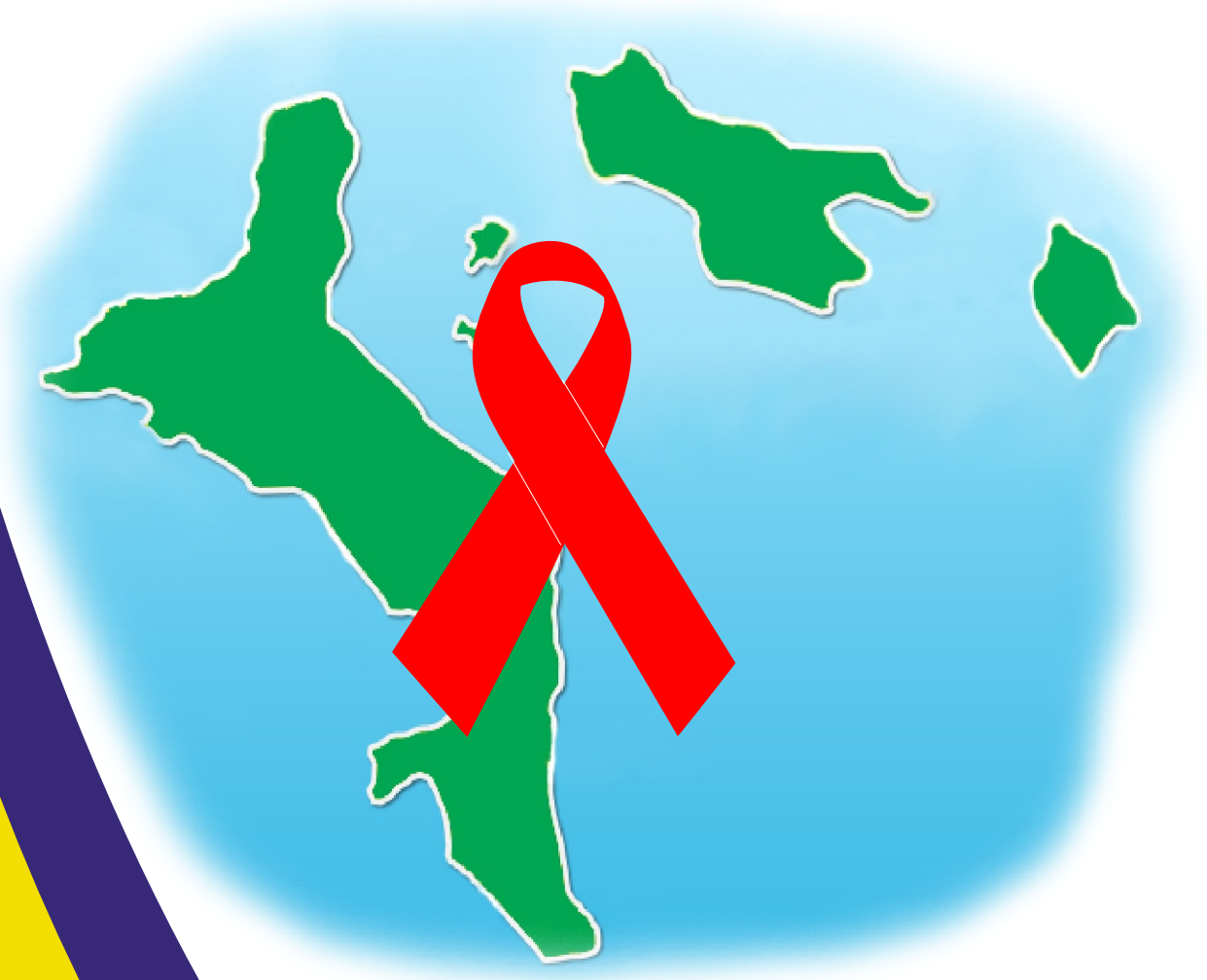
The HIV, AIDS and STIs Knowledge, Attitudes, Practice and Behaviour (KAPB) and Biological Surveillance Study Report 2013 for Seychelles



Republic of Seychelles

Ministry of Health

The HIV, AIDS and STIs Knowledge, Attitudes, Practice and Behaviour (KAPB) and Biological Surveillance Study Report 2013 for Seychelles

NATIONAL AIDS COUNCIL

SEYCHELLES

in collaboration with:

UNFPA

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FOREWORD

Surveillance of the HIV epidemic in Seychelles reveals that there is a trend towards an increase in the number of infections, and this varies among key population groups This latest study of HIV, AIDS and STIs Knowledge, Attitudes, Practice and Behaviour (KAPB) is the first since the KAP study conducted in 2003. In the intervening years, there have been major lifestyle changes in Seychelles, as well as the rapid emergence of Hepatitis C infections among IDUs. At both global and local levels, the dynamics of the HIV/AIDS situation are constantly changing, and regular investigation of knowledge, behavior and practices is critically important to establish trends and create a baseline that would inform new prevention strategies and policy decisions. This most recent KAPB study, undertaken in 2012, is critically important in this context.

Spearheaded by the National AIDS Council, the HIV, AIDS and STIs Knowledge, Attitudes, Practice and Behaviour and Biological Surveillance Survey 2012 targeted the general population,

aged 15 to 64 years, all over Mahe, Praslin and La Digue. The aim of the research was to find out how much each age group knows about HIV, AIDS and other Sexually Transmitted Infections; what type of attitudes they have towards people living with HIV and AIDS; and what kinds of sexual practices and behaviour are prevalent in the general population. Alongside this behavioural study, a biological surveillance was conducted to estimate the prevalence of HIV in that same population.

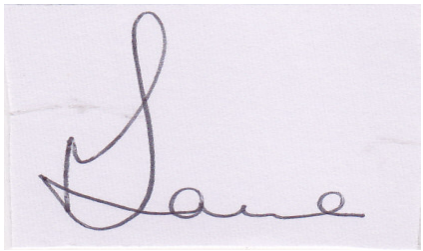
The result of the survey will be used for prevention and care strategies for the general population, in line with the National Strategic Plan for the Prevention and Control of HIV and AIDS and STIs in Seychelles 2012-2016, which draws its inspiration from the UNAIDS strategy document 'Getting to Zero' by 2015.

Furthermore it will be utilized by the National Monitoring and Evaluation Unit for HIV to report on indicators to the Global Fund, Global AIDS Response Progress (GARP) and Universal Access, and other international bodies.

Through its partnership with the United Nations, WHO, SADC,COI and others agencies, the government maintains its commitment to strengthening the capacity of different actors in HIV/AIDS prevention and promoting the coordination of interventions for greater effectiveness. The UN agencies' contribution to the national response in Seychelles has focused on strengthening coordination, policy and strategy development as well as capacity building to improve the quality of service delivery to most at risk and vulnerable population groups, including approaches to supporting behaviour change communication strategies amongst young people.

This evidence-based information will allow all agencies to better target, fine tune and deliver more appropriate prevention messages, treatment, care and support services.

I trust that data provided by this study will guide all stakeholders, not only the National AIDS Council or the Ministry of Health, but the other Government agencies, civil society , the private sector, faith-based organizations and all other actors in the fight to prevent and control HIV and AIDS in Seychelles.



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National AIDS Council (NAC) based in the Ministry of Health (Seychelles) withinthe National AIDS Control Programme, under the directorate of Programs of the Public Health Department, the Regional Health Centres, the National clinical Laboratory and the Disease Surveillance and Response Unit (DSRU).

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The Ministry of Health
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World Health Organisation (WHO)
United Nation Fund For Population Activities (UNFPA)
The Ministry of Finance

ACKNOWLEDGEMENT

Seychelles established its first evidenced -based national HIV prevalence in history together with its second behavioral study last conducted in 2003. The population - based HIV study was to assess knowledge, attitude, practices and behavioral risk factors related to HIV transmission among the population groups aged 15 to 64 years in Seychelles.The information will help to realign policies, the priories and programmatic actions of the strategic plan of the HIV and AIDS Response.

We acknowledge the work of the Research Team for their expertise in developing the tools, data collection, processing and reporting. Special recognition goes toward the field supervisors, enumerators, nurses for commitment in ensuring quality data collection.We also acknowledge the technical guidance of the Technical working group consisting of epidemiologist, NAC Coordinator, CDCU Representative, Statistician, AIDS Control Programme, Clinical Laboratory, NGOs, Joint UN Team, SBS Representative, Youth Health Centre Representative, Health Professionals and the National Institute for Health ansd Social Studies.

This study was implemented by the National AIDS Council, Public Health Department of the Ministry of Health, co-sponsored by the National AIDS Trust Fund, WHO and UNFPA

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LIST OF ACRONYMS AND ABBREVIATION

ACP	AIDS Control Programme
AIDS	Acquired Immuno-Deficiency Syndrome
ASFF	Alliance of Solidarity for the Family
DSRU	Disease Surveillance and Response Unit
ERI	English River
FAHA	Faith and Hope Association
HAART	Highly Active Antiretroviral Therapy
HASO	HIV and AIDS Support Organisation
HCW	Health Care Worker
HIV	Human Immuno-Deficiency Virus
HTC	HIV and AIDS Testing and Counselling
KAPB	Knowledge, Attitudes,Practices and Behaviour
MSM	Men Who Have Sex With Men
NAC	National AIDS Council
NATF	National AIDS Trust Fund
NSB	National Bureau of Statistics
PWID	People Who Inject Drugs
RDS	Respondent-Driven Sampling
SCR	Seychelles Rupees
STIs	Sexually Transmitted Infections
SW	Sex Worker
SWU	Students' Welfare Unit
WHO	World Health Organisation
UNFPA	United Nations Fund for Population Activities

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EXECUTIVE SUMMARY

The Seychelles has managed to collect a lot of data about HIV and STIs, with the sentinel site surveillance data and a Respondent-Driven Sampling Study on People who use drugs (PWID) and Men who have sex with men (MSM). However, the information is deemed to be insufficient as the country is unable to ascertain the prevalence of HIV and STIs in the general population. The national programmes to prevent and control HIV and AIDS need further information to guide its implementation.

The Seychelles ***HIV, AIDS and STIs Knowledge, Attitudes, Practice and Behaviour and Biological Surveillance Survey 2012*** has been designed to provide such information. It is a primarily quantitative study with qualitative components. It consists of two main studies: the collection of information on the levels of knowledge, attitudes, practices and behaviours and the testing of biological samples, mainly blood, to obtain biological surveillance data.

The main objective is to identify social and sexual behavioural patterns, attitudes, opinions about HIV and their possible links to prevalence of HIV, AIDS and STIs in the general population. The study is being conducted to better understand the prevalence of HIV in Seychelles and to identify drivers of the epidemic for policy formulation and programmatic actions developments and adjustments, in line with the ***National Strategic Plan for the Prevention and Control of HIV and AIDS and STIs in Seychelles 2012-2016***.

The sample is composed of 1691 persons living in Seychelles at the time of the study, i.e., from 1st to 31st h October 2012, who are aged 15 to 64 years. The sample is also stratified according to age, gender and district of residence. The main methods of data collection are a face-to-face interview through the administering of a pre-tested questionnaire to have information on levels of knowledge, the kinds of attitudes, and the behaviour patterns of respondents, and a biological sample (blood) from each respondent to test for HIV only, with a rapid test in a laboratory setting. All reactive blood samples underwent confirmatory tests.

The main instrument for behavioural surveillance survey is a pre-tested questionnaire. The pre-trial was conducted with 40 persons representing the sampled population groups, as per selected criteria: age, gender and district.

Strict ethical guidelines have been followed to ensure respondents' rights are respected and protected, including confidentiality, privacy, informed consent, reduced risks and harms and withdrawal. Stringent procedures have been established to protect the data sets from the behavioural surveillance and the biological samples, with limited access and on a need-to-know basis as primordial.

Data collection began on the 1st of October and ended on 31st October 2012. Data analysis was done using SPSS version 16.0 The main work is to match knowledge, attitudes and behaviours to the biological test results to study possible associations, if any. Results are to be disseminated for the first time during the National AIDS Council meeting on the occasion of World AIDS Day 2012.

The results to be published widely to government agencies, civil society partners and other stakeholders so that they can use the information to plan, design and implement their programmes, and to make necessary adjustments, if the need arises, show a mixed picture. There have been some improvements in knowledge and attitudes since 2003. However, there are still risky behaviours linked to multiple partners, low use of condoms and ignorance about HIV transmission, as well some entrenched stigma and discrimination. Blood results show a very low prevalence in the general population.

PART I. INTRODUCTION

1.1 BACKGROUND INFORMATION AND JUSTIFICATION

"*Any KAPB Study is a highly focused evaluation that measure changes in human knowledge, attitudes and practices in response to a specific intervention, usually outreach, demonstration or education.*" (Eckman and Walker, 2008 cited in *Knowledge, Attitude, and Practices (KAP) Studies for Water Resources Projects*)[1] KAP studies have been widely used in developing countries in a variety of fields, including the health sector and in domains such as HIV and AIDS and STIs. The main purpose of any KAPB study is thus to explore changes positive or negative in Knowledge, Attitude and Practices of the general population; in this case, about HIV, AIDS and other STIs. These studies provide information for the evaluation of any national, regional or community programme. They help to reveal increases or decreases in knowledge, changes in attitudes, behaviours and practices about HIV. They are also the first steps needed before the conception, development, the rolling out and scaling up of any kind of national, regional and community information, education and communication (IEC) programmes.

Biological surveillance studies help to determine more precisely the prevalence of any condition or disease in a given population. Sometimes, the studies focus on specific population groups, such as sex workers (SW) or young people of a selected age group. Biological surveillance of general populations tends to be rarer as they are costly and difficult to organise and manage. Combining behavioural and biological surveillance is scientifically sound as the two methods yield a higher return rate for biological samples (Coleman, Gutmanis, Bondy, McGeer, Salvadori and Louie, 2011 in the Social Research Methods Journal, Volume 5, Number 3, 2011)[2] Therefore, Seychelles is planning on conducting a KAPB and a Biological Surveillance Survey on HIV for the reason mentioned above and for those which are outlined below.

The Seychelles has recently developed its ***National Strategic Plan for the Prevention and Control of HIV and AIDS and STIs 2012-2016***, which comprises of the following documents:

(a) The National Policy on HIV and AIDS and STIs 2010
(b) The National Strategic Framework (2012)
(c) The National Costed Operational Plan(2012)
(d) The National Multi-Sectoral Monitoring and Evaluation Framework(2012)

The national strategic plan is also based on surveillance and research data[3]. For the first time, the priorities have been decided as a result of the data obtained from the respondent-driven sampling study on People Who Inject Drugs (PWID) and Men Who Have Sex With Men (MSM) conducted in 2011. Therefore, the activities of the plan are research-informed[3].

It is important to note that the Seychelles response to the pandemic dates back to 1987 when the first HIV infection was detected and the first full-blown AIDS case reported in 1992. By end of 2011, there were 502 cumulative cases of people living with HIV and AIDS where 58% (n=290) and 42% (n=212) were males and females respectively. . There were 323 PLHIV (182 males and 141 females), representing 56% males and 44% females. A cumulative 162 clients (87 males and 75 females) had been started on Highly Active Antiretroviral Therapy (HAART) to date (CDCU, 2012)[4].

However, whilst there has been some biological surveillance data made available, there are three main gaps that a Knowledge, Attitudes, Behaviour and Practices (KAPB) helps to fill regarding our knowledge of HIV in Seychelles. These are:

(a) The biological survey using RDS was conducted on only two key population groups: PWID and MSM. None was done on Sex Workers (SW) or the general population.
(b) For a long time, Seychelles has been unable to give a credible prevalence of HIV because there had never been any biological surveillance of the general population.

(c) The national strategic plan for the period 2012 to 2016 was not based this time of knowledge, attitudes, behaviours and practices of the general population, as the previous one was in 2005, when the data collected from the KAPB 2003 was used[3].

Conducting a KAPB at this time helps to better understand the HIV epidemic in Seychelles by providing two types of essential data: KAPB and biological surveillance of the general population. This is in line with the principles of ***Result-Based Management***, which have also been incorporated into the national strategic plan for HIV and AIDS and STIs[3]. A key component of any action national prevention and control programme is to ***Know Your Epidemic***. The KAPB Study 2012 has gone a long way in ensuring just that: Seychelles stakeholders and partners having comprehensive knowledge and understanding of the key drivers of the epidemic in the country.

Such data also helps to realign policies, the priories and programmatic actions of the strategic plan which is also scheduled for mid-term review in 2014. Moreover, the information guides national, regional and community IEC campaigns conducted by stakeholders and partners, such as the National AIDS Control Programme (ACP) and the Disease Surveillance and Response Unit (DSRU) of the Ministry of Health, the Ministry of Education (Personal and Social Education – PSE, and Students' Welfare Unit – SWU) and other government agencies and NGOs, such as HIV and AIDS Support Organisation (HASO), Faith and Hope Association (FAHA) and the Alliance of Solidarity for the Family (ASFF).

1.2 PURPOSE OF THE RESEARCH

The main objective of the KAPB Study 2012 is to: "***evaluate the knowledge, attitudes, practices and behaviours on HIV, AIDS and STIs and to systematically assess the HIV prevalence in the general population aged 15 to 64 years."***

Measuring HIV prevalence in general population combined with data from sentinel surveillance data to provide more complete picture of the national HIV prevalence. This is expected to vary from prevalence among the two key population groups already studied in 2011.

2.0 SPECIFIC OBJECTIVES OF THE RESEARCH

The specific objectives of the KAPB and Biological Surveillance Study 2012 are to:

(a) Determine the levels of knowledge, attitudes, practices and behaviours about HIV, AIDS and STIs of the general population, both male and female, aged 15 to 64 years;
(b) Establish a baseline for KAPB for future research;
(c) Generate data from these evaluations to guide policies and programmes for all stakeholders, both state and non-state actors;
(d) Determine the proportion of people with HIV among the age group 15 – 64 years;
(e) Determine the association between HIV and AIDS knowledge, attitudes, practices and behaviour among different age groups;
(f) To determine the possible associations between HIV transmission and risk behaviours across different groups, disaggregated by gender, age groups and district;
(g) Examine knowledge of the different types of available services as well as reasons for accessing or not accessing such services;
(h) To assess attitudes, stigma and discrimination towards PLHIV;
(i) Identify key risk behaviour patterns and facilitating factors for HIV and STI transmission in the population;
(j) Provide evidence to monitor the progress of the national HIV, AID and STIs response efforts.

3.0 RESEARCH QUESTIONS

In order to achieve above objectives, the following research questions have been developed:

(1) What is the level of knowledge attitude and practices about HIV, AIDS and STIs among the general population by age, gender and district?

(2) What is the HIV prevalence in the general population by age, gender and district?

(3) What are the links between the levels of knowledge, the types of attitudes, practices and behaviours and the prevalence of HIV?

(4) What are the links between demographics and social determinants and levels of knowledge, the types of attitudes, practices and behaviours and the prevalence of HIV?

