a change.* Female FGD (age 25–29), Butha-Buthe

> *My husband and I did not always agree on many issues, but after listening to everything that is taught here, I was able to tell him that, "No, I learned …that you have to ask me first and not to force yourself on me. We have to touch each other and get each other in the mood and ready before we can have fun together making love. But first we have to do all this in a safe way." Also when it came to having extramarital partners, my husband seemed like he did not understand the dangers. But I talked to him about it and told him to change his behavior and stop having other partners and that he should use condoms because he will bring diseases into our family.* Female FGD (age 30+), Mokhotlong

> *To me these dialogues have been of great importance because I was able to take good care of my husband and make him aware of consequences of having affairs if he was proceeding with them. They helped us to be well.* Female FGD (age 30+), Butha-Buthe

3.4.1.1.2 Community dialogues strengthened trust with spouses and sexual partners.

Most participants were able to reach new levels of commitment and trust, which led to a further strengthening of their relationships with their sexual partners.

> *I would join future discussions because now I am able to go to the clinic to have mine and my wife's blood tested. We now have love and trust in my family.* Male FGD (age 25–29), Butha-Buthe

My relationship has been affected in that now we talk about things and discuss everything. I explain to my partner that I have a new way of doing things that I learned about at the village discussions. And if she does not trust me, I show her the book that I bring to the discussion to make notes in. She reads from the book and understands better. Male FGD (age 25–29), Butha-Buthe

3.4.1.1.3 Community dialogues improved sexual techniques used with spouses and sexual partners.
The dialogues introduced a wider range of options for couples interested in exploring techniques with their sexual partners. As a result, most participants reported that they improved their sexual techniques and skills, introduced an added dimension, and further strengthened their relationships.

Using one's hand is ideal because there is no way that infection can occur. You use your own hand, after using it you will not have any health problems. Female IDI (age 45), Leribe

...Another thing is that when we had sex we just went to penetration, but now we talk first and get ourselves excited. We touch each other here and there, with the light on without fearing anything. This is what we did not know because we just had sex in the dark. But now, even when we bathe, we are not scared of each other; he gets undressed and I undress, then we clean our bodies and we get to sex having touched each other and enjoying it! Female FGD (age 23), Mokhotlong

…We never knew how to touch or to approach our husbands. It gave us light. We discussed, tipped each other on the things we could do when our husbands are away, and our bodies urge for sex. We learned that we could try masturbation. Female IDI (age 42), Leribe

3.4.1.1.4 Community dialogues contributed to more open conversations about gender norms.
Some participants related a sense of discovery about their own ability to change gender norms and strengthen their relationships with their sexual partners.

Previously, we used to fear our partners; we felt uncomfortable to talk about sex issues with them. Now I know how to freely talk. When I have a need for sex, I am now able to initiate, to ask him. I used to think that he is the only one with the right to talk. I didn't realize that sex is our mutual business, meant to be enjoyed by both of us. Female IDI (age 42), Leribe

They have personally helped me a lot, as I am now free to talk about sex issues, unlike before, when I used to think that they can only be initiated and discussed by my husband. It is now our collective business. I am free to talk to him about sex as a result of dialogues. Female IDI (age 42), Leribe

3.4.1.2 The community dialogues had positive effects on overall family wellbeing.
The improvement in partner relationships included the improved ability to communicate more effectively within families. It was stated that couples started to walk together, which had stopped happening prior to the dialogues. Most participants said they had a more peaceful and harmonious family environment; almost all stated that participation in community dialogues improved their relationships with their own family members.

Now you see people walking together—you see a man or a woman with their spouse walking together going to the shop, even people that you never thought were family. Female FGD (age 30+), Leribe

… There is a lady here whom I have never seen with her husband. This lady once came and listened as I spoke and seemed interested, then I saw her walking past my house with the husband. I even shouted back at them and told them I envy them. Female FGD (age 30+), Butha-Buthe

…In my capacity as head of the trade union, people we talked to showed interest, in that they said these things enlighten them and there is love and understanding in the families as a result of these things. Female FGD (age 30+), Leribe

There has been a change because families are now making decisions together. It is important to continue educating the people, going from village to village.
Male IDI (age 19), Butha-Buthe

3.4.1.3 Community dialogues had positive effects on a supportive community environment.
Most participants agreed that the dialogues were able to create safe and respectful places for discussion and learning. Dialogues were perceived as contributing toward community cohesion and unity, while allowing discussion on very serious matters that affect everyone. Participants also stated that community dialogues contributed to a sense of community mobilization.