4.0 Literature Review

There are some key issues regarding the conducting of behavioural and biological surveillance studies on HIV and AIDS. These include the following:

(a) The relevance and scientific value of KAP studies;
(b) The main linkages in terms of behaviours, attitudes and practices and HIV prevalence;
(c) Methodological consideration

4.1 Relevance and scientific value of KAP studies

KAP studies have been conducted in a variety of domains within the health sector. Immunisation of children is a case in point (Nath et al, 2008 in Online Journal Health and Allied Sciences, India)[5]. The effects of diabetes and retinopathy constitute another domain (Kaliyaperumal, n.d)[6]. KAP studies in HIV and AIDS and STIs have also been conducted worldwide, from Europe to Africa and Asia, for a number of years. Examples range from Kosovo in Europe (United Nations Kosovo Team, 2008)[7] to Niger, in Africa (Chamberlain Diala, Seyi Olujimi, Folami Harris, and Kale Feyisetan, 2011)[8].

4.2 Main linkages between behaviour and HIV prevalence

KAP studies are conducted to better understand people's level of knowledge, types of attitudes, behaviour and practices regarding HIV and AIDS and STIs. More specifically, they allow researchers to look at predictors of HIV prevalence, such as age of first sexual intercourse, adolescence, condom use and sexual practices. The researchers present three main predictors: age of first sexual intercourse, discrimination and condom use.

In terms of age of first sexual intercourse, studies have shown that it is a strong predictor of HIV infection. The median age for first sex in Sub Saharan Africa is higher - 18-20 years - compared Latin America which is 15 years (Brown, 2001)[9] and 18 in India (National AIDS Control Organisation – NACO - New Delhi, 2006)[10]. A fairly recent study from South Africa showed that less than 10% of young adults had sex before the age of 15 years (Human Sciences Research Council, South Africa 2008)[11].

Further analysis by gender shows that young male adults are more likely to have their first sexual intercourse at an earlier age than females (Human Sciences Research Council, South Africa 2008[11]; National Family Health Survey, 2005-6[12]). It is important to note that higher prevalence of HIV was seen in women who had sexual intercourse at ages below 16 years (Demographic and Health Surveys, n.d[13]).

Regular condom use has been seen to be effective strategy in prevention HIV and other STI infection (Davis-Beatty R. Karen and Weller C. Susan, 1999)[14]. However, it is not often the case that people are aware of this fact. Indeed, a study in Kenya showed that only 10% of the youth with a median age of 17 years surveyed admitted that HIV could be contracted through unprotected sex. Moreover, whilst only 4 out of ten of these same youth acknowledged that condoms can prevent HIV, two thirds agreed that condoms can prevent pregnancy (Yotebieng M, Halpern CT, Mitchell EM, Adimora AA, 2009)[15].

Knowledge about the protection of condom against HIV is high although actual use is low. It is noted that although 92 % of young urban slum youth dwellers in India had good access to condoms, condom use itself is very limited. Major barriers that can explain low %age use of condoms in India include the lack of privacy in stores selling condoms (NACO, 2006)[10]. This is further confirmed by reports that In 8 communities from North West Province of South Africa, although accessibility and awareness of condoms were high, these did not lead to the use of condom in risky sexual encounters or when people were not in a position to negotiate protected sexual intercourse. Major barriers cited are the lack of information, low negotiation power, myths and perceptions of reduced pleasures during sexual intercourse with condom use (Human Sciences Research Council, South Africa 2008)[11].

Discrimination and stigma are other factors that can explain HIV prevalence, especially in key populations, such as Men who have sex with men (MSM). Indeed, Dr. George Ayala, Executive Officer of the Men who have sex with Men Global Forum notes in *Our Own Words: Preferences, Values and Perspectives on HIV Prevention and Treatment: A Civil Society Consultation with MSM and Transgendered People (December 2010)*[16] that: "*It is well known that there is a strong connection between human rights violations and the spread of HIV. These interviews paint a clear and often disturbing picture of exactly how things like stigma, discrimination and violence can interfere with HIV services*."

The study draws on 39 open-ended interviews with MSM and transgender respondents from 27 different countries throughout Africa, Asia, the Caribbean, Eastern Europe, Central Asia, Latin America, North America and Western Europe. Despite the diversity of locations represented, respondents identified a common set of barriers to HIV services that was strikingly consistent across regions. Five factors emerged as serious impediments to access:

1) Homophobia and transphobia

2) HIV stigma

3) Criminalisation and repressive policies

4) Lack of awareness among providers, and

5) Safety.

Studies show that discriminatory behaviours also exist amongst adolescents (KAP Sierra Leone, 2002)[17]. For example, adolescents in Sierra Leone displayed some contradictory attitudes to People living with HIV (PLHIV). While 69% strongly sympathised with the PLHIV and barely 1% considered them as immoral, 60.2% of the adolescents felt that PLHIV should be discriminated against. A large number of the respondents (68%) stated that an infected employee must not be allowed to continue work or an infected student must be sent away from school. A significantly high %age (78%) stated that they would not share a meal with a PLHIV and worse still, 81% would not buy food from a trader who is a PLHIV.

These are some of the issues studied in the behavioural surveillance part of the survey.

PART II METHODOLOGY

5.0 METHODOLOGICAL CONSIDERATIONS

"Data generated by HIV surveillance systems can be used in three major ways: to plan HIV prevention and care programs, to monitor the impact of the national response to the epidemic, and to lobby for a more effective response in the future" (Pisani Elizabeth, Lazzari Stefano, Walker Neff and Bernhard Schwartlander, 2003)[18]. The authors further note that If HIV infection rises to substantial levels in well-defined subpopulations with high risk, and if behavioral surveillance has shown that these subpopulations are linked to other populations, surveillance activities should be expanded to monitor first behavior and then HIV infection rates in those other populations. Where those other populations are essentially indistinguishable from all sexually active adults, biological and behavioral surveillance in groups' representative of the general population should be instituted. This is exactly what the present KAPB and biological surveillance study 2012 is trying to do, given that the HIV prevalence in MSM and PWID from the RDS Survey conducted in 2011 are above the proposed threshold of 5% (Pisani et al., 2003)[18].

Together with a number of developing countries and international partners, The Joint United Nations Program on HIV/AIDS (UNAIDS) and The World Health Organization (WHO) have developed recommendations for HIV and behavioral surveillance suitable to different epidemic states. These are the same guidelines that this study is following (Pisani et al., 2003)[18].

5.1 METHODOLOGY

Quantitative and qualitative data collection methods were applied. Quantitative indicators are essential for measuring results and gauging impact while qualitative indicators can provide a more nuanced understanding of results. Most of the questionnaire items consist of quantitative data, such as number of partners, frequency of certain types of behaviours. There are also a number of open questions to help the researchers describe the respondents' feelings and opinions about certain issues, such as the non-use of condoms or their attitudes towards HIV positive persons.

5.1.1 SAMPLING

The selected sampling frame is ***random, stratified, by age, gender and district***. The total sample size is one thousand six hundred and ninety-one individuals (N=1691), from 15 to 64 years.

Sample size for general population (infinite population)

$$n = \frac{Z^2\ 1-\alpha/2\ p\ (1-p)}{d^2}$$

Where,

At 95 % Confidence Interval, Z0.05, $\alpha = 1.96$ p = Prior information; for safest point, overall knowledge of HIV among community people was 80 %,

so "p" = 0.8 1-p = 1-0.8=0.2

d = Effect size (precision),

Assuming over knowledge of community people must have fluctuated in between 1 % point, i.e., (79% to 81%), if so, "d" is expressed as decimal (0.01).

n= $\frac{1.96^2 \times (.02) \times (.02)}{(0.01)^2}$ = 1536.64 **(rounded up to)**= **1537**

The sample is further increased by 10 % to account for contingencies such as non-response recording error and sample attrition.

N + 10% of n = 1537 + 154 = **1691**

Therefore, there were to be total 1691 respondents for KAP survey for general population

However, it is important to note that the data set from the National Census 2010 is made up of the population as it was found in August 2010. Therefore, the selection of the sample was done using people aged 13 to 62 years, to ensure that the sampling frame is correct for 2012.

One thousand six hundred and ninety-one individuals, both Seychellois and foreigners, are thought to be sufficient for the purpose of the study. Foreigners who were part of the National Census 2010 and who are still living in Seychelles at the time of the study in October and November 2012 were considered as eligible for the study. The final sample itself takes into consideration cost, time and practicalities.

The sample frame table is thus as follows:

Table 1: Sample Frame from 2012 Population Estimates

District	Male	Female	Total	% OF TOTAL	Sample size
Anse Aux Pins	1284	1300	**2584**	**4.2%**	**71**
Anse Boileau	1337	1353	**2690**	**4.4%**	**74**
Anse Etoile	1617	1636	**3253**	**5.3%**	**89**
Anse Royale	1384	1400	**2784**	**4.5%**	**76**
Au Cap	1492	1510	**3002**	**4.9%**	**82**
Baie Lazare	1234	1249	**2482**	**4.0%**	**68**
Baie Ste Anne	1734	1755	**3488**	**5.7%**	**96**
Beau Vallon	1425	1443	**2868**	**4.7%**	**79**
Bel Air	946	958	**1904**	**3.1%**	**52**
Belombre	1270	1285	**2555**	**4.1%**	**70**
Cascade	1507	1525	**3032**	**4.9%**	**83**
English River	1463	1481	**2944**	**4.8%**	**81**
Glacis	1273	1288	**2561**	**4.2%**	**70**
Grand Anse Mahé	1055	1068	**2123**	**3.4%**	**58**
Grand Anse Praslin	1257	1272	**2529**	**4.1%**	**69**
La Digue	943	955	**1898**	**3.1%**	**52**
Les Mamelles	908	919	**1827**	**3.0%**	**50**
Mont Buxton	1030	1043	**2073**	**3.4%**	**57**
Mont Fleuri	1120	1134	**2254**	**3.7%**	**62**
Plaisance	1242	1257	**2499**	**4.1%**	**69**
Pointe Larue	1009	1021	**2030**	**3.3%**	**56**
Port Glaud	884	895	**1779**	**2.9%**	**49**
Roche Caiman	1201	1215	**2416**	**3.9%**	**66**
St Louis	1070	1082	**2152**	**3.5%**	**59**
Takamaka	943	955	**1898**	**3.1%**	**52**
Total	**30628**	**30997**	**61625**	**100.0%**	**1691**

5.2 INCLUSION CRITERIA

(i) All persons selected who are aged 15 to 64 years;
(ii) All persons who meet the first criterion who are present at the time of the enumerator's visit and who consent to take part in the study.
(iii) All persons who have not been interviewed before and who meet criteria (i) and (ii).
(iv) All minors for whom parental consent has been sought and given.
(v) All persons who are sober enough to answer questions.
(vi) All persons who are mentally able to understand the questions.
(vii) All persons who meet criteria (i) to (vi) and can understand Seychellois, Mauritian and Reunionais Creole and / or English and / or French. There is mutual understanding between the enumerator and the respondent and thus, the interview can be conducted.

5.3 EXCLUSION CRITERIA

(i) **Any person aged 14 years and below and 65 years and above at the time of the study period, i.e., from** the beginning and end of October 2012 – the ***data collection period***, are automatically be rejected from the sample.

(ii) All persons selected by the computer, but who are not physically present during the data collection period living or travelling abroad or on outer-lying islands are also be excluded from the sample.
(iii) All persons who refuse to participate in the study. To compensate for this, at least 10% has been added to the sample.
(iv) All persons who are mentally incapacitated to answer the questions, including those who are under the influence of alcohol and / or other drugs.
(v) All minors for whom parental has not been sought or has not been given for their participation.
(vi) All persons for whom more than three visits are needed to obtain their participation in the study.
(vii) All persons unable to understand the principles, objectives and methods of the survey and thus unable to give informed consent.
(viii) All persons who have already given a biological sample.
(ix) All persons who do not understand any of the following languages (Seychellois, Mauritian and Reunionais Creole, English and French) and thus there is no mutual understanding between the enumerator and the respondent.

5.4 ENROLMENT OF MINORS

The enrolment of minors is done only with the following procedures.

(i) The legal guardians or the parents are asked for permission to interview their child, in the presence of the child.
(ii) If the parents or legal guardians refuse, then the proceedings are ended.
(iii) If the parents or legal guardians give their consent, then the child is asked to give his or her consent. After both have given consent, the interview takes place in private with the child.
(iv) If a parent or legal guardian gives their consent for HIV testing, then the child is asked to give his or her consent. After both have given consent, then the drawing of blood takes place. If the parent or legal guardian refuses to give consent for the biological sample, then the proceedings are ended.

Minors are included in the study as this meets criteria for the following international obligations:

(a) Millennium Development Goals

The key goal is No. 6 which is to: "*Combat HIV/AIDS, malaria and other diseases".* The main target is No. 7:"*Have halted by 2015 and begun to reverse the spread of HIV/AIDS*". The indicator is: ***Condom use rate of the contraceptive prevalence rate*** which is the number of women aged 15–49 years in marital or consensual unions who are using contraception by using condoms as a proportion of all of women of the same age group in consensual unions who are, or whose sexual partners are practising, any form of contraception.

The second indicator is: ***Condom use at last high-risk sex*** which is described as the %age of young people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner in the last 12 months.

The third indicator is: ***percentage of population aged 15–24 years with comprehensive correct knowledge of HIV/AIDS*** which is the share of women and men aged 15–24 years who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission and who know that a healthy-looking person can transmit HIV.

The fourth indicator is: ***contraceptive prevalence rate*** which is the %age of women and men who are using, or whose sexual partners are using, any form of contraception including condoms and natural methods. It is usually reported for men and women age 15–49 in marital or consensual unions.

Another goal is No. 8: *Develop a global partnership for development*. The key target is: *In cooperation with developing countries, develop and implement strategies for decent and productive work for youth.* The indicator is the ***Unemployment rate of young people aged15–24 years*** which is the number of unemployed people ages 15–24 divided by the labour force of the same age group. This is covered in the demographics section of the questionnaire, with questions No.5 and No. 6.

(b) Global AIDS Response Reporting

There are numerous indicators for the Global AIDS Response Reporting. The table below gives the list of indicators.

Global AIDS Reporting Indicators
Percentage of young men and women aged 15-24 who are HIV infected, disaggregated by age groups (15 to 19 years and 20 to 24 years) and gender
Percentage of young women and men aged 15–24 years who have had sexual intercourse before the age of 15 years
Percentage of women and men aged 15–64 years who have had sexual intercourse with more than one partner in the last 12 months
Percentage of women and men aged 15–64 years who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse
Percentage of women and men aged 15–64 years expressing accepting attitudes towards people living with HIV
Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
Percentage of women and men aged 15–64 who received an HIV test in the last 12 months and who know their results
Sexually active young women and men aged 15- 24 years who received an HIV test in the last 12 months and know their results.

The SADC Protocol and Indicators and the Seychelles National Indicators also follow all of the Global AIDS Reporting ones, as well as the MDGs. All these mechanisms request that data is collected on minors, aged 15 to 17 years.

5.5 LIMITATIONS OF THE STUDY

This study is subject to a number of limitations which are listed below.

Behavioural Study

(a) Given the nature of the questions asked and their potential sensitivity of the issues raised, it is expected that there might be unwillingness of potential respondents to participate in the survey as a whole resulting in a somewhat lower response rate compared to surveys on less sensitive issues. Moreover, these same sensitive questions may not be answered, leading to a lower sample for these, in particular.
(b) The questions are drafted in English, but it is expected that from more than 90% of the respondents, the questions are asked in Creole. The enumerators may have some difficulty, in spite of training, to conduct the interview in a flowing manner, with few or no hesitations, which may cause the respondent to feel that the process is less credible than it is. In such cases, they are likely to respond in a socially acceptable manner to some of the questions on sexual behaviour or refuse to answer these.
(c) Some of the questions are open and are coded, depending on the kinds of responses that have been given. While these kinds of questions allow for more description and exploration of certain issues, it is also important to note that answers given might be lost in interpretation if the coding is not exact. Moreover, it is impossible to call back the respondent to seek clarification for the responses given.
(d) Face-to-face interviews can also lead to socially acceptable responses. This fact depends on how the respondents feel about the gender and other characteristics of the enumerators, and their need to be socially acceptable in front of them and not judged by them. Some KAP studies allow for self-administration for sensitive questions. However, for this survey, it has been decided that this practice is impractical, implying going back to collect the form or asking participants to drop it at a specific point or to post it. It might imply further costs. Therefore, enumerators were given training to ensure that they are able to remain professional and impassive when answers which may shock them in other spheres of their own lives are given to them during the survey.
(e) All persons unable to understand any of the following languages: Seychellois, Mauritian and Réunionnais Creole, English and French. If the enumerators cannot understand the language of the participant, then he or she is excluded.
(f) All persons unable to understand the principles, objectives and methods of the survey and thus unable to give informed consent.

4.5.2 BIOLOGICAL SURVEILLANCE

(a) It is expected that more attrition of the sample may occur when it comes to collecting biological samples for testing. It might not be possible to relate specific individual behaviour patterns to results obtained for HIV and other STIs. Enumerators were trained to ensure that they are able to present the study in such a way that potential participants do see the benefits of their participation.
(b) All persons unable to understand any of the following languages: Seychellois, Mauritian and Réunionnais Creole, English and French are being excluded from the study. If the enumerators cannot understand the language of the participant, then he or she is excluded.
(c) All persons unable to understand the principles, objectives and methods of the survey and thus unable to give informed consent.
(d) All persons who have already given a sample.
(e) All persons who refuse to take part in the study.
(f) All minors for whom parental consent was not given.
(g) All persons not meeting the age criteria.

(h) All persons who are under the influence ofillicit drugs or alcohol or other substances, or who do not fully understand the informed consent procedures, were not be enrolled in the study.

5.6 INSTRUMENTS

The selected instrument for behavioural surveillance is a questionnaire administered in a face-to-face interview with the following details given below. The questionnaire is in appendix 4.

Section	Number of Questions
0: Questionnaire Identification Data	
1: Background characteristics	16 (Q1 to Q16)
2: Knowledge, opinions, and attitudes towards HIV/AIDS	22 (Q17 to 38)
3: Knowledge, opinions, and attitudes towards STIs	11 (Q39 to Q49)
4: Marriages & live-in relationships	8 (Q50 to 57)
5: Sexual history: numbers and types of partners	30 (Q58 to Q87)
6: Sexual history: regular partners	4 (Q88 to Q91)
7: Sexual history: commercial partners	5 (Q92 to Q96)
8: Sexual history: non-regular partners	5 (Q97 to Q101)
9: Female and Male condoms	17 (Q102 to Q118)
TOTAL NUMBER OF QUESTIONS	118

5.6.1 Pre-testing

The questionnaire was meant to be pre-tested with a sample of 40 persons to have 4 persons, 2 males and 2 females, in each of the age-groups, at Perseverance 1 and 2. The sites are chosen because the persons living there, whilst they were counted as part of the 2010 Census, are nowliving in a new district altogether. There is less likelihood of their being present in the final sample. Based on the findings, the questionnaire was re-drafted to incorporate the necessary changes.