They have surely brought us together. They build the consensus with the community, and together we work cooperatively, and united we solve problems. Female IDI (age 55), Mafeteng

Oh, I too agree that dialogues in my own community have made everybody want to stay informed about their lives. Everybody is on the alert about what happens to their siblings and children. Female FGD (age 25–29), Mokhotlong

In my village there were those who did not believe that AIDS exists, but now support groups are there and they talk about this issue… Male FGD (age unknown), Mafeteng

They support and encourage those of us who are infected… not to think HIV/AIDS means death and start counting our days on earth. Male IDI (age 38), Maseru

Yes, our groups are where they are because of supportive encouragement. Encouraging words like, let's stop going to drinking places, visiting bars and canteens while leaving the issue of our lives at stake behind. Let us go to the support groups to talk about one love [and] use the motto one love. Female IDI (age 41), Mafeteng

The discussions are very good. We have even bonded to a point that, wherever we meet, we talk about the issues versus our progress in the villages. Female FGD (age 30+), Mafeteng

3.4.2 Perceived negative effects of community dialogues on partnerships
A few participants said they were experiencing difficulty after participating in the community dialogues. Difficulties ranged from developing mistrust to aggravating existing potential conflict and even possible termination of the relationship.

3.4.2.1 Community dialogues undermined trust and aggravated potential conflicts with partners.

A few participants experienced difficulties and mistrust when they communicated with their partners about subjects discussed in the dialogues. A few said they had encountered conflict and a weakening of their relationships after participating in the dialogues.

> *I have a girlfriend—in fact two girlfriends to be precise—so I do not hide this information from them both. I sometimes discuss those issues with them and make them aware of what is happening and what is not. Sometimes it gets difficult for me because they ask me questions as to how do I teach people something and do the opposite, since I'm in love with them both and that often causes tension between me and them.* Male IDI (age 25–29). Butha-Buthe

> *Yes, these issues in our community sometimes bring certain changes in families, or at times even bring misunderstandings. …At home, when a wife tries to explain these issues to her husband and tell him what is not happening, sometimes the husband lays a hand on the wife. …Many of them (male partners) do not attend these discussions, but even if they attend, they like to…be ignorant. Even though a person still understands what's going on, just that he doesn't want to listen to his wife when she tries to reason with him concerning such issues.* Male IDI (age 25–29), Butha-Buthe

3.4.2.2 Community dialogues led to termination of a relationship with a partner.

At least one relationship was reported to have been terminated following the dialogues.

> *OK, the first time we met after the dialogue workshops, she noticed that I was different, somehow, so she asked me what the matter was. I told her everything about what I was taught, since I had always assumed she slept around. And then at some point she told me that she thinks we should break up.* Male IDI (age 18–24), Butha-Buthe

3.5 Moving Forward with Community Dialogues in Lesotho

Most participants agreed that they would like to see the community dialogues continue in the future, and many made suggestions about how this could best take place. Their suggestions included expanding the community dialogue content and coverage, increasing resources available to community dialogues, and making programmatic changes.

3.5.1 Continuation and expansion of the community dialogue coverage

Most participants suggested that the geographic coverage of community dialogues be expanded to include villages not yet exposed to them. To achieve this, participants felt that the dialogues should not only be initiated in "untouched" villages and communities, but also through the involvement of specific target groups, such as school-based learners, prison inmates, employers, and others.

3.5.1.1 Suggestions for moving forward: Continue and expand the community dialogues.

> *I wish these discussions could continue, because our desire is for all people to know about this disease of HIV/AIDS and also about the danger of these behaviors of extramarital affairs.* Female FGD (age 25–29), Butha-Buthe

> *Yes, I would like them improved by encouraging the people to increase the number of support groups in their respective communities; there are so many people who have to be enlightened.* Male FGD (age unknown), Mafeteng

I have done three villages to date. During the project we did one village and two villages after the project. We need to cover more villages though. Female IDI (age 24), Butha-Buthe

If the existing groups could be strengthened, or groups could also be increased in number as a way of giving opportunity. Maybe get a support from the government, such that it allows other groups to come in this village. Male IDI (age 33), Mafeteng