The pre-test involved interviewing 31 persons (12males and19 females) and the questionnaire was then adjusted accordingly.

The biological sampling protocol was also rehearsed and any issues (consent form, timing, and handling participants' concerns) that arose were taken into consideration and changes required were made.

5.7 ETHICAL CONSIDERATIONS

To ensure the highest level of respect for ethics, the study addresses the following issues as follows.

5.7.1 Informed consent

All participants are given the opportunity to give informed consent. The forms for both parts of the study are in Appendix 1. No participant is obliged in any way to participate in the study. For those who are less than 18 years of age, parental and / or guardian consent is sought, as well as their own permission to proceed.

The information is read out to the respondents (parents and guardians). Their understanding of the content and issues is checked through questioning and probing by the enumerators. If the latter decide that the respondent has truly understood the meanings, issues and contents of the informed consent forms, then they sign on behalf of the respondents (parents and guardians) to ensure that no name or possible personal identifiers can be linked to them.

There are three informed consent forms:

(a) One for the behavioural surveillance in English and Seychellois Creole for adults
(b) One for the behavioural surveillance in English and Seychellois Creole for minors
(c) the biological surveillance in English and Seychellois Creole for adults and minors

5.7.2 Confidentiality and privacy

All questionnaires have a unique number to allow researchers to identify the participant to allow linkage of behavioural and biological data. However, no names are used at any time. Enumerators who are relatives of participants are not allowed to interview them.

All test specimens, results and behavioral data are linked through a unique number. No personal identifiers are collected.

All blood samples are kept under lock and key with only the assistant researcher and the laboratory technicians engaged in testing at the laboratory of the Ministry of Health having access to them. The samples are not identified in any way to the individual participant through personal identifiers.

Participants are provided with their unique 4 identifier number after blood sample have been taken to enable them to trace their results at CDCU.

5.7.3 Withdrawal

All participants have the right to withdraw at any time in the study, with no pressure from staff or enumerators or having to explain their decision. This aspect is also reiterated strongly to participants during the informed consent phase.

5.7.4 Risks to participants

There are some risks involved for the participants and these are explained to them. Some of these risks are low or very low. The risks include pain from drawing blood, possible infections, possible allergies to chemicals used for cleaning the arm, as well as fear and anxiety about the drawing of the blood samples and the whole processes associated with the study.

5.7.5 Risks to interviewers and HTC nurses

As the HTC nurses are carrying needles and syringes with them as they go about to interview the potential respondents and return to regional bases, there is some risk associated with this. With the issue of drug abuse and PWID, it is important to ensure that there is adequate security for the data collectors and the HTC nurses. Therefore, all home visits are conducted as follows:

(a) The data collection team, composed of the enumerator and the HTC nurse, is taken by car from the regional base or site to a central point or to the addresses or to a point near the targeted addresses for that day.

(b) They are also given the telephone numbers of the regional supervisor, the driver, the lead and assistant investigators in case of any problem.

(c)They received training on how to assess the security situation of the sites where they are working and to take avoidance actions immediately by returning to the regional base or site if the situations warrant such actions. They can call the driver to pick them up immediately.

(d) An occurrence notebook is also kept with the regional supervisor to ensure that the incidents are properly recorded and assessed through weekly debriefing meetings.

Exposure to blood borne pathogens remains a significant occupational hazard to all Health Care Workers. The risk of acquiring HBV infection from occupational exposure is at least 30% from a percutaneous or mucosal exposure to blood and body fluids from a patient with acute or chronic HBV infection (Zimmerman & Middleton 2007)[19]. Indeed, all HCWs are at risk of contact with blood and human secretions, as well as needle stick injuries. This can happen to any HCW, such as those those working in operating rooms and clinical laboratories, respiratory therapists, surgeons, doctors, dentists, as well as medical, dental and nursing students (Smelzer and Bare, 2003)[20]

Therefore, the PEP procedures are as follows. Universal precautions apply, such as hand washing, decontamination of equipment and devices, use and disposal of needles and sharps safely (no recapping), the wearing protective items, prompt cleaning up of blood and body fluid spills and systems for safe collection of waste and disposal.

However, should there be an exposure of any kind, the following procedures are used:

5.7.5 (a) Immediate steps post-exposure

- Wash exposed wound or skin with soap and water
- For needle or sharp injury, allow to bleed for a few seconds before washing
- Inform supervisor and lead investigator of type of exposure and the actions taken
- Assure confidentiality to the HTC nurse
- Ensure support and referral for treatment

The supervisor shall ensure that the HTC nurse is picked up from site to be taken to CDCU to initiate treatment. The respondent number and questionnaire numbers are noted. When the blood tests have been done, further action is as follows:

(a) Should the source person be HIV negative, discontinue PEP and retest at 6 weeks, 3 months, and 6 months;
(b) Should the source person be HIV positive, then the HTC nurse is counselled, supported, and referred for continued treatment using the standard PEP regimen.
(c) The respondent is still free to seek his or her results, should he or she wants to.

5.7.5 Inducements

There was no payment to respondents for either the behavioural or the biological surveillance study.

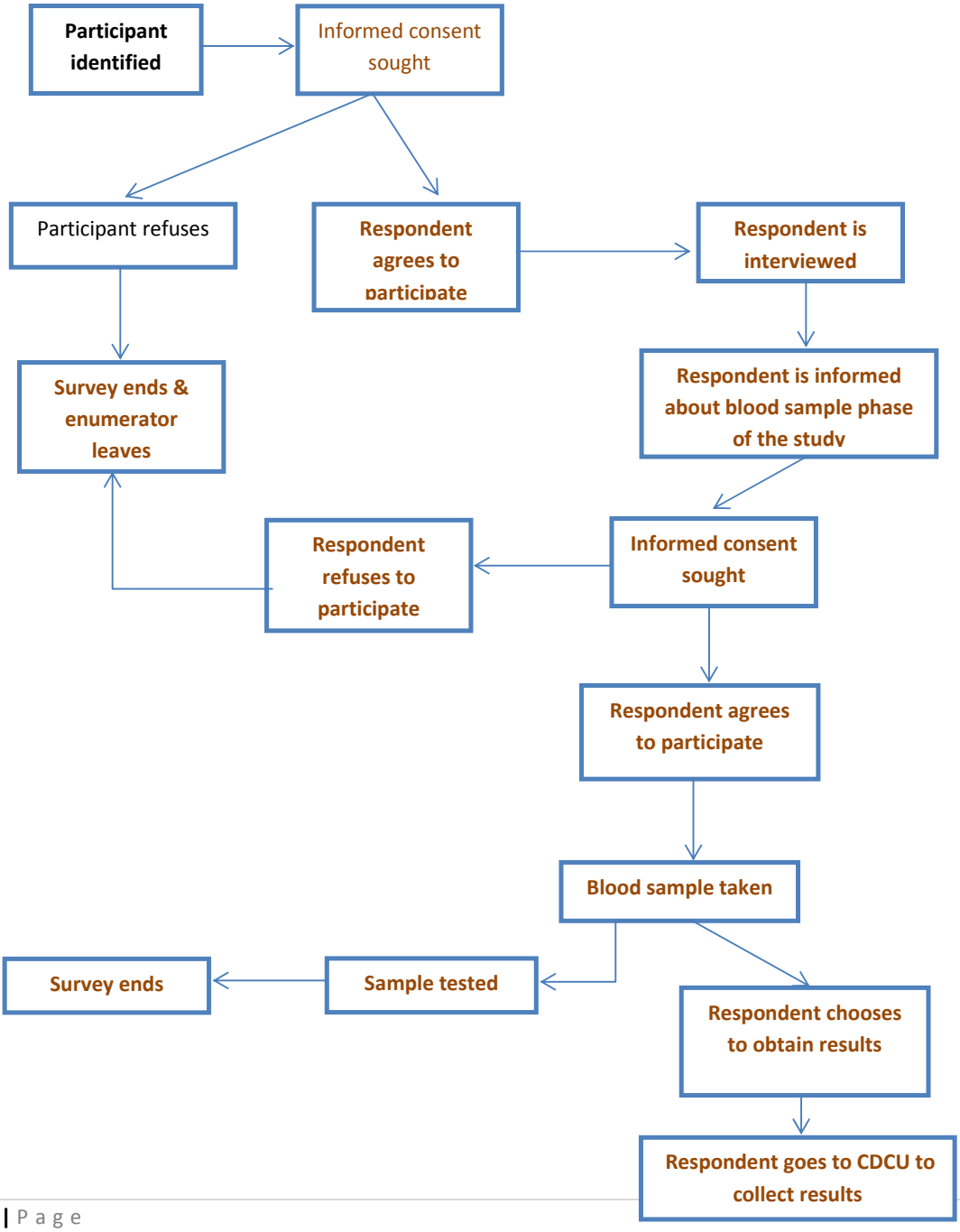
PART III DATA COLLECTION AD PROCEDURES

6.0 DATA COLLECTION PROCEDURES

There are two main parts to the data collection phase. The first one is the behavioural surveillance interview using the questionnaire and the second part is the drawing of the blood sample for testing for HIV and STIs. This phase was meant to take place during 31 days, from 01st October to 30th October 2012. However, the research extended the period for another threedays up to 03rd November to allow the data collection team a little more time to find respondents, such as transfers to otherdistricts.

The procedure is detailed below in figure 1.

Figure 1: Overall procedure for data collection



The enumerators accompanied by HTC nurses proceeded to the households where the identified individual lives. When he or she was present and agreed to participate in the study, only then was he or she be interviewed. Afterwards, the HTC nurse asked the respondent to give a blood sample of 4ml as only HIV was to be tested. The participants are free to obtain their results, should be they interested to do so, by contacting the CDCU, using their unique numeral identifier.

6.1 STUDY SITES AND PERSONNEL

There was one base – the Ministry of Health, Blue Roof Building, National AIDS Council Secretariat based in the AIDS Control Program Unit for operations and management, as well as storage of data, For data collection itself, there were plans to use four sites in the regional health centres: Anse Royale for South, Anse Boileau for the Western region, Beau Vallon for North, English River for the Central region, Anse Aux Pins for the Eastern region. For the inner islands, Baie Anne Hospital for Praslin and Logan Hospital for La Digue were the bases. During data collection phase, these sites were not used because the supervisors used their cars to collect and transport the enumerators, nurses, questionnaires and blood samples.

Twenty–eight qualified nurses and or midwives conducted HIV Testing and Counseling HTC (pre and post-test counseling) and gave information as well as IEC materials to all respondents. The respondents were free to seek the results of their test after two weeks. To allow them to do that, they had their unique numerical identifier so that staff at CDCU could match their results with them. The Nurse/midwife are also trained in and responsible for providing pre- and post-test information about HIV and other infections, HIV test, and where people can go for additional HIV services. They also collected blood though aseptic techniques label and store the biological specimens for the survey, correct identification of samples, complete laboratory request forms, referral identification number, and other clinical documents.

Surveillance staff, including the regional site supervisors, enumerators, HTC counselors also received special training on how to carry out the surveillance protocol and comply with surveillance procedures.

Laboratory Technicians within the National Clinical Laboratory processed the tests, oversaw specimen storage, and delivered results of the tests to the base. The laboratory technicians and the counsellors received training on the receiving, documentation and standard operational procedures for this project prior to commencement.

Data manager designed the sampling size and database and input data from the questionnaires and forms, with special attention to review and data cleaning before entry to avoid double entry.

6.2 TESTING PROCEDURES

Specimens were collected by trained nurses using standard HTC guidelines and procedures. Universal precautions were observed during blood specimen collection. Four milliliters (4 ml) of venous blood were collected (EDTA Container) from participants using venipuncture. After the specimen was collected, the HTC nurse labelled the specimen container with the questionnaire number and recorded the numbers in the 'specimen log book' and linked with the participant's respondent number identification number.

Specimens collected on sites at the home of respondents were transported (by car in a in a specimen box everyday to the clinical laboratory of the Ministry of Health where experienced laboratory technicians trained for the survey will process the samples).

Collected blood specimen was tested in the clinical laboratory using RAPID screening/Alere. HIV1/2 determines as a first test if the first test is non-reactive the result is to be recorded as HIV- Negative.

If that first test is reactive, a second test is done using HIV1/2 Acon strip test and if still reactive a third test which is a confirmatory test is done using Inno-lia HIV1/2 score and the result is recorded as final HIV status.

All reactive specimens from Praslin and La Digue were transported to the Clinical Laboratory of the Seychelles Hospital for confirmatory test.

All collected specimens were accompanied with their corresponding data collection forms and laboratory request form to the clinical laboratory.

At the laboratory, each blood sample was centrifuged for 5 minutes at 3000 rpm. Two 0.5-ml serum tubes were aliquoted for each sample by laboratory technicians into cryotubes from the vacutainer tube and the total number of cryotubes aliquoted was recorded. One aliquoted serum was used for rapid HIV testing.

Quality assurance testing was performed on all positive samples using HIV Acon and Inno-LIA HIV1/2 score in parallel. The other aliquots were stored at -20^{o}c. At the time of testing only one aliquot per test was retrieved from storage and documented.

The laboratory technician filled the testing worksheet which bear sample ID, date of specimen collection, assigned laboratory number and initials of personnel receiving specimen. Manufacturers' instruction of individual test kit was followed to perform all the testing. Package inserts were included in standard operational procedures.

Proficiency testing was done at the beginning of testing period in each laboratory involved. Quality assurance confirmatory testing was performed on all Reactive samples using Inno-LIA hiv1/2 score (line immuno assay)

Specimens were tested using the national testing algorithms for HIV. Laboratory technicians and the counselors were trained on the receiving, documentation and standard operational procedures for this project prior to commencement.

The remaining serum is stored by the clinical laboratory technician of Seychelles Ministry of Health @-80^{0}C. All results were counterchecked and signed off by a senior Laboratory technician before dispatch. All test results were dispatched within 07 days (two calendar weeks) of sample receipt in the laboratory.

HIV testing was screened using Alere HIV1/2 rapid test strip (Alere medical). Reactive specimens were confirmed using Inno-LIA hiv1/2 score. A standardized laboratory log book was used for recording all test result done in the laboratory.

Storage of specimens for future biological testing

Participants are asked to consent to storage and possible additional testing of blood for new tests for HIV, STIs and any other medical conditions. Specimens may be stored for up to five years at the National Clinical Laboratory. If a researcher wishes to use these specimens in a future survey, they will need to submit a research proposal to the Ministry of Health and the Health Research and Ethics Committee of the same ministry, who will act then on the participants' behalf to weigh the risks and benefits of future testing of specimens. Respondents are informed that they will not be contacted and informed of any of the results obtained from further and future tests.

Table 2 –Specimen collection and laboratory tests

Test	Laboratory	Volume
Specimen: Serum		
Alere HIV-1/2 and HIV 1/2 ; Acon	Rapid tests to be conducted in the Laboratory.	4mls
HIV Quality Assurance: Innolia Line Assay	All HIV Reactive samples will be run in the Clinical Laboratory	

6.3 DATA MANAGEMENT AND ANALYSIS

Hard copies of the questionnaires were transported to the Central Unit for data entry. All data was entered by the data entry clerks and backed-up daily in a Behavioral Surveillance Database created specifically for the study. Data is managed by the survey data manager who will run weekly cleaning and validation programs and provides feedback to the field to carry out appropriate corrective actions.

Sample collection and transport are monitored through paper records. These forms are collected weekly verified by the Data Manager and taken to his office and entered into a database. Test results for HIV are recorded into an HIV results form at the testing sites and results for other infections are recorded at the laboratory and entered locally into a Laboratory Test Result Database. Data errors and missing data are cross-checked against hard copy data where available.

Hard copy and back-up disks of all data are stored in locked file cabinets at the AIDS Control Program office. Databases containing this information, hard copy files and consent forms will be destroyed five years after the completion of the survey.

The data collected was analysed using the software SPSS version 16.0. The software is the latest version and is designed to manage and analyse statistical data.

6.3.1 The data management and analysis plan summary

Verification of the representativeness of the sample compared to the source population
Analysis was done to verify that the number of males and females in the final sample based on exploitable data (responses versus non-responses) represents the source population to a 95% confidence level. This also includes analysis by district and age groups.

Frequency table:
All questions from 1 to 118 are counted in a frequency table. For each question, where appropriate, the non-responses and answers indicating that the respondents did not know the answers are counted. The proportions (number of accepted responses divided by number of respondents) and averages of answers, where appropriate, are also calculated.

This helps to provide an overview of the division of the obtained data, shed light on the composition of the frequency table, allows certain categories to be grouped together and also puts non-responses into figures. The frequency table also aids in highlighting certain inconsistencies.

• **Data comparison / Cross-Tabulations:**
Simple and complex cross tabulations are made. The simpler ones address gender differentials, age differences, as well as those that might occur with the comparison of results for the districts. More complex cross tabulations include the kinds of knowledge and the HIV prevalence. The same applies for types of attitudes, sexual practices and behaviours.

Useful comparisons are also organized where possible, in line with the objectives of the study. For example, specific objective (e) which is to "*Determine the association between HIV and AIDS knowledge, attitudes, practices and behaviour among different age groups*" involves determining the level of knowledge on HIV and the sexual practices of respondents, types of attitudes and sexual practices, types of relationship and types of attitudes. The data can also be compared with the HIV status of respondents to help determine any linkages, as required by specific objective (f) which is to "*determine the possible associations between HIV transmission and risk behaviours across different groups, disaggregated by gender, age groups and district*".

6.4 TRAINING

All persons involved in collecting data were given training based on a training manual, adapted from other AIDS Indicator Surveys (AIS) conducted in Africa. These manuals are used for training data collectors with a focus on informed consent, interview skills and completion of the structured questionnaire in local language, specimen collection and maintaining confidentiality. (Training Manuals available upon request)

Types of Personnel	Training Components
Enumerators	Questionnaire review & practice, data collection standard operating procedures and protocols, with practice of informed consent forms, communication/counselling skills, ethical issues, such as confidentiality, privacy, respect and professionalism.
Nurses	Standard operating procedures for blood draw &sampling, pre and post-test counselling, review of consent forms, handling parents & minors and other respondents, ethical issues: professional behaviour, confidentiality, privacy and respect. Information on treatment sites, making referrals and HIV and other STIs.
Laboratory technicians	Instructions on standard operating procedures

PART IV RESULTS AND DISCUSSION

7.0 RESULTS

7.1 Status of questionnaires

The proposed total sample was 1691. A total of 1185 or 70% are returned valid questionnaires; therefore there has been a sample attrition of 30%, which is considered acceptable given the extreme personal nature of the study.

The KAP Study 2003 analysed 1706 questionnaires. However, cluster sampling method was used compared to simple random sampling in 2012.

Table 7.1 below gives a summary of the status of potential respondents. There is a high heterogeneity of the sample. There is a lot of mobility as well. Some respondents were not available due to their own death (14), of having left the country for good (12), not able to be located or even of having been transferred to outer-lying islands. Still other potential respondents (total of 69; 18 females and 51 males) were either out of the country for a protracted period of time, extending over the time limits given for data collection.

Other persons chose to respond to the questionnaires, but then refused to give a blood sample or some refused to participate in the survey in its entirety (total of 111; 47 females and 64 males). A number of respondents were not found in the district identified as per the 2010 census. Some could be found in other districts, but others could not be located at all. Even district administrators did not know where they were presently located. (Table 7.1)

TABLE 7.1: Status of questionnaires and respondents

QUESTIONNAIRE STATUS	F	M	TOTAL
Completed	630	532	1162
Address Unknown	57	74	131
Refusal	50	73	123
Overseas	18	51	69
Questionnaire Not Received	35	31	66
Transfer	19	22	41
Not Available	9	28	37
Partially Completed	20	5	25
Dead	5	9	14
Left Seychelles	0	12	12
Unable To Respond Due To Disability	3	9	12
Completed?	1	0	1
In Prison	0	1	1
TOTAL	847	847	1694

7.2 Socio-demographic Characteristics of Respondents

Of the 1185 valid questionnaires returned, i.e., questionnaires that could be used for analysis, there are 1133 Seychellois (95.6%); of whom 514 (45.3% of Seychellois respondents) are males and 619 (54.6% of Seychellois respondents) are females. The other nationalities that are most common in the sample is Indian with 19 persons (1.6% of valid questionnaires) in total (12 males and 7 females) and Malagasy with 10 persons or 0.84% in total (2 males and 8 females). The other nationalities include 5 Philippinos, 4 Africans and 4 other Asian groups. Four respondents did not state their nationality.

In 2003, Seychellois was also the majority population with 98%.

In total, there are fewer males than females who agreed to participate in the survey, with 538 males and 647 females or 45.4% compared to 54.6%. In the Indian group, more males chose to participate to a ratio of 2:1, with 13 males compared to 6 females. In the KAP Study of 2003, there were 941 females or 55.1% and 765 males or 44.8%.

TABLE 7.2: Number of respondents by sex and nationality

		Sex of respondents		**Total**	**%**
		Male	***Female***		
Nationality	Seychellois	514	619	1133	95.6
	Indian	12	7	19	1.6
	Sri Lankan	0	1	1	0.1
	Mauritian	0	1	1	0.1
	Malagasy	2	8	10	0.8
	Philippino	4	1	5	0.4
	British	0	1	1	0.1
	Other Africans	1	3	4	0.3
	Other Asians	2	2	4	0.3
	Other Europeans	2	1	3	0.3
	Not Stated	1	3	4	0.3
Total		**538**	**647**	**1185**	**100.0%**

The respondents come from all districts of Mahé, Praslin and La Digue. The five districts with the largest number of potential respondents in descending order are Baie Sainte Anne, Praslin (96), Anse Etoile (89), Cascade (83), Au Cap (82) and English River (81). On the other end of the scale, the five districts with the lowest population sample in the study are Bel Air, Les Mamelles and Takamaka with 52 potential respondents, Pointe Larue (56) and Mont Buxton (57) (Figure 7.1.)

The five districts with the most respondents per sample size who agreed to participate in the study are in descending order Anse Boileau (87.8%), Baie Sainte Anne (83.3%), Grand Anse Praslin (81.2%), Mont Fleuri (80.6%) and Plaisance (78.3%). The five districts with the weakest response are in ascending order Les Mamelles (51.9%), English River (55.6%), Baie Lazare (57.4%), La Digue (58.0%) and Roche Caiman (59.1%). In all five cases, the enumerators and nurses lost almost 50% of the potential respondents through a number of situations mentioned above (Table 7.3).

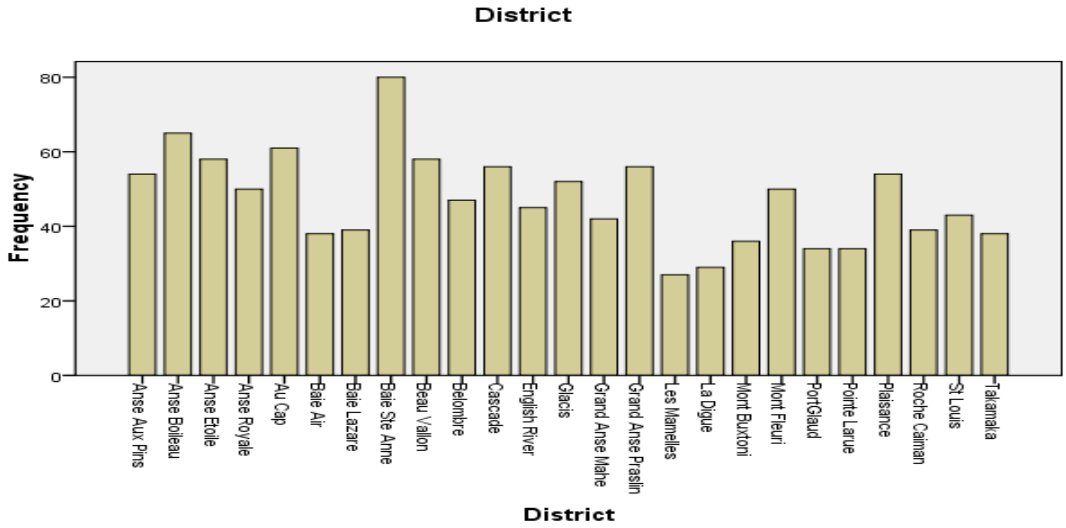


FIGURE 7.2: Respondents by district

TABLE 7.3.1: Sampling size and level of response per district

District	Proposed Sample Size	Number of Valid Q Returned	% of Valid Q Returned per District	% of Valid Sample
Anse Aux Pins	**71**	54	76.1	4.6
Anse Boileau	**74**	65	87.8	5.5
Anse Etoile	**89**	58	65.2	4.9
Anse Royale	**76**	50	65.8	4.2
Au Cap	**82**	61	74.4	5.1
Bel Air	**52**	38	73.1	3.2
Baie Lazare	**68**	39	57.4	3.3
Baie Ste Anne	**96**	80	83.3	6.8
Beau Vallon	**79**	58	73.4	4.9
Belombre	**70**	47	67.1	4
Cascade	**83**	56	67.5	4.7
English River	**81**	45	55.6	3.8
Glacis	**70**	52	74.3	4.4
Grand' Anse Mahé	**58**	42	72.4	3.5
Grand' Anse Praslin	**69**	56	81.2	4.7
Les Mamelles	**52**	27	51.9	2.3
La Digue	**50**	29	58.0	2.4
Mont Buxton	**57**	36	63.2	3
Mont Fleuri	**62**	50	80.6	4.2
Port Glaud	**49**	34	69.4	2.9
Pointe Larue	**56**	34	60.7	2.9
Plaisance	**69**	54	78.3	4.6
Roche Caiman	**66**	39	59.1	3.3
St Louis	**59**	43	72.9	3.6
Takamaka	**52**	38	73.1	3.2
Total	**1691**	**1185**		**100**

Most respondents, as indicated in Figure 7.2, come from the Eastern region of Mahé, followed by the Northern and Central regions. The lowest number of respondents comes from La Digue, which is the district with the smallest population in any case.

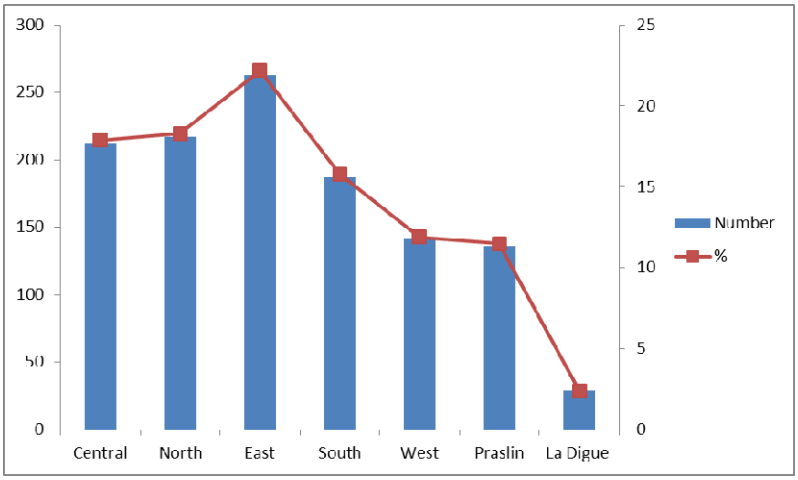


FIGURE 7.3.2: Respondents by region

The highest level of education attained by the respondents is shown in table 7.4. Most respondents (489 or 41.3%) had completed their post-secondary education either in technical (234 or 19.7%) or academic studies (255 or 21.5%) compared to those who had finished secondary school (470 or 39.7%). There were 96 (8.1%) persons who had finished schooling at primary level, whilst 28 (2.4%) had completed A' Levels studies, 45 (3.8%) have a diploma, 30 (2.5%) have a first university degree, 10 (0.8%) have a Masters' degree and 1 (0.1%) respondent has a doctorate.

TABLE 7.4: <u>Level of Education</u>

Highest educational level		
	Frequency	**%**
Primary	96	8.1
Secondary	470	39.7
Post-Secondary/Technical	234	19.7
Post-Secondary Academic	255	21.5
A Levels	28	2.4
Diploma	45	3.8
Bachelor	30	2.5
Masters	10	0.8
Doctorate	1	0.1
No Data / Values	16	1.4
Total	**1185**	**100**

Most respondents are skilled workers, mainly masons, carpenters and mechanics (352 or 29.7%), followed by semi-professional workers such as clerks, secretaries, assistant accountants and office managers (190 or 16.0%) and unskilled workers (158 or 13.3%). Semi-skilled workers, such as apprentices to masons, carpenters and mechanics account for 9.8% of the sample (116), whilst students make up 9.1% (108), professionals 7.5% (89), retired or pensioners 2.6% (31) and the unemployed 10.2% (121). Of the sample, 20 respondents (1.7%) did not state their present occupation.

TABLE 7.5: Respondents' occupation

Occupation Groups		
	Frequency	**%**
Professional	89	7.5
Semi-professional	190	16
Skilled	352	29.7
Semi-skilled	116	9.8
Unskilled	158	13.3
Pensioner/Retired	31	2.6
Student	108	9.1
Unemployed	121	10.2
Not Stated	20	1.7
Total	**1185**	**100**

Most of the respondents (947 or 79.9%) were Roman Catholics followed by other Christian denominations (103 or 8.7%), such as Anglican (78 or 6.6%), Seventh Day Adventists (20 or 1.7%), Assemblies of God (9 or 0.8%) and other Christians (46 or 3.9%). The sample was also composed of 17 (1.4%) Hindu, 13 (1.1%) Muslim, and 5 (0.4%) Baha'i respondents (Figure 7.3).

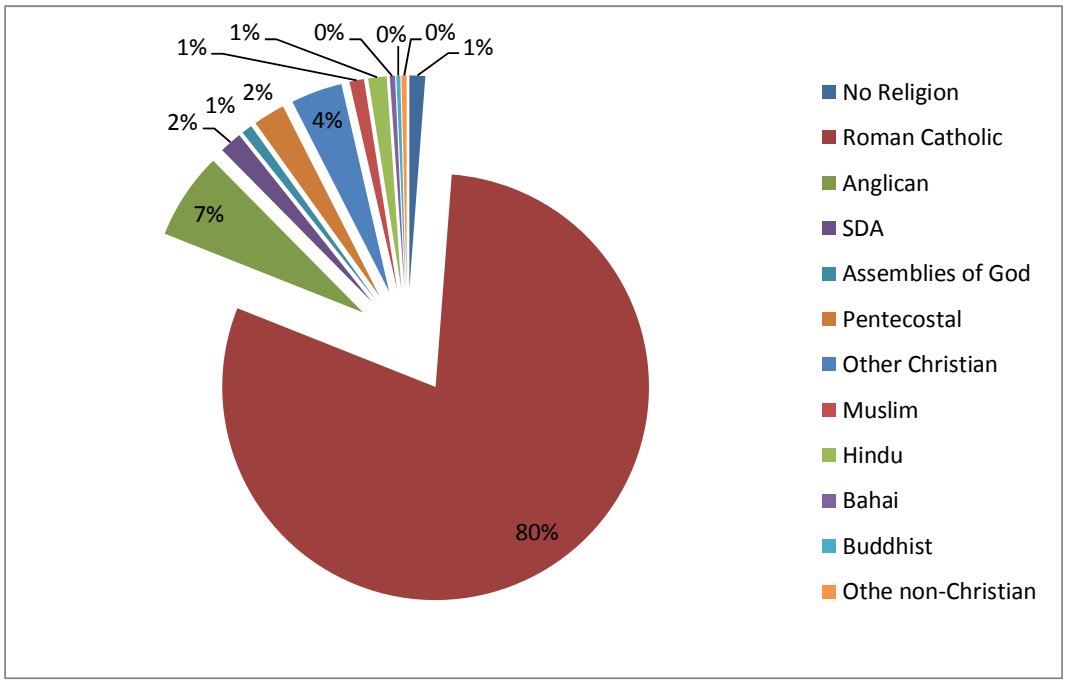


FIGURE 7.3.4: Respondents by religion

Other characteristics of the sample - Alcohol and Drug Use

The questionnaire also probed for information about the use of alcohol and other drugs. For alcohol, most of the respondents (888 or 74.9%) drink alcohol. At any one sitting, 158 (13.3%) respondents have only 1 drink, 205 (17.3%) of them report having 2 drinks, 155 (13.1%) have 3 drinks and 111 (9.4%) have 4 drinks. At least 230 (19.3%) respondents have 5 drinks or more at any one time of whom 100 (8.4%) have 5 drinks and 130 (10.9%) have more than 5 drinks (Figure 7.4 and Table 7.6).

Respondents and Alcohol use

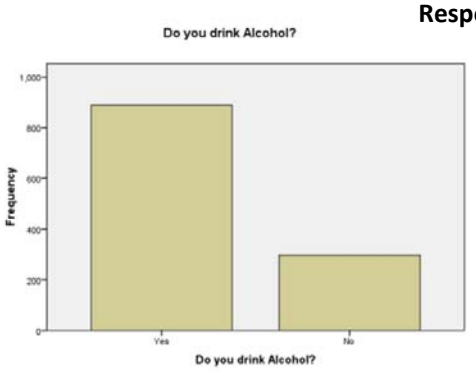


FIGURE 7.4: Respondents' alcohol use

TABLE 7.6: Alcohol drunk at one sitting / occasion

Amount drunk	Frequency	%
A single drink	158	13.3
2 drinks	205	17.3
3 drinks	155	13.1
4 drinks	111	9.4
5 drinks	100	8.4
More than 5 drinks	130	10.9
DK / NR	326	27.6
Total	**1185**	**100**

7.3 Illegal Drug use

The most common illegal drug of choice is cannabis in its herbal form or marijuana which has been used at least once by 145 or 12.2% of respondents of whom 118 (9.9%) are males and 27 (2.3%) are females. In its resin form or hashish, there are 76 or 6.4% of respondents who have ever tried it with 62 males (5.2%) and 14 females (1.2%). It is interesting to note that 58 or 4.9% of participants used drugs of any type in the last month of whom 49 (84.5%) were males and 9 (15.5%) were females (n=58).

In 2003, 11% of males who reported drug use confirmed that they had tried marijuana before compared with 1% of females. Hashish had been tried by 7% of males compared with 0.3% females. The use of cannabis amongst males seem to have remained fairly constant with a slight decrease in the general population compared to the clusters in 2003. However, for females for both types of cannabis, there has been a slight increase from 1% to 2.3% for marijuana and for hashish, from 0.3% to 1.2%.

7.4 Injecting drug use

Illegal drug use is minimal in the sample, with 1026 or 86.6% persons reporting not using drugs at all (cf. Figure 7.5). There are 6 or 0.51% respondents who report injecting drug use in the last 12 months. They had also started quite young, with reported ages being 12, 13, 17 and 20 for four of them. As for the two others, they had started at 25 and 30 respectively. Three respondents have reported using heroin every day.

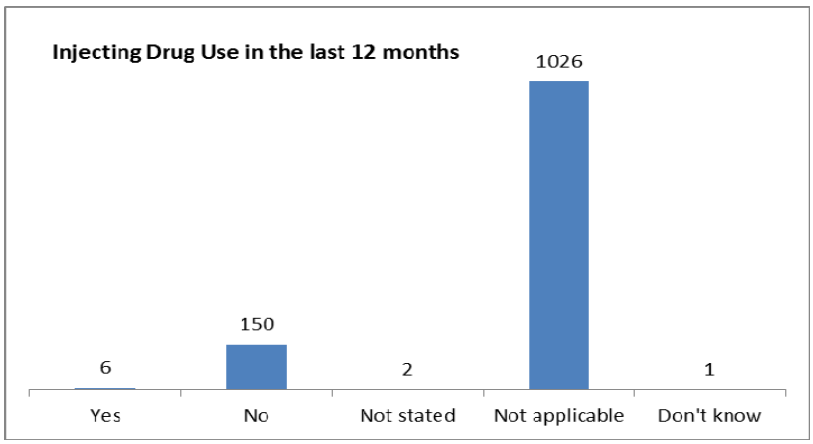


FIGURE 7.5: Injecting drug use in the last 12 months

7.5 STI Knowledge

Most respondents (1010 or at least 85.2%) report that they know about diseases that can be transmitted through sexual intercourse whereas 117 of them (9.9%) say that they do not know of such diseases (Table 7.7).

TABLE 7.7: Knowledge of STIs

	Frequency	**%**
Yes	1010	85.2
No	117	9.9
DK / NR	58	4.9
Total	**1185**	**100**

In the KAPB Study of 2003, regarding symptoms and signs of STIs in males, "*both males and females mentioned genital discharge (38%) as the most frequent symptom, followed by burning pain on urination (32%), genital ulcers/sores (18%) and swelling in groin area (11%)*"(KAP 2003). As for signs and symptoms of the disease in females, "*both males and females mentioned genital discharge as the commonest symptom*" (KAP 2003).

Some of the respondents have also experienced having an STI. Hence, 32 or 2.7% (5 males and 27 females) report having had an abnormal and unusual genital discharge during the past 12 months and 8 or 0.7%, with an equal number of males and females, report having had a genital ulcer and or sore during the past 6 months.

In 2003, there were reports of genital ulcers in the past 12 months in 1% of respondents among those who had sex were reported, with no difference by sex. The KAP Study 2003 also notes that "*However, among males, 86%*

of the reported cases were among married or persons living with a regular sexual partner, while among females 67% were among singles."