I think these dialogues were properly planned, but I can only suggest that they should be broad and cover the whole country. Male (age unknown), Mafeteng

Phela's coverage should increase. Every Mosotho should know about it. Female IDI (age 45), Leribe

3.5.1.2 Suggestion for moving forward: Involve specific groups and institutions.

I… *would like to add that taking the discussions to schools would introduce the education early enough so that the children grow up with a good understanding of these important issues from an early age.* Male FGD (age 25–29), Butha-Buthe

It is vital and therefore supposed to be taken everywhere, even to our own children. These messages should be carried out to schools, so that even our children know these issues. Female IDI (age 42), Leribe

I find it very important especially in here in Correctional Services Unit (prison), where I am currently gathering this useful knowledge from you which I can then pass over to others who did not have an opportunity to come here. Male FGD (age unknown), Mafeteng

*We can also ask chiefs to organize public gatherings in other communities where we would address people on this issue.*Female IDI (age 20), Butha-Buthe

The easy thing would be to hold public meetings (lipitso) *in big and small villages. We could hold public meetings at the chief's place to explain issues about HIV and AIDS to people.* Male IDI (age 24), Mafeteng

One way is to get into such places as churches. Another way is to visit work places. Male IDI (age unknown), Maseru

We should hold them first on our own. I also suggest that our bosses should be there. Female FGD (age 25–29 from Butha-Buthe

3.5.2 Expansion of the content of community dialogues

Most participants suggested that the content of the community dialogues be expanded to include associated HIV counseling and testing activities and cultural activities, such as community competitions that enhance the message. It should be noted that soap opera-type dramas, movie nights, and follow-up discussions formed part of community dialogues in the study districts. Requests for more cultural activities may reflect the need for a heightened cultural approach.

3.5.2.1 Suggestion for moving forward: Incorporate cultural activities.

My opinion is that we should keep making dramas for people who do not understand, so that they should finally understand. Female FGD (age 25–29), Butha-Buthe

I think if we could work as a group and make dramas on one love, I think people would be attracted to watch and see what this one love truly is? Female FGD (age unknown), Maseru

I would suggest that radio programs be done, and they should also be broadcast over TV. Female IDI (age 49), Leribe–Pitseng

3.5.2.2 Suggestion for moving forward : Include HIV counseling and testing.

Yes, I would like it to be a few villages, and also asking men and women who test people to come to the rallies, so that while we are still talking about these issues of HIV, there should be people counseling and testing other people. Female FGD (age 25–29), Butha-Buthe

3.5.2.3 Suggestion for moving forward: Incorporate community competitions.

I wish there would be some virginity competition, especially in school among the girls, whereby a girl who will be found to be a virgin will be given some award, and boys as well. This will be done to encourage the youth to abstain and keep their virginity. Male IDI (age 37), Butha-Buthe

3.5.3 Increasing resources available to community dialogues

Salient suggestions were related to resources available to this initiative, either from donors or the government. Myriad suggestions included injections of financial and personnel resources and materials that support community dialogues.

3.5.3.1 Suggestion for moving forward: Inject more financial assistance into community dialogues.

I have already mentioned that Phela should be assisted financially for better coverage. Female IDI (age 45), Leribe

Maybe get a support from the government, such that it allows other groups to come in this village. Male IDI (age 33), Mafeteng

I would encourage those from the department of HIV/AIDS to help us, support us in all the ways possible (in order to) tell other people who still do not know about this illness. Female IDI (age 21), Butha-Buthe

Well, I was just saying that it should be brought to attention that people should not work on an empty stomach to do a job well done; sometimes we need to travel by car… Phela does not provide money, so we cannot travel. Female FGD (age 30+), Maseru

We should be given incentives because they are the only thing that can encourage us. Female IDI age 49), Leribe–Pitseng

That is why you hear us say we do not have commodities; that is the very commodities we need… ones which enable us to do our work, and we are unable to do the work properly because of these things. Male FGD (age 30+), Mokhotlong

Yes, we cannot work on empty stomachs. We need transport fares as well. We need an incentive to get motivated. Female FGD (age 30+), Maseru

Yes, they are reluctant to participate, there are a few people who take part in our discussions, so we are suggesting little gifts and believe they could help. Female FGD (age 25–29), Butha-Buthe