The KAPB Study 2012 also probed for health-seeking behaviours among those who have reported having a sign or a symptom of an STI. For those who had an abnormal and unusual genital discharge during the past 12 months, 25 respondents (5 males and 20 females) sought treatment from any source – a hospital, a private health facility or a traditional healer and 17 of them (68%) waited an average of 1 week before seeking advice and or treatment.

Table 7.8 shows that 2 (8%) respondents chose to wait for more than a week but less than a month and 3 (12%) decided to wait for more than a month of experiencing the symptoms before seeking medical help. Of the 25 persons, they all received prescriptions and medicines, but one person (a female) did not take all of the medication claiming that she felt better.

TABLE 7.8: Health-Seeking Behaviour for STIs

Health-Seeking Behaviour of Respondents having an abnormal and unusual genital discharge during the past 12 months			
Situation	**Males**	**Females**	**Total**
Seek treatment	5	20	25
Waited a week	2	15	17
Waited more than 1 week	2	0	2
Waited more than 1 month	1	2	3
Not Stated (length of wait)	1	4	5

7.6 HIV Knowledge and Source of Information

Most of the respondents (1179 or 99.5%) report having heard of HIV and AIDS, whilst very few of them (5 or 0.4%) indicate that they have never heard of the disease. Four of the 5 persons are males and 1 is a female; 3 are skilled workers, 1 is a semi-skilled worker and 1 is a semi-professional. All 5 have a negative blood result (Figure 7.6).

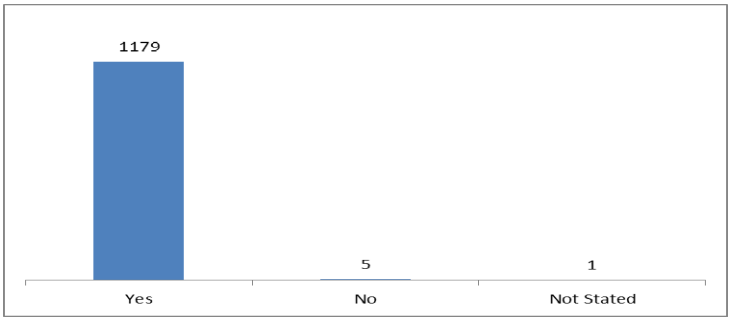


FIGURE 7.6: Awareness of HIV and AIDS

In 2003, 99% of respondents also indicated that they had heard of HIV and AIDS.

When it comes to the source of information about HIV and AIDS, interestingly, only 275 (23.2%) respondents mention the Ministry of Health as the primary source of information, compared to 252 (21.2%) who indicate

the source as newspapers and magazines and 220 (18.5%) who obtain information from relatives, friends and peers. Few people get their information about HIV and AIDS from other ministries (74 or 6.2%), private health facilities (39 or 3.3%), the Internet (38 or 3.2%), NGOs (27 or 2.3%), workplace (16 or 1.4%) and traditional healers (10 or 0.8%).

Indeed, most people (981 or 82.7%) obtain their information about the disease from radio and television. A popular source for the younger respondents (137 or 11.6%) is the school (Figures 7.7 and 7.8).

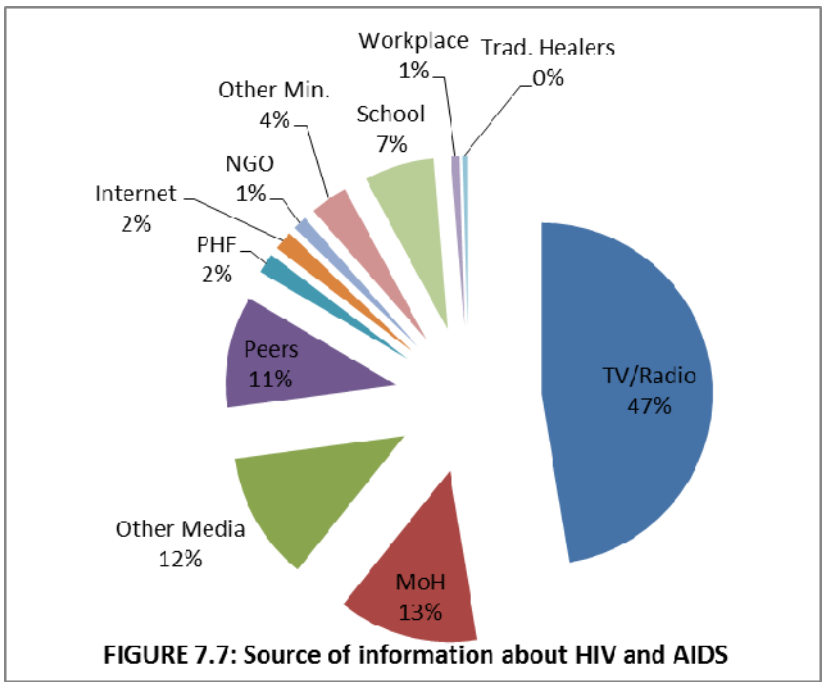


FIGURE 7.7: Source of information about HIV and AIDS

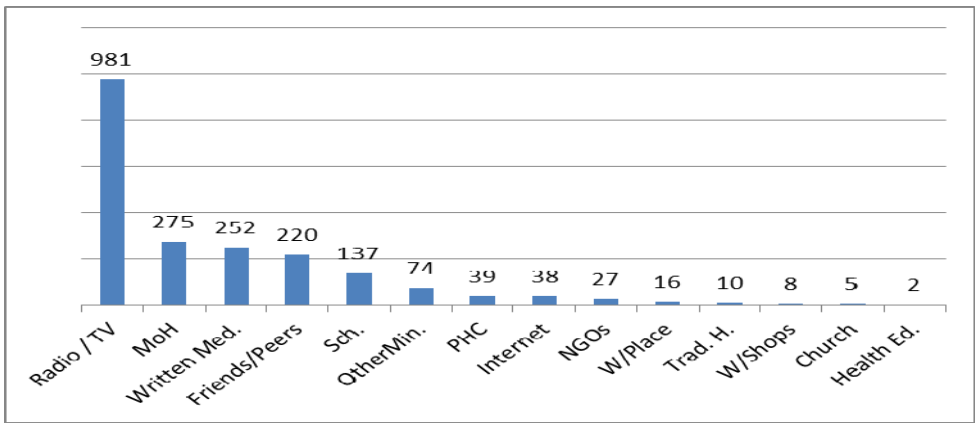


FIGURE 7.8: Source of Information about of HIV and AIDS

Most people, 52.1% or 617, as indicated in Table 7.9, know of a PLHIV or of a person who has died of AIDS-related diseases. There are 256 (41.5%; n=617) males and 361 (58.5%; n=617) females.

In 2003, the figure was 46%.

TABLE 7.9: Knowledge of PLHIV

	Yes	No	DK / NR	Total
Male	256	260	24	540
Female	361	262	22	645
Total:	**617**	**522**	**46**	**1185**

7.7 HIV Testing Knowledge and Behaviours

More than half of the sample (697 or 58.8%) has had a HIV test done whereas 480 or 40.5% have never tested, 3 (0.25%) persons indicating that they do not know whether they have done so and 5 (0.42%)not answering the question. More females (441 or 63.3%; n=697) compared to 256 males (36.7%; n=697), by a ratio of 2:1 have done a HIV test before (Table 7.10).

These figures are similar when compared with the findings of 2003. The KAP Study 2003 notes that "*Females (63%) had more frequently been tested for HIV than males (p<0.0000) and also more likely to be voluntarily tested, although the difference was not statistically significant. Approximately 15% of males did not look for the HIV test result, compared with 21% among females (p>0.05).*"

Whilst the figures for females have remained constant, for males they have more than doubled with 36.7% now having had done a HIV test before.

In terms of highest level of education attained, table 7.9 below shows that the tests are most common amongst respondents with higher than primary education attainment. In the case of those with post-secondary education, more than half have done an HIV test, e.g., secondary with 50.4% (n=470), post-secondary technical with 59.4% (n=234), post-secondary academic with 69.8% (n=255) and respondents who are graduates with 87.8% (n=41).

TABLE 7.10: Lifetime HIV testing (Ever had a test)

	Yes	No	DK / NR	Total
Primary	46	50	0	96
Secondary	237	230	3	470
Post-Secondary Technical	139	92	3	234
Post-Secondary Academic	178	75	2	255
A Levels	17	11	0	28
Diploma	37	8	0	45
Bachelor	26	4	0	30
Masters	9	1	0	10
Doctorate	1	0	0	1
DK / NR	7	9	0	16
Totals:	**697**	**480**	**8**	**1185**

At least 33.9% (402) of the sample do not believe that HIV tests are confidential compared to 52.6% (623) who believe that they are so, whilst 12.7% (151) indicate that they do not know and 0.7% either do not state (4 or 0.3%) or respond to the question (5 or 0.4%). There seems to be a degree of mistrust about the tests' confidentiality (Figure 7.9).

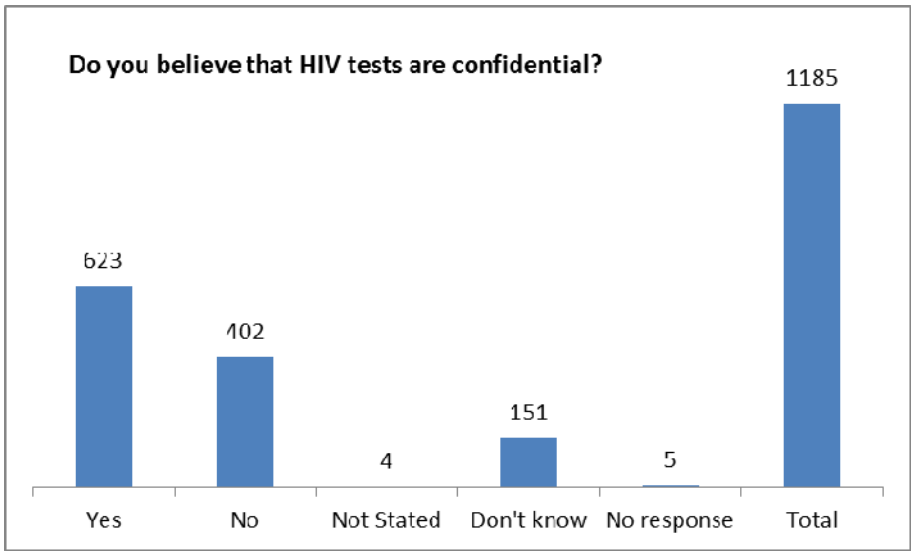


FIGURE 7.9: Belief in the Confidentiality of HIV Tests

For 456 or 65.8% (n=693) of those who have done a HIV test, it was voluntary whilst for 237 or 34% (n=693), it was required. This question was left with no answer for 4 respondents (1%). It is also interesting to note that 6% or 44 persons who have done a HIV test chose not to get their results (Figure 7.11).

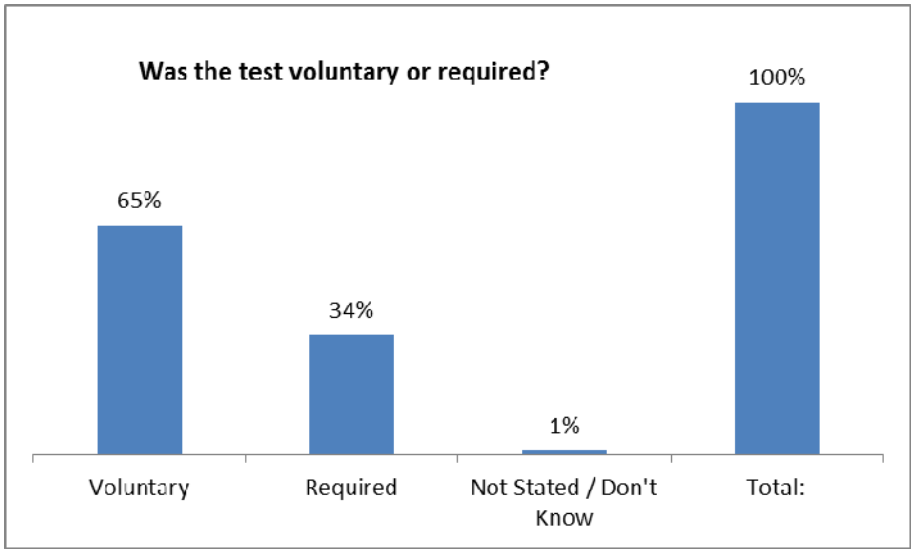


FIGURE 7.10: Nature of the HIV Tests

7.8 Knowledge of protective behaviours

Abstinence

Most respondents indicate that they do not quite know what the term abstinence means. At least 45.5% are unable to correctly define it and only 37.2% are able to give a correct definition. Abstinence seems to be confused with faithfulness to one partner, with 13.6% of respondents describing it as such, with males showing less knowledge than their female counterparts. More males (296 or 54.9%; N=539) report that they do not know what abstinence really means.

Moreover, the level of knowledge is lower in the groups of respondents with the lowest level of education attainment, i.e., from primary to post-secondary academic. There are more than 50% of persons who do not know the meaning of abstinence, primary – 73.9% (N=96) and secondary – 54.0% (n=470). However, with respondents who have completed higher levels of education, the level of knowledge is higher (both A' Levels and Diploma – 72.0% (n=75); Bachelor and Masters – 80.0% (n=40). (Tables 7.11 and 7.12)

TABLE 7.11: Knowledge of abstinence

Understanding of abstinence					
No sex	**No sex**	**Periodic abstinence**	**Faithful to one partner**	**DK / NR**	**Total**
Frequency	441	22	161	561	1185
%	37.2	1.8	13.6	47.4	100
Male	152	14	73	304	543
Female	289	8	88	257	641

TABLE 7.12: Knowledge of abstinence by level of education attainment

	No Sex	Per. Abs.	Faithful to one partner	DK / NR	Total
Primary	16	1	8	71	96
Secondary	110	11	82	267	470
Post-Secondary/Technical	93	3	24	114	234
Post-Secondary Academic	136	5	38	76	255
A Levels	20	0	4	4	28
Diploma	32	2	1	10	45
Bachelor	24	0	2	4	30
Masters	8	0	1	1	10
Doctorate	1	0	0	0	1
Not Applicable	1	0	1	14	17
Total:	**441**	**22**	**161**	**561**	**1185**

7.9 Condom knowledge

There are 1010 respondents or 85.2% (445 males or 44.1% and 565 females or 55.9%) who report having heard of a male condom whilst 16 persons or 1.4% indicate that they have never heard of one and 159 respondents or 13.4% choose not to answer the question or report that they do not know (Table 7.13).

TABLE 7.13: Awareness of male condoms

	Yes	No	No Data / Values	Total
Male	445	8	85	538
Female	565	8	74	647
Total:	**1010**	**16**	**159**	**1185**

In 2003, 99% of the respondents report having heard of a male condom.

The sources of information about male condoms are mostly from the radio and television for 54.4% of the sample, from the Ministry of Health for 34.1%, from schools for 20.5% and from print media for 9.1%. As for the other sources such as workshops, workplaces, peers and friends and private health centres, they are in the minority with 0.4%, 7.6%, 2.0% and 7.4% respectively. NGOs fare poorly, with only 1.3% of respondents obtaining information about male condoms from them.

The complete table is presented below.

TABLE 7.14: Source of information about male condoms

Source of information	Male	Female	Total
Radio and television	280	365	645
Ministry of Health	156	248	404

Schools	108	135	243
Print media	51	57	108
Workplaces	43	47	90
Private health centres	39	49	88
Leisure places, discotheques	10	17	27
Peers, relatives and friends	16	8	24
Other ministries	7	13	20
Internet	9	9	10
NGOs	5	10	15
Youth Health Centre	1	6	7
Meetings and workshops	2	3	5
Shops	2	2	4
Word of mouth	2	1	3

Most respondents that is 1113 or 93.9% of whom 94.8% of males (n=538) and 93.2% (n=647) of females know where to obtain a male condom. In 2003, there were only 2% (39/1692) of the respondents did not know a place where condoms could be obtained, without any difference by gender.

TABLE 7.15: Knowledge of source for male condoms

	Yes	No	No Data / Values	Total
Male	510	22	6	538
Female	603	37	7	647
Total	**1113**	**59**	**13**	**1185**

The five main sources for male condoms are family members (94.9%), government health centres (81.8%), the hospital pharmacy (29.1%), the private health centres (18.6%) and the shops (16.0%).

The least popular places to obtain male condoms in ascending order are NGOs (0.08%), workplaces (0.8%), peer educators (0.8%), discotheques (0.9%) and vending machines (1%).

The complete table is presented below.

TABLE 7.16: Sources to obtain male condoms

Source of information	Male	Female	Total
Family members	516	609	1125
Ministry of Health /Health centres	430	540	970
Hospital pharmacy	140	205	345
Private health centres	110	111	221
Shops	95	95	190
Family Planning Clinic	28	78	106
CDCU	15	25	40
Friends, peers	17	7	24

Outreach activities and sites	9	11	20
Hotels and bars	7	9	13
Vending machines	7	7	14
Discotheques	2	9	11
Peer educators	5	5	10
Workplaces	4	5	9
NGOs	0	1	1

The results obtained in 2012 are in sharp contrast to those obtained in 2003, when 37% of both males and females preferred to get their male condoms from the health centres, followed by private pharmacies with 20% for males and 19% for females and shops were also mentioned by 14% of males and 11% of females.

Of the 1185 respondents, 802 or 67.7% believe that condoms can protect you from getting HIV. However, an important number of them (288 or 24.3%) do not believe that this is so. At least 79 or 6.7% of respondents also indicate that they are not sure of the answer.

TABLE 7.17: Condoms as protection against HIV

	Yes	No	No Data / Values	Don't Know	Total
Male	390 (48.6%) n=802)	102 (35.4%)	8 (50%)	38 (49.4%)	538 (46%)
Female	412 (51.4%) n=802	186 (64.6%)	8 (50%)	41 (50.6%)	647 (54%)
Total:	**802 (67.7%) N=1185**	**288 (24.3%)**	**16(1.3%)**	**79 (6.7%)**	**1185 (100%)**

Most respondents in each highest education attainment group believe that condoms can protect one from getting HIV. In all categories, the percentage of 'yes' is well above 50%:

Primary – 72.3% (n-83)
Secondary – 73.8% (n=427)
Post-Secondary – 72.6% (n=456)
A' Levels – 82.1% (n=28)
Diploma – 68.2% (n=41)
Bachelor – 86.7% (n=30)

Note: *In the chart, the values for 'no response' and 'don't know' have been removed, keeping only the 'Yes' and 'No' answers.*

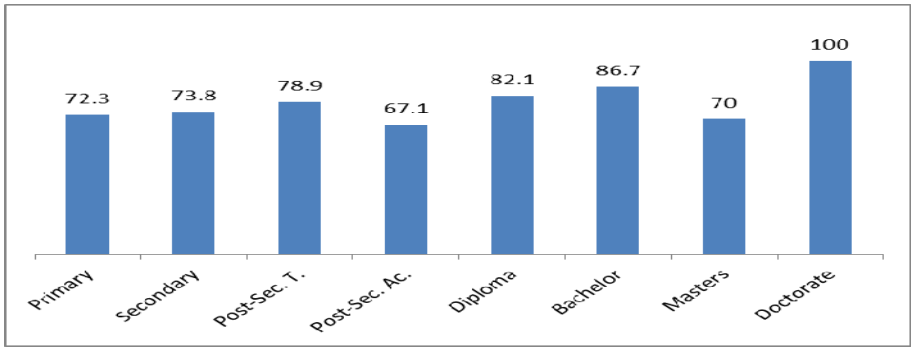


FIGURE 7.11: Percentage of belief of condoms as protection by educational level

The same trend of more than half of the occupation groups believing that condoms can protect one from HIV continues as can be seen in Figure 7.11 below. In all occupation groups, except for retirees and pensioners, which have 45%, the percentage is well above 50%.

However, the percentage of persons who believe that condoms do not protect from HIV is also above 20% in most groups, such as the professionals, semi-professionals, skilled workers, semi-skilled workers and the unemployed. Students are the only grouping that has less than a fifth of them believing that condoms are not good protective measures for HIV, at 15%.

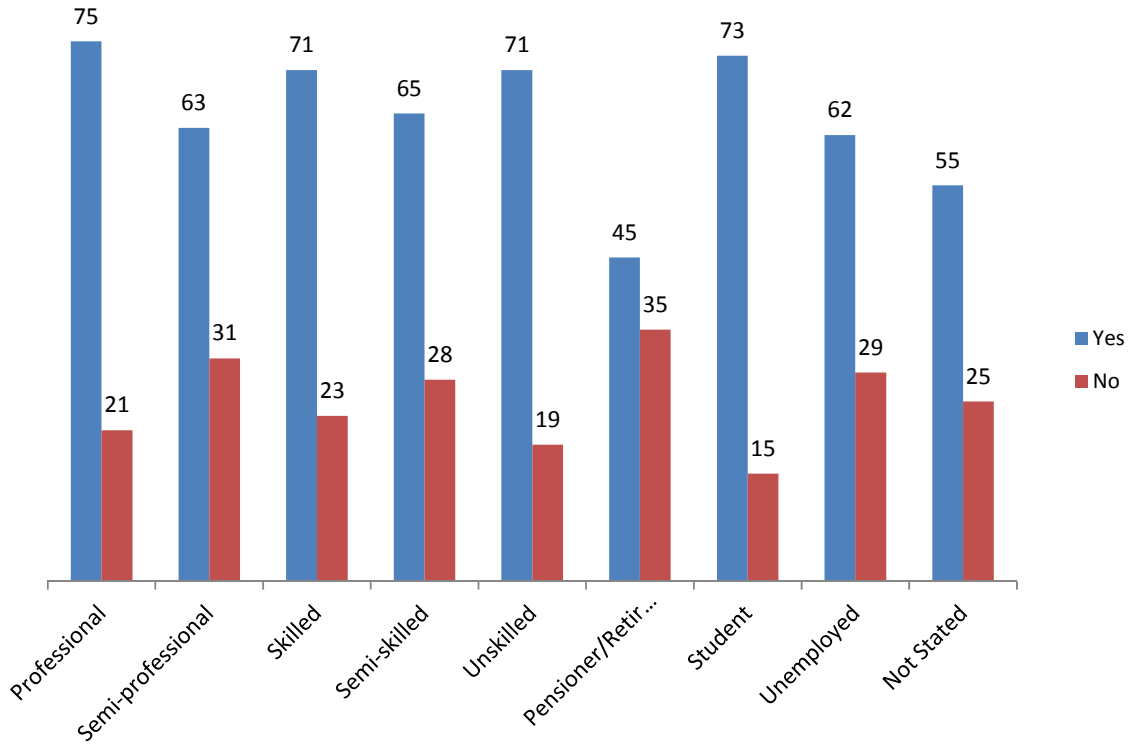


FIGURE 7.12: Percentage of respondents by profession & belief that condoms can protect from HIV

Condom use stands at 51.2% of the sample in general.

TABLE 7.18: Lifetime Condom Use

Question 104	Have you and a sexual partner ever used a male condom?				Total
	Yes	No	No Data / Values	Never had sex	
Male	258	162	17	101	544
Female	349	190	26	82	647

Total:	**607**	**352**	**43**	**183**	**1185**

Most respondents (1052 or 88.7%) indicate that it would be easy or very easy to obtain a condom right away compared to 29 or 2.4% who say that it would be difficult or very difficult to obtain one immediately. Only 2 respondents found it impossible to obtain a condom right away (Table 7.20).

TABLE 7.19: Ease of accessibility to a male condom

	Sex of respondents		**Total**
	Male	**Female**	
Very easy	286	313	599
Easy	200	253	453
Difficult	10	16	26
Very difficult	2	1	3
Impossible	1	1	2
No Data	39	63	102
Total:	**538**	**647**	**1185**

In 2003, 3% (45/1554) mentioned that condoms were difficult / very difficult to obtain.

Respondents would prefer to obtain their condoms from health centres (792 or 66.8%), hospital pharmacies (222 or 18.7%) and private health centres (170 or 14.3%) as indicated in Table 7.21.

TABLE 7.20: Preferences for sources of condoms

	Male	**Female**	**Total**
Health Centres	356	436	792
Hosp. Phar.	92	130	222
Private	90	80	170
Shops	52	43	95
FP Clinic	11	33	44
Bars/Guest Hses	9	4	13
Outreach Posts	7	4	11
CDCU	3	3	6

In 2003, it was noted that similarly to 2012, respondents preferred to obtain condoms in health centres followed by private and hospital pharmacies. Males (14%) were more frequently than females (7%) interested in obtaining these from shops. Only few respondents mentioned bars, guesthouses or hotels as potential sources where condoms could be obtained.

7.10 Female condoms

Most respondents (991 or 83.6%) report that they are aware of the female condom, with more females reporting knowledge of the condom; 85.7% (n=647) compared to 81.0% of males (n=538). Table 7.22 also shows that at least 14.8% or 175 respondents do not know of the female condom.

TABLE 7.21: Knowledge of female condoms

	Male	Female	
Yes	436	555	991
No	94	81	175
DK / NR	8	11	19
Total	**538**	**647**	**1185**

In 2003, there were similar results with 82% (1386/ 1698) of respondents having heard of the female condoms, with more females being more likely to be aware compared with males.

As for the sources of information about female condoms, more respondents were made aware through the radio and television (41.6%), followed by the Ministry of Health (26.9%), schools (14.5%) and print media (6.7%) than any other sources. Less popular sources of information are NGOs (1.0%), Internet (1.3%) and workplaces 3.5%). (Table 7.23)

TABLE 7.22: Source of information about female condoms

Sources	Male	Female	Total
TV/Radio	241	252	493
MoH	89	230	319
Schools	78	94	172
Print Media	33	46	79
Private Health	19	45	64
Workplaces	17	24	41
Other Min.	6	12	18
Internet	10	5	15
NGOs	2	10	12

In 2003, the most reported source of information related to female condoms by the respondents was television (54%), followed by radio (18%), health centres (8%) friends (6%) and newspapers (5%) among others.

However, the use of the female condom is low with 73.7% of respondents never having used one compared to 5.5% who have used it at least once in their lifetime. More females (75.8%; n=647) have never used the female condom compared to 71.2% (n=538) of males. If the respondents who are not sexually active are removed from the sample of males and females, the percentage is even higher, with 92.3% of males (n=415) and 93.7% of females (n=524) (Table 7.23)

TABLE 7.23: Lifetime use of female condoms

	Sex of respondents		Total
	Male	**Female**	
Yes	32	33	65
No	383	491	874
DK / NR	124	126	250
Total:	**538**	**647**	**1185**

Respondents report overwhelmingly knowing where to obtain female condoms, with 63.9% or 757 of the total valid sample. Nineteen percent of respondents (226) indicate that they do not know where to obtain a female condom. Of those respondents who answered this question, the percentage is 67.9% (n=430) for males and 84.1% for females (n=553).

TABLE 7.24: Knowledge of source of female condom

	Sex of respondent		Total
	Male	**Female**	
Yes	292	465	757
No	138	88	226
	430	553	N=983

The most popular places to obtain a female condom are listed in Table 7.25. The services of the Ministry of Health are the major sources for the product for both men and women.

TABLE 7.25: Places from which to obtain female condoms

	Male	Female	Total
Health centres	254	376	630
Hosp. Pharm.	61	76	137
FP Clinic	24	93	117
CDCU	10	12	22
Shops	8	16	24

This information was not available from the KAP Study 2003.

Respondents also gave their views about ease of access to female condoms. Compared to male condoms, more respondents found it difficult to obtain a female condom immediately. Four hundred and forty-eight of them or 37.8% found it very easy or easy to have access to a female condom right away compared to nearly 89% for male condoms. Indeed, 201 of them or 16.9% found it difficult or very difficult to obtain one, whereas 10 or 0.8% indicate that it is impossible for them to get one right away. (Table 7.26)

TABLE 7.26: Ease of accessibility to a female condom

	Sex of respondents		Total
	Male	Female	
Very easy	43	70	113
Easy	141	194	335
Difficult	64	115	179
Very difficult	9	13	22
Impossible	3	7	10
DK / NR	278	248	526
Total	**538**	**647**	**1185**

In terms of preference for the male or the female condom, most respondents chose the male condom by a ratio of more than 1:9, with 74 or 6.2% of persons preferring the female condom compared to 680 or 57.4% prefering the male condom. The number of females having a preference for the male condom is almost on par with that of males, with 333 (48.9%; n=680) and 347 respectively (51.1%; n=680). Two hundred and one or 16.9% of respondents have no preference one way or the other for the condom.

It is also interesting to note that 230 respondents (19.4%) chose not answer the question or indicated that they do not know how to answer it.

TABLE 7.27: Preference for the male/female condom

	Sex of respondent		Total
	Male	Female	
Male	347	333	680
Female	16	58	74
No preference	93	108	201
DK / NR	82	148	230
Total	**538**	**647**	**1185**

In the KAP Study of 2003, this question was not asked.

The reasons for the preference varied from ease of accessibility, to discretion in carrying it around, familiarity and the way the product is presented to the consumer (marketing characteristics). Table 7.28 gives the results for the reasons for the preference of one condom over the other, with presentation issues such as colours and flavours (775 or 65.4%) as well as accessibility (230 or 19.4%) clearly leading the way as the main considerations for both males and females. Being familiar with the product also affected the choice of respondents (142 or 11.9%).

TABLE 7.28: Reasons for preference of condoms (male or female)

	Male	Female	Total
Presentation	372	403	775 (65.4)
Accessibility	122	108	230 (19.4)
Easier to use	95	110	205 (17.2)
Familiarity	65	77	142 (11.9)
Easier to carry	30	28	58 (4.9)

7.11 Stigma and Discrimination

Generally, respondents tended to be accepting and tolerant of PLHIV in some circumstances, but not in others. Thus, 1039 or 87.7% of them are prepared to live with a close relative who is HIV positive; 1051 or 88.6% believe that a student living with HIV should be allowed to continue schooling and 1036 or 87% also think that a teacher can continue working if he or she is not sick. (Table 7.29 and Figures 7.13, 7.14 and 7.15)

TABLE 7.29: Would you be willing to live with a close relative, who is infected with HIV?

Answers Given	Frequency	Valid %
Yes	1039	87.7
No	99	8.4
DK / NS	47	4.0
Total	**1185**	**100**

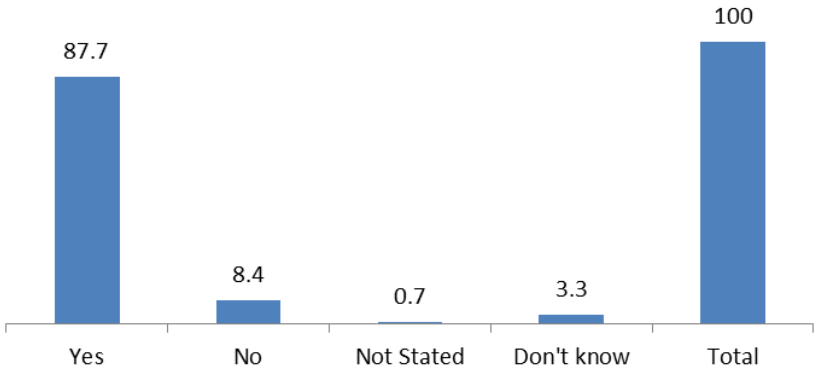


FIGURE7.13: Percentage of respondents willing to live with PLHIV

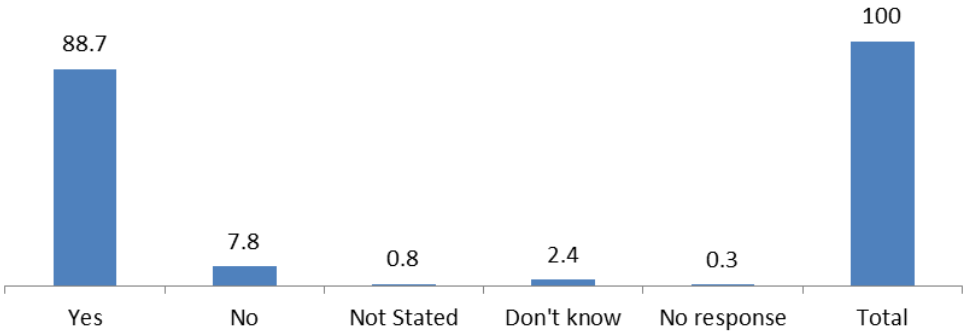


FIGURE 7.14: Percentage of respondents who believe a PLHIV (student) should pursue education

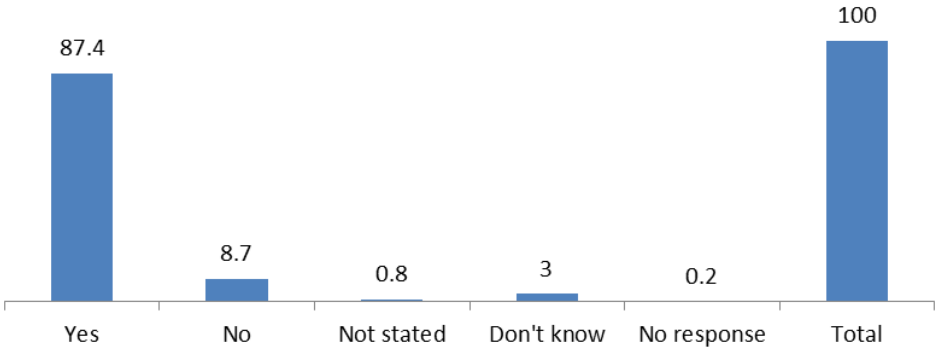


FIGURE 7.15: Percentage of respondents who believe a PLHIV (teacher) can continue teaching

However, when it comes to buying food from a food seller or a shopkeeper who is a PLHIV, then the level of tolerance and acceptance drops, e.g., only 623 or 52.5% persons are willing to purchase food from him or her. The number of respondents who would prefer to keep it secret if there is a relative who is a PLHIV is 837 or 70.6%.

These results are presented in the charts below, from 7.16 and 7.17.

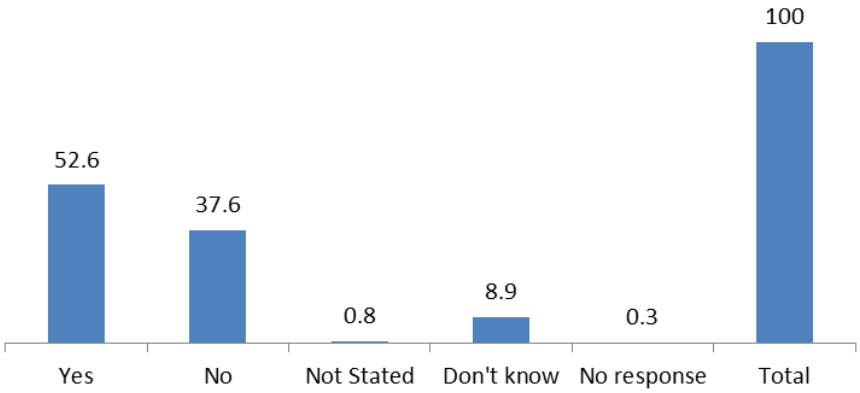


FIGURE 7.16: Percentage of respondents who would buy food from a food seller who is PLHIV

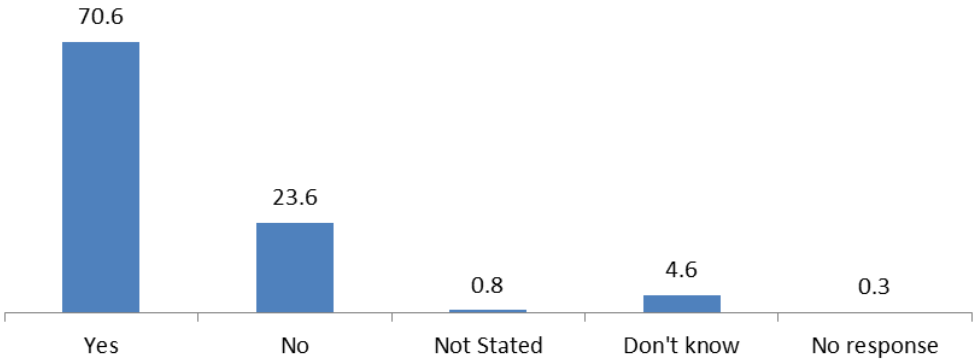


FIGURE 7.17: Percentage of respondents who would to keep it secret if a family member who PLHIV becomes ill

It is important to note that the figures for tolerance was much higher in 2003, with 90% and above in most categories as indicated in Table 7.30 below. There has been a significant drop in the number of people willing to buy food from food sellers who are PLHIVs. The percentage of people willing to keep secret the illness off a family member who is PLHIV has remained basically constant, 70.6% in 2012 compared to 65.5% in 2003.

TABLE 7.30: Attitudes towards PLHIVs

Questions	Level of knowledge			
(Responses based on correct attitudes)	Good	%	Poor	%
	(n=857)		(n=740)	
Would you be willing to share a meal with a person you knew had HIV/AIDS?	782	(91)	626	(85)
	(n=877)		ı=756)	
Would you be willing to live with a close relative infected with HIV?	847	(97)	692	(92)
	(n=891)		(n=752)	
If a student has HIV but is not sick, should he/she be allowed to continue in school?	851	(96)	685	(91)
	(n=888)		(n=743)	
If a teacher has HIV but is not sick, should he/she continue teaching in school?	838	(94)	656	(88)
	(n=786)		(n=675)	
If you knew a shopkeeper/food seller had HIV, would you buy food from he/she?	574	(73)	396	(59)
	(n=811)		(n=693)	
If a member of your family became ill with AIDS, would you want it to remain secret?	555	(68)	440	(63)

Source: KAP Study 2003 Final Report (Ministry of Health, 2004)

Table 7.31 gives results for respondents who believe that it is possible for HIV to be transmitted in the ways as indicated in the transmission modes column. There are still people (17.3%) who believe that mosquito bites, sharing a meal (7.4%) or sharing a bus seat (6.3%) can cause a person to be infected with HIV. However, the

actual modes of transmission are also understood as 91.1% of respondents know that sharing needles and syringes can lead to HIV infection.