3.5.3.2 Suggestion for moving forward: Ensure material resources for community dialogues

I can point out that they were changing rapidly, but Phela left us disgruntled. And then addressing people without equipment is the great problem. We fail to convince them because we do not have equipment. Male IDI (age 63), Maseru

Even though they wanted to get some material to supplement what I was talking to them about, unfortunately I did not have such supplementary material... like pamphlets for people to read and know about Phela or what it is. Male IDI (age 38), Maseru

To strengthen our work and disseminate information effectively, we need some information material or books to give to the community. We need some material to use in the communities and in the groups that we have formed. Female FGD (age 30+), Maseru

3.5.4 Programmatic changes to community dialogues

Most participants made practical suggestions for programmatic changes to community dialogues. Their suggestions addressed the timing of community dialogues and their duration and frequency. Suggestions also addressed the format of the dialogues and the establishment of age-specific groups.

3.5.4.1 Suggestion for moving forward: Consult about timing of community dialogues.

In the country there are many jobs with their different times—for instance, now it's harvest time; we are busy, the boys are coming from initiation. Hence I say before and after Christmas are very busy times, and we can't meet up in a proper way. And now it's January, schools are re-opening; so if we could be given a certain period in a year to meet. Female FGD (age 30+), Butha-Buthe

Just like these other societies, we could suggest time for our discussions, because putting a time frame could sometimes alter our discussion and cause other people to leave having not fully understood. Female IDI (age 42), Leribe

We are going, but with difficulty as you will find that we go to one village per month, and we cannot divide ourselves so that this group goes there and this group goes there because we still have challenges looking after our families Male FGD (age 30+), Mokhotlong

3.5.4.2 Suggestion for moving forward: Shorten the duration of community dialogues.

I think it was too long and a bit discouraging for participants, taking into account that they have their own personal commitments. So my suggestion is that they [community dialogues] should take at least 1 hour or less. Female IDI (age 54), Mafeteng

3.5.4.3 Suggestion for moving forward: Consult about the frequency of community dialogues.

Again, I think the dialogues should be held more often, because if there is only one seminar people tend to go back to their old ways. Male IDI (age 25–29), Butha-Buthe

I think the discussions should go on for a week. And this week-long discussions should be held quarterly. Male IDI (age 25–29), Butha-Buthe

Well I think the dialogues can be more important if since we held them weekly, we should change that to daily basis and every week there must be a time when we go out to the public and spread the word. Female FGD (age 30+), Butha-Buthe

3.*5.4.4 Suggestion for moving forward: Form age-specific groups for community dialogues*

If people are of different ages it is really a problem, but if they are of the same age they are free to talk. A youngster will be shy to talk about certain things in the midst of grown-up people; the same goes for the elderly. Male FGD (age 30+), Leribe–Pitseng

We discussed about them before and said they should be grouped based on their age groups so that they can be able to open up. Female IDI (age unknown), Mafeteng

I think if people could be divided into different groups—for example, adults, young males and children. With this I think the discussions can be heightened. Male IDI (age 25–29), Butha-Buthe

They should be focused on older people and the youth as well as school children. The youth is divided into those who are still in school and those who are not. Male IDI (age 25–29), Butha-Buthe

4. CONCLUSIONS AND RECOMMENDATIONS

This qualitative evaluation sought to assess participants' perspectives and assessments of community dialogues conducted between mid-2009 and September 2010 to address MCP. Before asking questions about these perspectives, two questions were asked that provided background contextual information on perceived major challenges facing communities and perceptions of MCP as a driver of HIV and AIDS.

Most participants identified major issues facing the community: 1) substance abuse, 2) HIV and AIDS, 3) poverty and unemployment, 4) physical infrastructure challenges, 5) teenage pregnancy, 6) 7) crime, and 8) community apathy. These clearly reflect poor socioeconomic circumstances that may increase vulnerability to risky sexual practices, including unprotected sex, MCP, and socially unacceptable behavior. Socioeconomic challenges are known to play an important role in increasing risky behaviors and sexual risk-taking, and should be taken into consideration when addressing MCP, along with structural barriers such as poverty, unemployment, and physical infrastructure challenges.