TABLE 7.31: Levels of knowledge about HIV transmission

Transmission modes	Male	Female	Total	% of total (N=1185)
Mosquito bites	112	93	205	17.3
Sharing meals	49	39	88	7.4
Sharing needles	488	592	1080	91.1
Sexual Intercourse	506	621	1127	95.1
French Kissing	216	238	454	38.3
Tattoo and body piercing	435	552	987	83.3
Sharing a bus seat	32	43	75	6.3
Buying meat from PLHIV	128	130	258	21.8
PLHIV teacher	85	93	178	15.0
MTCT	383	528	911	76.9
Bood Transfusion	406	529	935	78.9
Public toilets	63	68	131	11.1

However, the level of knowledge has greatly improved from 2003 when 59% of males and 67% of females believed that mosquitoes could transmit HIV compared to 17.3% overall and 76% of males and 81% of females thought that sharing a meal with a PLHIV could also transmit the virus. In 2012, only7.4% of respondents still believed that.

7.12 Current relationships and live-in conditions

This section of the report of findings looks at the kinds of relationships respondents have. Most of them (862 or 72.7%) had either been married or living with a man or woman with whom they have had a sexual relationship. A minority (311 or 26.2%) have never lived or been married to a person with whom they have had a sexual relationship and 12 or 1% of the respondents chose not to state the live-in situation.

TABLE 7.32: Relationships and live-in conditions

Had ever been married or lived with a sexual partner	Frequency	%
Yes	862	72.7
No	311	26.2
Not Stated	12	1

Most respondents (423 or 35.7%) are also single, i.e., they are not married and not living with a sexual partner; others (355 or 30.0%) are not married and living with a sexual partner and some others (293 or 24.7%) are currently married and living with their spouse. Some respondents (55 or 4.6%) are also not living with their sexual partner.

TABLE 7.33: Current relationships and live-in conditions

	Frequency	%
Currently married and living with spouse	293	24.7
Currently married living with other sexual partner	37	3.1
Currently married and not living with spouse or sexual partner	55	4.6
Not married living with sexual partner	355	30
Not married not living with sexual partner	423	35.7
DK / NR	22	1.9
Total	**1185**	**100**

The majority of the respondents (809 or 68.3%) have children compared to 363 or 30.6% who do not.

TABLE 7.34: Respondents with children

Answers	Frequency	%
Yes	809	68.3
No	363	30.6
DK / NR	13	1.1
Total	**1185**	**100**

The respondents (921 or 78%) were for the most part sexually active during the last 12 months, compared to those who were not (168 or 14%). For some of the respondents, the question was not applicable because they had never had sex before and some of them (31 or 3%) chose not to answer the question or did not state their current situation.

TABLE 7.35: Sexual activity in last 12 months

Sexual Activity in last 12 months	Frequency	%
Yes	921	77.7
No	168	14.2
DK / NR	96	8.1
Total	**1185**	**100**

More males than females in the sample had sex during the last 12 months – 80.7% (n=538) males compared to 75.3% (n=647).

TABLE 7.36: Sexual activity in last 12 months by gender

	Yes	No	DK / NR	Total
Male	434	63	41	538
Female	487	105	55	647
Total	**921**	**168**	**96**	**1185**

7.13 Sexual and reproductive Health Data

For a better understanding of the sexual practices and relationships of the respondents, the questionnaire also probed for situations such as age of first sex and contraceptives, as well as breastfeeding patterns.

The findings are presented below.

The age of first sexual experience ranges from 5 to 34 years (1 or 0.1% for both ages). There are 116 or 9.8% of the sample population who have had their first sexual experience before the age of 15 years, the national legal age of consent. Between 5 and 11 years, there are 9 persons; at 11 years, there are 5 and there are 16, 30 and 56 respondents for the ages of 12, 13 and 14 respectively. (Figure 7.18) It is important to note that for age at first sex for age 9 the respondent was a female aged 41 years and for ages 5 and 8 both were males aged 55 years.

Between the ages of 15 and 17 years, there are 422 or 36% of respondents who have had a first sexual experience. Between these ages, they are still legally a child. (Figure 7.19)

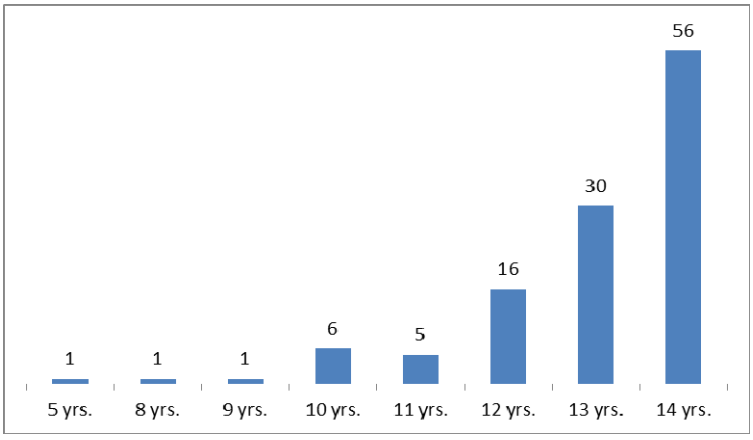


FIGURE 7.18: Age of first sex between 5 to 14 years (n=116)

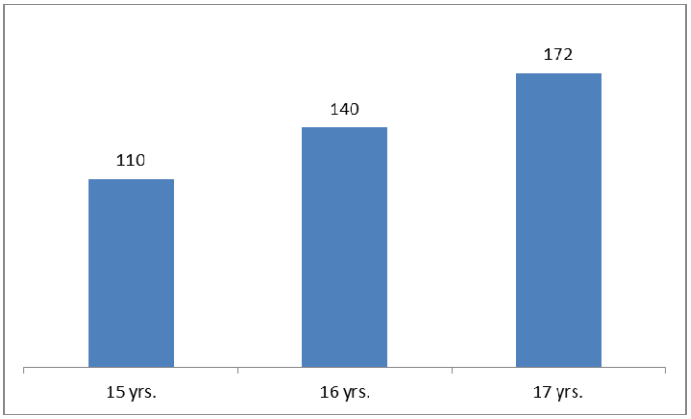


FIGURE 7.19: Age of first sex between ages 15 to 17 yrs. (n=422)

Table 7.37 below gives the complete data set for age of first sex.

TABLE 7.37: Age of first sex

Age in Years	Frequency	Valid %
1**	66	5.6
5	1	0.1
8	1	0.1
9	1	0.1
10	6	0.5
11	5	0.4
12	16	1.4
13	30	2.5
14	56	4.7
15	110	9.3
16	140	11.8
17	172	14.5
18	184	15.5
19	90	7.6
20	66	5.6
21	54	4.6
22	21	1.8
23	12	1
24	10	0.8
25	11	0.9
26	8	0.7
27	2	0.2
28	7	0.6
29	2	0.2
33	1	0.1
34	1	0.1
DK / NR	112	9.5
Total	**1185**	**100**

** Had never had sex before

The results of the KAP Study of 2003 show that the median age at first sexual intercourse was 17 years for males and 18 years for females. In 2012, the median age for males is 16 years and 18 years for females.

For some of the respondents, the circumstances of the first sexual experience were by mutual consent. For a few others, the experience was traumatic. Some report rape (3 or 0.3%), sexual abuse (7 or 0.6%), family pressure to have sex which may imply forced sex work or pressure from the boyfriend (2 or 0.2%) as well as unplanned encounters where alcohol was involved (13 or 1.1%) or the respondents attended a party (5 or 0.4%).

Table 7.38 gives the complete data set for circumstances of first sexual act.

TABLE 7.38: Circumstances of first sexual intercourse

Circumstances	Frequency	%
Mutual consent	915	77.2
Peer pressure	46	3.9
Rape	3	0.3
Sexual abuse	7	0.6
Family pressure	2	0.2
Alcohol	13	1.1
Pressure by boyfriend	2	0.2
Experimenting	45	3.8
Wedding day	7	0.6
During a party	5	0.4
DK / NR	140	11.8
Total	**1185**	**100**

There are 463 or 39.1% of respondents who have had oral sex before compared to 657 or 55.4% who report never having had sex in that way before. More males had oral sex (43.8%; n=538) than females (35.1%; n=647). The response 'not applicable' includes respondents who have never had any kind of sexual contact before.

TABLE 7.39: Respondents who have had oral sex before

	Frequency	%
Yes	463	39.1
No	657	55.4
DK / NR	65	4.5
Total	**1185**	**100**

In 2003, the results were as follows: "*males more frequently reported having had oral sex with a partner compared with females*." Fifty-three percent of males had oral sex with a partner compared to 47% of females. Compared to 2012, there seemed to have been more reports of such sexual activity in2003.

As for anal sex, 81 or 6.8% of respondents report having experienced it compared to 992 or 84% who have not done so. (Table 7.40)

TABLE 7.40: Respondents who have had anal sex before

	Frequency	%
Yes	81	6.8
No	992	83.7
DK / NR	112	1.1
Total	**1185**	**100**

In 2003, 54% of males and 46% of females reported having had anal sex before.

Most respondents (1059 or 89.4%) have never had sex for money or a gift before compared to 30 or 2.5% who have done so.

TABLE 7.41: Respondents who have had sex for money or gifts

	Frequency	%
Yes	30	2.5
No	1059	89.4
DK / NR	96	8.1
Total	**1185**	**100**

For the 30 respondents who have reported having sex for material gain, 13% of them indicate that it happened once only, whilst 6.7% say that it occurred twice and 26.6% admit that there were three or more incidents. However, half of them did not answer this question.

TABLE 7.42: Frequency of sex for gain in last 12 months

	Frequency	%
Once	4	13.3
Twice	2	6.7
Three times or more	8	26.6
Did not happen	1	3.3
No Response / Don't Know	15	50.0
Total	**30**	**100**

The five most common ages for having a first child were 17 and 21 for 82 respondents or 6.9% of the sample, followed by 19 years for 77 or 6.5%, 20 years for 68 or 5.7% and 22 years for 59 respondents or 5.0%. Note that this question was asked to both males and females. There are 10 respondents who have had their first child when they were less than 15 years of age: 1 person for 10, 12 and 13 years and 7 persons for 14 years.

TABLE 7.43: Age when first child is born

Age in Years	Frequency	%
10	1	0.1
12	1	0.1
13	1	0.1
14	7	0.6
15	14	1.2
16	20	1.7
17	42	3.5
18	82	6.9
19	77	6.5
20	68	5.7
21	82	6.9
22	59	5
23	54	4.6
24	38	3.2
25	50	4.2
26	36	3
27	30	2.5
28	23	1.9
29	18	1.5
30	24	2
31	6	0.5
32	10	0.8
33	8	0.7
34	7	0.6
35	6	0.5
36	2	0.2
37	1	0.1
38	1	0.1
39	3	0.3
40	3	0.3
43	2	0.2
55	1	0.1
DK / NR	408	34.4
Total	**1185**	**100**

Most of the respondents (761 or 92.9%) report having their children breastfed compared to 25 or 3.1% of them who indicate that this was not so. (Table 7.44)

TABLE 7.44: Breastfeeding

	Male	Female	Total	%
Yes	288	473	761	92.9
No	8	17	25	3.1
DK / NR	25	8	33	4.0
Total	**321**	**498**	**819**	**100**

There are 313 (26.4%) respondents who report their children being breastfed for more than a year, whilst 175 (14.8%) indicate that the children were breastfed from 6 months to a year and 102 (8.6%) indicate that the breastfeeding lasted 1 to 3 months and 3 to 6 months. There are 288 males and 473 females who report that their child was breastfed.

TABLE 7.45: Duration of breastfeeding

	Frequency	%
1-3 months	102	8.6
3-6 months	102	8.6
6 months -1year	175	14.8
>1 year	313	26.4
Still breastfeeding	1	0.1
DK / NR	492	51.5
Total	**1185**	**100**

7.14 Contraceptive use

There are 805 respondents (68%) who have used contraceptives before compared to 331 or 28% who have never done so.

TABLE 7.46: Lifetime use of contraceptives

	Frequency	%
Yes	805	67.9
No	331	27.9
DK / NR	49	4.1
Total	**1185**	**100**

The most common methods of contraceptives are the oral pills, followed by condoms and injections with 52%, 44% and 25% of the 805 respondents who use contraceptives reporting using these.

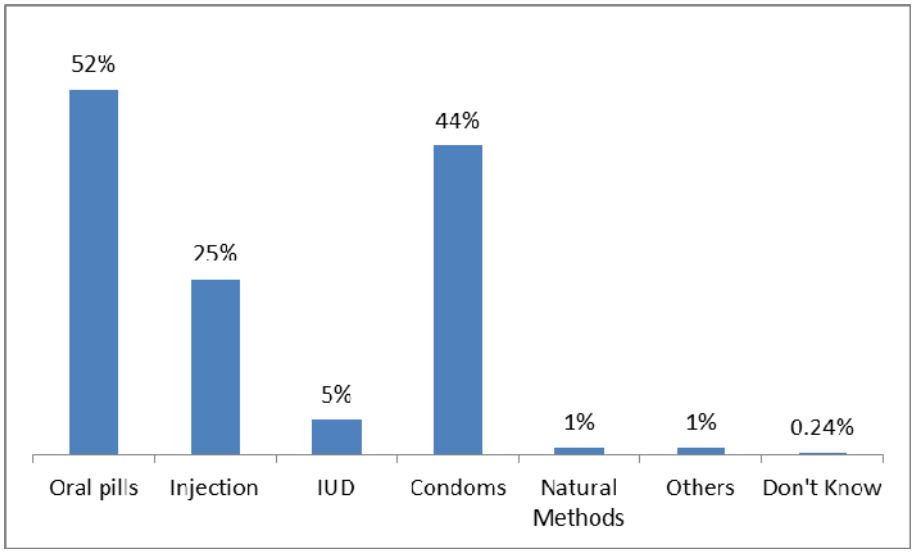


FIGURE 7.20: Most common methods of contraceptives (n=805)

7.15 HIV-Related Practices and Behaviors

Experience with Multiple, Concurrent Sexual Partnerships

Of the 921 respondents who report having had sexual intercourse in the last 12 months, 434 or 47.1% (n=921) are males and 487 or 52.8% (n=921) are females. Only 175 out of 873 respondents report that they used a condom at the last sexual encounter with a regular partner, 14 out of 23 used one with a commercial sexual partner and 21 out of 49 made use of one with a casual sexual partner at the last sexual contact.

For sex with a regular partner, the decision to use a condom was a joint one made by 46.8% (n=173) of respondents who had sex with a regular partner, compared to 53.2% who made the decision alone, either the respondent (36.9%) or the partner (16.3%).

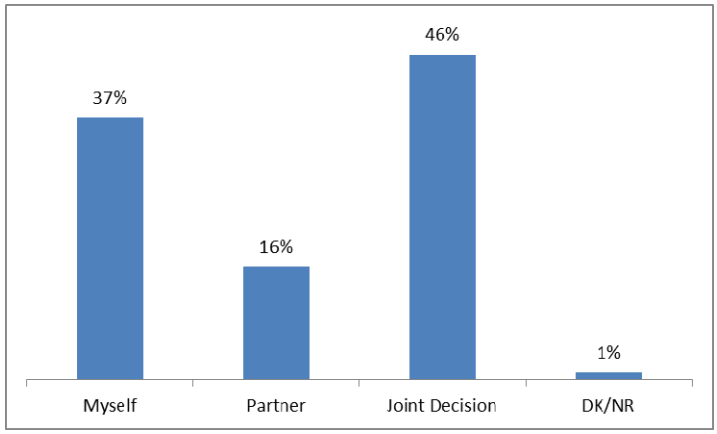


FIGURE 7.21: Decision-making process to use a condom with regular partner (n=173)

There are 14 respondents who report having had a commercial sexual partner in the last 30 days. The decision to use a condom at the last sexual encounter was made by jointly by only 2 or 13% of the respondents, with 3 or 19% of the commercial partners making the choice alone and 9 or 56% of the respondents making that decision on their own.

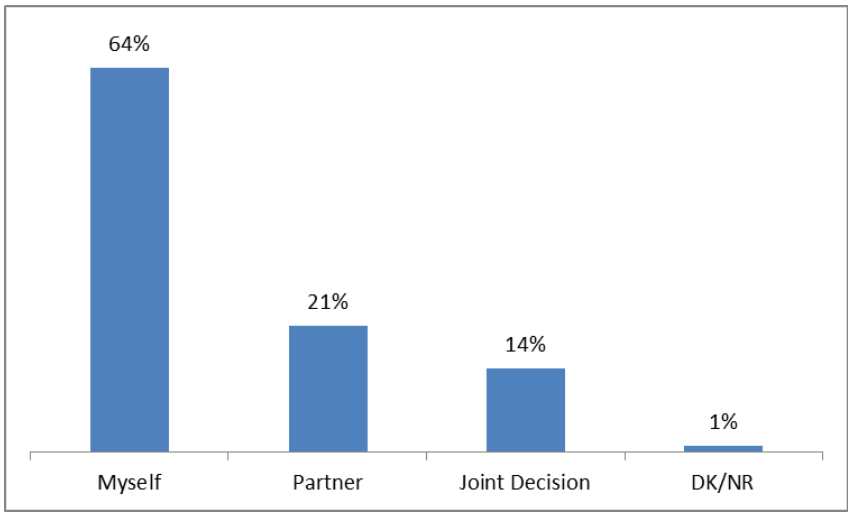


Figure 7:22: Decision process to use a condom with a commercial sex partner (n=14)

When it comes to sex with a casual partner, there are 21 respondents who report doing so in the last 12 months. For 12 or 57.1% of them, the decision to use a condom is taken alone; for 1 or 4.7% of them, it was the partner who suggested using a condom while it was 8 or 38.1% of them who decide together whether to use a condom or not.