Most participants viewed MCP as a driver of HIV in their communities and identified several reasons why. These referred to the ripple effect of widening sexual networks; the practice of unprotected sex; transactional sex as a means of survival; lack of information on HIV; lack of knowledge of one's own HIV status and the status and sexual history of others; the drive for self-gratification; MCP as an acceptable common practice; and ignorance or dismissive attitude toward MCP. The testimony of the community dialogue participants corroborate other evidence that MCP constitutes a significant driver of the HIV in Lesotho, where it is linked to more than 60 percent of all new HIV infections (Khobotle et al. 2009; Government of Lesotho 2006)

Almost all participants perceived the community dialogues as making an overwhelmingly positive contribution to their communities. The range of perceived positive contributions to which participants testified included:

- improved sexual behavior (reduction in MCP practices, practice of protected sex, reduction of transactional sex)
- increased positive attitude toward open communication about sex and other sensitive issues and improved communication with spouses, children, parents, families, and peers and within communities on these topics
- increased information dissemination and knowledge to respond to HIV and AIDS
- improved health-seeking behavior, including uptake of HIV testing
- increased acceptance of one's own HIV status
- increased sense of personal contribution and empowerment in the community
- perceived reduced HIV transmission, sexual crimes, sickness, and death in the community

It is worth mentioning that a minority of the participants expressed negative views regarding the use of community dialogues to discuss MCP. Negative views included the perception that community dialogues were culturally unacceptable, that they instigated community and interpersonal conflicts, or that they did not generate sufficient interest or lead to behavior change. The limited negative criticisms of MCP community dialogues were highlighted in other studies (C-Change 2009).

Based on the qualitative study and the nature of the sample, firm conclusions and generalizations cannot be drawn, and it is too early to discern whether the community dialogues contributed to reducing MCP. Notwithstanding, study findings suggest that community dialogues are on the right path

to contribute to reducing HIV prevalence in hyper-epidemic countries as a component of broader combination prevention approaches. These broader approaches include campaigns that promote voluntary medical male circumcision and condom use, alcohol reduction, and other targeted HIV risk-reduction (Shelton 2007).

Recommendations

If the methodology of the community dialogue intervention is to be used in the future to address MCP or other drivers of HIV, it is important to consider suggestions made by study participants. The following recommendations are based only on participant suggestions.

- ☑ ***Target communities most in need, as well as specific institutions and key opinion leaders.***
  Along with conducting formative research to target communities most in need of the intervention (i.e., highest in HIV prevalence, MCP, poverty), participants indicated that key institutions should be involved in the dialogues, such as schools, prisons, businesses, and churches—institutions that reach youth, the incarcerated, employers and employees, and congregants. In addition, community chiefs and other opinion leaders should be involved to ensure more comprehensive buy-in and coverage.

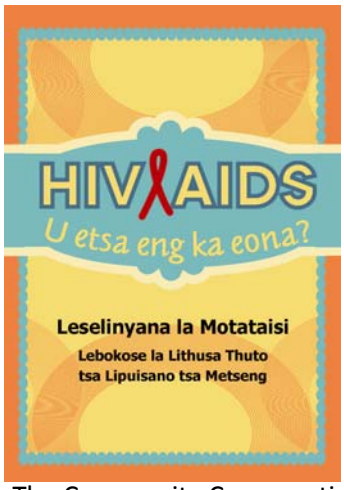
- ☑ ***Link the dialogue project with strategic cultural and community activities.***
  Community dialogues should incorporate more local cultural and community activities. Suggested activities included dramas related to MCP, HIV counseling and testing at local rallies, and sponsored community competitions among youth.

- ☑ ***Provide ample financial, human, and material resources to support community dialogues.***
  While USAID resources were made available to conduct the community dialogues, study participants said more financial support was needed from their government and local donors. They argued for meals and travel for those conducting and reaching out to communities, as well as minimal incentives to encourage participation in the dialogues. They also said more resources are needed in the way of materials to disseminate.

- ☑ ***Obtain feedback and consensus on the most appropriate timing, duration, and frequency of community dialogues.***
  When designing the community dialogues, C-Change consulted extensively with community members to understand their preferences for the timing, duration, and frequency of dialogues. However, some participants found the timing to be insufficiently considerate of harvest time and holidays. Some found the duration of the dialogues too long, while others found them either too frequent or not frequent enough. If community dialogues continue, more consultation on these issues should be conducted with community members.

- ☑ ***Consider providing age-specific groups during parts of the dialogue process.***
  C-Change worked with existing community groups to promote sustainability. These existing groups often included younger and older people, and participants felt that this inhibited some from speaking freely. To address this issue, it is recommended that subgroups be formed—groups of adults, young males, and/or young females— when groups are large enough to promote more open dialogue on sensitive sexual topics.

Community Conversation Toolkit (for HIV prevention)



The C-Change community dialogue program ended in Lesotho in 2011. As part of the exit strategy, C-Change's worked with Phela and other groups to adapt the Community Conversation Toolkit (for HIV prevention in Lesotho Sesotho for community groups involved in dialogues, including by incorporating local proverbs and artwork. The aim was to provide community groups with an interactive toolkit that could be used to continue discussions during the transitional period—where C-Change support ended and another began. Phela has since received support from another partner funded by the US Government to continue the community groups and expand the community dialogue program for the next three years.

The Community Conversation Toolkit is designed to mobilize adults aged 20 and older in communities to initiate discussions around HIV prevention. The associated materials address key HIV drivers identified in Lesotho, such as MCP, cross-generational sex, gender-based violence, and alcohol abuse. The toolkit includes a guide and six distinct materials that are used by small groups in facilitated or social settings. These aim to mobilize communities for HIV prevention.

The materials comprise a facilitator's guide, community mobilizers' cards, role-play cards, storytelling-finger puppets, promotional proverbs and best-kept-secrets throw boxes, promotional playing cards, and dialogue buttons. The materials can assist community groups to expand their outreach activities into environments such as bars, where playing cards and other materials can serve as job aids in facilitating their discussions about HIV prevention.

C-Change printed 200 copies of the Community Conversation Toolkit for the use of community groups and conducted trainings for selected groups in the five districts (Butha-Buthe, Leribe, Mafeteng, Maseru, and Mokhotlong). Final design files are available on the C-Change website for download and reproduction (http://c-changeprogram.org/resources/community-conversation-toolkit-hiv-prevention).

5. REFERENCES

C-Change. 2009. *A Baseline Survey of Multiple and Concurrent Sexual Partnerships Among Basotho Men in Lesotho.* Washington, DC: C-Change/ FHI 360. **http://c-changeproject.org/resources/baseline-survey-multiple-and-concurrent-sexual-partnerships-among-basotho-men-lesotho-july**

C-Change. 2010. *Relationships: Intimacy Without Risk. Facilitator's Guide to MCP Community Dialogue.* Washington, DC: C-Change/ FHI 360. http://c-changeproject.org/resources/relationships-intimacy-without-risk-community-dialogue-program

Government of Lesotho. 2006. *National HIV & AIDS Strategic Plan (2006-2011)*. Maseru: National AIDS Commission.

Khobotlo M., R. Tshehlo, J. Nkonyana, et al. 2009. *Lesotho: HIV Prevention Response and Modes of Transmission Analysis.* Maseru: Lesotho National AIDS Commission. http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/LesothoMOT13April.pdf

Shelton, J. 2007. Ten Myths and One Truth about Generalised HIV Epidemics. *Lancet* 370 (9602): 1809–11.

UNAIDS. 2009. Feature Story: Consultation Held on Definition and Measurement of Concurrent Sexual Partnerships. April 24. http://www.unaids.org/en/resources/presscentre/featurestories/2009/april/20090424consultationsexualpartnerships/

ANNEX: GUIDING QUESTIONS FOR DATA COLLECTION

The following guiding questions were used for data collection for the IDIs and FGDs:

1) What do you think are the major issues facing your community right now?
2) What role do “concurrent sexual partnerships” play in the spread of HIV in your community?
3) Tell me what you thought about participating in the community dialogues?
4) What are your views on the use of the community dialogues for a sensitive topic like concurrent sexual practices?
5) What effect do you think the dialogues have had on your community?
6) What effect has participation in the dialogues had on your communications or discussions with your own sexual partners? How effective are community dialogues in discussing such topics? What is your perceived appropriateness of having community dialogues?
7) What are your views on the potential effect community dialogues can have on concurrent sexual partnerships?
8) Indicate whether or not you think this approach will influence people to change this behavior. Why or why not?
9) Explain the degree to which you would like to see these community dialogues occur in the future
10) Would you participate in community dialogues again? Please state why or why not.
11) Would you recommend them to any of your friends or family members?

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