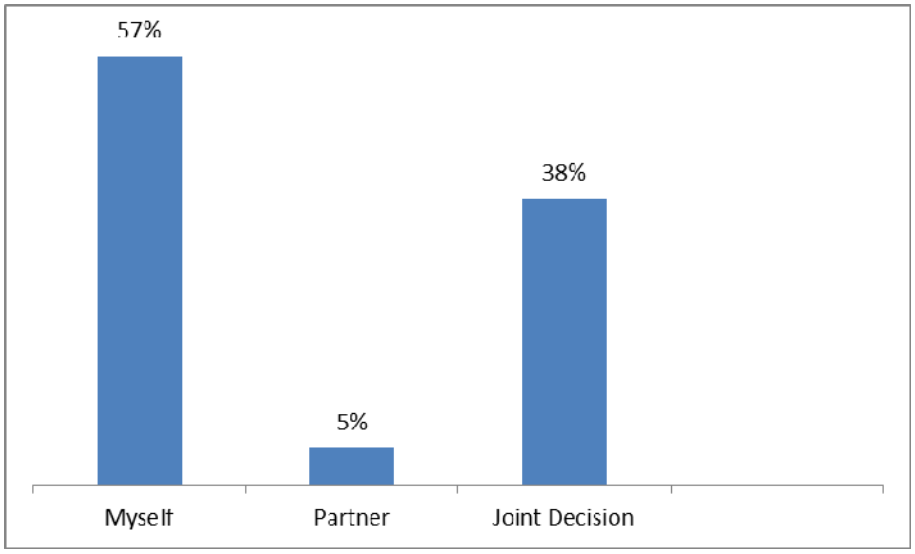


FIGURE 7:23: Decision process to use a condom with casual a sex partner (n=21)

As to why condoms were not used for regular partners, the most common reasons are that they were not necessary (214 or 32.0%; n=668) and that they trusted each other (224 or 33.5%; n=668). With commercial partners, the most common reasons are the partners objected to their use (4 or 28.6%; n=14) and there were none available at the time (2 or 14.3%; n=14).

For casual partners, condoms were not used primarily due to the respondents and their partners thinking that they were not necessary (7 or 33.3%; n=21), they do not like condoms and they used other contraceptive methods – 5 persons or 23.8% (n=21) for both cases.

The tables 7:47 to 7:49 illustrate further the results mentioned above.

TABLE 7.47: Reasons for not using a condom with a regular partner

Reasons Given	Frequency	%
Not available	14	1.2
Partner objected	14	1.2
Don't like them	46	3.9
Used other contraceptive	96	8.1
Did not think it was necessary	214	18.1
Did not think of it	8	0.7
Allergic to condom	6	0.5
Not used to it/Never used	16	1.4
Too excited	2	0.2
Trust partner	224	18.9
Use natural method	3	0.3
In the process of having a child	11	0.9
Partner has done sterilization	9	0.8
Has passed menopause year	5	0.4
Total	**n = 668**	**100**

TABLE 7.48: Reasons for not using a condom with a commercial sex partner

Reasons Given	Frequency	%
Not available	2	25.0
Partner objected	4	50.0
Did not think it was necessary	1	12.5
Did not think of it	1	12.5
Total	**n = 8**	**100**

TABLE 7.49: Reasons for not using a condom with a casual sex partner

	Frequency	%
Not available	3	14.3
Partner objected	1	4.8
Don't like them	5	23.8
Used other contraceptive	5	23.8
Did not think it was necessary	7	33.3
Did not think of it	4	19.0
Total	**n = 21**	**100**

Generally, most respondents (545 or 46.0%) do not use a condom for sex with a regular partner whereas some report using it every time (106 or 8.9%). If we add rarely and never, the respondents' non-use of a condom rises further, from 46% to 52%.

TABLE 7.50: Frequency of use of condoms with a regular sex partner

Frequency of use of condoms	Frequency	%
Every time	106	13.1
Almost every time	28	3.5
Sometimes	59	7.3
Rarely	71	8.8
Never	545	67.3
Cannot Remember	1	0.1
Total	**n = 810**	**100**

For commercial sex partners, most respondents use a condom every time (12 or 86%) whereas only 2 or 13% use it rarely and 3 or 19% never use it.

TABLE 7.51: Frequency of use of condoms with a commercial sex partner

Frequency of use of condoms	Frequency	%
Every time	12	52.2
Almost every time	4	17.3
Sometimes	2	8.7
Rarely	2	8.7
Never	3	13.1
Total	**n = 23**	**100**

In the case of casual sexual partners, the use everytime and never are almost equal, 19 or 90% and 18 or 86%.

TABLE 7.52: Frequency of use of condoms with a casual sex partner

Frequency of use of condoms	Frequency	%
Every time	19	38.8
Almost every time	3	6.1
Sometimes	3	6.1
Rarely	6	12.2
Never	18	36.7
Total	**n = 49**	**100**

7.15 High-Risk Behaviours

There are 81 respondents (9.6%) who report ever having anal sex, with 44 males and 37 females. The number of male partners ranges from 1 to 5 in the last 12 months. There were also 7 males who report having a male sexual partner and 4 of whom had sex with one of their partner in the last 12 months.

TABLE 7.53: Number of male partners for anal sex

Number of male partners	Frequency	%
1	24	72.7
2	4	12.1
3	2	6.1
4	1	3.0
5	2	6.1
Total	**n = 33**	**100**

There are 34 respondents who report having had anal sex with a female partner in the last 12 months. Most (33 or 97.1%) have 1 partner and (1 or 2.9%) have 2 partners.

TABLE 7.54: Number of female partners for anal sex

	Frequency	%
1	33	97.1
2	1	2.9
Total	**34**	**100**

7.16 Biological Data

There are 9 positive blood results out of 1078 blood tests done. All respondents are Seychellois and there are 4 males and 5 females. It is to be noted that 96 persons or 8% of the sample (54 males and 42 females) took part in the behavioural part of the study but refused to give a blood sample.

TABLE 7.55: Blood results by gender

	Positive	Negative	Refused	Reactive	Indeterminate	Total
Male	4	479	54	0	1	538
Female	5	599	42	1	0	647
Total	**9**	**1078**	**96**	**1**	**1**	**1185**

In terms of age, the range is from 16 years to 57 years as indicated in the table below.

TABLE 7.56: Blood results by age

Age in years	Number of positive results
16	1
21	1
25	1
26	1
27	1
34	1
38	1
50	1
57	1
Total	**9**

As for highest level of education attained, most respondents with a positive blood result have completed secondary education (6 or 67%) and the other 3 or 33% ended schooling at post-secondary; 2 (22%)from the technical field and 1 (11%) from the academic field.

TABLE 7.57: Blood results by highest level of educational attainment

Level of education attained	Number of positive results
Primary	0
Secondary	6
Post-Secondary/Technical	2
Post-Secondary Academic	1
Total	**9**

In the case of occupation, the respondents with positive blood results are mostly unemployed persons (4 or 44%) and there is 1 or 11% in each of the following occupation groupings: semi-professional, skilled workers, semi-skilled workers, student and unskilled workers.

TABLE 7.58: Blood results by occupation

Occupation	Number of positive results
Semi-professional	1
Skilled	1
Semi-skilled	1
Unskilled	1
Student	1
Unemployed	4
Total	**9**

8.0 DISCUSSION

8.1 Population characteristics

The sample population shows a number of characteristics about the population of Seychelles that are important to consider when conducting surveys on the general population. These are as follows.

8.1.1 Mobility

The population is very mobile, with people within two years moving from one district to another. The sample has a number of respondents who have moved from their original district of the Population and Census of August 2010. Some of them could not be found at all, even with the help of district administrators, who did not know them or their whereabouts. With the allocation of housing and with work in the hospitality industry on Praslin and La Digue, some of the Mahé residents had moved to Perseverance 1 and 2 and to the inner islands.

Movement can also be seen in the number of Seychellois who had gone overseas for vacation, work and study. A significant number of Indian workers who ended up in the sample had also already left the country at the end of their contract.

8.1.2 Heterogeneity

The population of Seychelles is no longer homogenous. There is now a wide variety of nationalities, ethnicities and cultures present in the country. In the final sample, there were 4% of the sample made up of foreign workers, mostly Indians, Malagasy, Sri Lankans, Philippinos and Africans.

There is also a variety of live-in and relationships conditions, with most people (36%) being single, without their sexual partner living in the same house. Other people are living in concubinage (30%), unmarried and living with a sexual partner, whereas married couples living together make up 25% of the sample population. This is consistent with the data from the National Bureau of Statistics whose Statistical Bulletin No. 2 of 2012 show that non-nuptial births are now 80% of all births in Seychelles indicating that couples are not married.

A number of Seychellois authors and studies (Maiche, 2003, CEFRAD, 2002, Chang-Him, 2000 and Pardiwalla, 2009) have indicated that this weak family structure may be due to a history of slavery which "*prevented healthy family values, and constructed a culture of irresponsible sexual attitudes, weak paternal responsibility and a weak culture of marriage*."

8.1.3 Male and female participation

In the final sample, there were an equal number of males and females (847). However, during the data collection phase, there has been an attrition of male respondents by 36% compared to female attrition of 24%. This is also consistent with male participation in public and health-related activities, as indicated in a population-wide survey of attendance and hospital admissions undertaken in Denmark which concluded that there was lower pattern of male contact rates with the general practitioner (Juel and Christensen, 2007). In Seychelles, even at school, boys avoid going for their medical and dental check-ups. As such, men show less interest in participating in surveys that relate to health issues.

8.2 *Drug use / alcohol use*

It is not surprising that some 75% of the sample drink alcohol as this is a common enough behaviour amongst adults and children in Seychelles. It is notable too that 25% of the respondents indicate that they do not drink alcohol at all.

8.4 Knowledge of STIs

Awareness of STIs is quite high (85%), but awareness of HIV and AIDS is much higher (99.5%). Most respondents have been made aware of the virus and the disease through the media, radio and television, more than direct contact or information from Ministry of Health services. The family is another source of information. Perhaps, disappointingly, the information obtained by the population does not come from the primary actors in the field, such as NGOs and the Ministry of Health. However, the information on the media most likely comes from these two sources more than any others. Therefore, in an indirect but effective way, the message is getting across to the population.

People also have knowledge of STIs because they have experienced it themselves. This is true for 3% of the sample who have had to seek advice or treatment for an STI. The wait time before seeking treatment is well within a week for most of them, showing that they are aware of the urgency of addressing this health issue.

8.5 Knowledge of HIV

People also have knowledge of HIV and AIDS through the following situations:

8.5.1 Knowledge of PLHIV

52% of respondents, slightly more women than men know of someone who is a PLHIV or someone who has died of AIDS. This is comparable to KAP 2003 when 43% of males and 49% of females knew a PHIV.

8.5.2 Having done a HIV test themselves

59% of respondents have also done a HIV test before, even if for the most part, the test was required. Compared to 2003, there were 37% of males and 63% of females who had already done a HIV test. For 40% of the men and 60% of the women, the test was required in 2003. Indeed, any slight increase and may be due to various requirements such as insurance and overseas studies rather than people voluntarily having tests done.

However, beyond this, there is quite a lot prejudice about HIV and AIDS in the following areas:

8.5.3 Confidentiality of tests

With 33% of respondents not believing that these are confidential. If the number of persons who do not believe that the tests are confidential (402) is added to those who say they do not know (151), then the total is 553 which are 47% of the sample. Therefore, almost half of the general population does not trust the secrecy and confidentiality of the tests for HIV. In 2003, the level of trust was much higher with 84% of males and 85% of females believing that it was possible to obtain a confidential HIV test. This is an important issue and it demands attention as voluntary testing depends a lot on the trust that the public has on the services on offer.

8.5.4 Abstinence

Moreover, only 37% of people know what *abstinence* is. There is also a general confusion about the term with the population with the lowest educational attainment being the groups that are least in the know about abstinence. It seems that knowledge of HIV is thus quite superficial. When it comes to details, the knowledge is quite lacking. The KAP Study 2003 showed that 73% of males and 79% of females understood the concept of abstinence as a means of protection from HIV. This decline in 2012 may be due to the fact that this time

respondents were asked too specifically define the term abstinence rather than simply being asked about its protective properties.

8.5.5 Condom use

Only 68% of respondents believe that condoms can protect you from HIV. If the number of respondents who do not believe in condoms as a means of protection against HIV (288) is added to those who indicate that they do not know whether this is true or not (79) and those (6) who chose not to say anything (perhaps, expressing some forms of doubt), then the total is 373 or 31% of the sample population. The figures were slightly higher in 2003, with 76% of males and 77% of females believing that condoms can protyect from HIV transmission.

8.6.1 Stigma and discrimination

Generally, respondents tended to be accepting and tolerant of PLHIV in circumstances which are far removed from their personal life. Hence, they are at ease (at least 80% for both items) with a student living with HIV continuing his or education and a teacher continuing to work if he or she is not sick. However, when it comes to more personal aspects such as purchasing food and letting others know that they have a PLHIV as a relative, then the percentage drops to under 60% for both items. Thus, 38% of people would not buy food from a PLHIV working as a food seller and only 24% of respondents would be open about a relative who is a PLHIV.

In 2003, the level of tolerance was higher for most attitudes as the scores remain in the high 70's for the most part. However, in 2012, the level of knowledge regarding injecting with soiled needles and syringes is higher because of the public education around this issue, with a number of controversial television and radio programmes on harm reduction measures. In 2012, fewer people believe that mosquitoes are capable of transmitting HIV.

8.6.2 Blood results

The positive blood results represent a prevalence rate of 0.83% of the sample population who agreed to do a blood test. However, if the whole sample is taken, then the prevalence rate is 0.75%, both of which are still under 1% for the general population. These results confirm that the HIV pandemic is still concentrated in some key populations as shown by the results of the random-sample driven survey with MSM and PWID in 2011 (14% for MSMs and 5% for PWID).

An interesting result is that all the respondents with positive blood results seem to be of lower socioeconomic status and all had already done a HIV test. Coupled with the lack of knowledge about abstinence and the mistrust of the Ministry of Health and others to maintain confidentiality for HIV tests, there are some gaps that need to be addressed soonest on the national response to HIV and AIDS.

Condoms are not seen as protection against HIV per se. For a number of respondents, condoms are viewed as a method of contraceptive, to prevent pregnancy only. Thus, some respondents indicate that they do not use condoms because they are using other methods of contraception and that they trust their partner and thus have no need for a condom.

8.6.3 Health education programmes

Most people are getting their information from the media and family members, more so than from the entities that are meant to provide such information.

8.6.4 High risk behaviour

There have been relatively few people engaged in high risk behaviour. However, of those who do so, a few still do not use condoms regularly. Moreover, the decision process is one-sided in many cases with partners refusing to use them or accepting people's health status at face value. Some of the respondents are still taking risks with unprotected sex with commercial sex and casual partners. Decisions to use condoms are not taken together, with each individual deciding on his or her own whether to use a condom or not.

PART V RECOMMENDATIONS AND CONCLUSION

9.0 RECOMMENDATIONS

There are some important issues highlighted by the results of the KAPB Study 2012. The following needs to be done:

1. To reach all types of groups within the population, especially migrant workers, people who have lower socio-economic status and educational level and young people, especially boys and men.

2. To make more use of radio and television to give messages targeting the general population as these two are the primary media for information and awareness-raising.

3. To have more targeted information, education and communication strategies so that difficult-to-reach sub-populations can be reached.

4. To address the mistrust regarding confidentiality of tests and results of tests and health professionals working in the field of HIV and AIDS.

5. To use more options such as shops to allow people to have greater access to condoms.

6. To have more promotion of the female condom which has very little uptake and is quite unknown by some of the population.

7. To have NGOs engage with the local population or with their target groups in more meaningful ways so that they can significantly contribute to the national response.

8. To strengthen the roles and functions of key partners which are presently inactive or whose assets and abilities are left untapped, such as workplaces, private health centres and peer educators and counselors.

9. To revamp information, education and communication messages and strategies about male and female condoms so that people can see both as protective measures from HIV and other STIs. For too many people, the male condom is simply a form of contraceptive.

10. To have people realise that HIV and AIDS and STIs cannot be determined through face value and while trusting one's partner is a laudable sentiment, it is also important to have better protection from HIV through the more frequent use of condoms.

11. To have more information, education and communication programmes targeting children as there is sexual abuse and pressure to have sex at an immature age.

10.0 CONCLUSION

There are some important lessons learnt from the findings of the KAPB Study 2012. These are as follows:

The characteristics of the Seychelles population

(a) The Seychelles population has changed from a homogenous group to a quiet diverse one with multiple sub-populations and cultures. There is also high level of internal and external migration, leading to constant change in the population of various districts and villages and in the nation as a whole.

(b) There are now many foreigners in our midst and their interactions with the local population must be considered in any national response to any pandemic or in the development of national strategies of any kind.

Knowledge of STIs, HIV and AIDS

(a) Knowledge of HIV and AIDS and STIs are quite superficial. Whilst the population may know people who are PLHIV, but they are unable to adequately describe how the virus is transmitted and what protective measures are most effective. The years of sensitization and awareness rising has made only a little dent in national consciousness and awareness.
(b) They are also unable to name STIs even if they know that these exist.
(c) The level of knowledge on abstinence is still low and is confused with other aspects of the ??

Attitudes towards HIV and AIDS

(a) Attitudes towards HIV and AIDS still have a lot of stigma and discrimination despite the many years of advocacy and lobbying. Most people are prepared to accept PLHIV from afar, but when the situation comes closer to home, and then the prejudices emerge, with people wanting to keep relatives who are PLHIV secret and refusing to buy food from PLHIV food sellers.

(b) There is still much distrust of health professionals working in the field of HIV and AIDS. There are a significant number of respondents who consider HIV testing not to be confidential.

Behaviours and Practices

(a) Most respondents even those with non-nuptial relationships are not engaged in too much high risk sexual behaviour. Drug use, commercial sex and anal sex seem to be minimal. There are few respondents with multiple partners and high-risk behaviour.

Health Education

(a) Health education programmes are somehow not reaching people of low educational level and socio-economic status. There are over-represented in this sample for lack of knowledge and understanding of STIs and HIV and AIDS, including condom usefulness and abstinence. There is thus a need for public education programmes to use languages and images that these populations can understand and assimilate.

PART VI REFERENCES AND APPENDICES

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APPENDICES

Appendix 1 – Informed Consent Forms (*Both available in Seychellois Creole*)

1.1 Behavioural Surveillance Informed Consent Form

Questionnaire identification number |___|___|___|___|

Household identification number |___|___|___|

Respondent number |___|___|___|

Sub-district / Enumeration Area _____/ _____

District _____

Region _____

Introduction: "My name is …… I'm working for the Ministry of Health, and we are interviewing people all over the Seychelles as part of a national survey on HIV and AIDS. We want to get a picture of how HIV might be spreading in Seychelles, and what we can do about it. Have you been interviewed already for this study? (**IF THE RESPONDENT HAS BEEN INTERVIEWED BEFORE, DO NOT INTERVIEW THIS PERSON AGAIN.)**

Tell them you cannot interview them a second time, thank them, and end the interview). If they have not been interviewed before, continue:

Confidentiality and consent: "I am going to ask you some personal questions that you may find difficult to answer. Your answers are completely confidential- that means your name will not be written on this form or associated with it in any way, and your name or identity will never be used in connection with any of the information you tell me. All the information we collect from over 1600 interviews will be analysed together to give us a general picture of the situation in the country as a whole. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviours. We would greatly appreciate your help in responding to this survey. The survey will take about 60 minutes to ask the questions. Would you be willing to participate?"

(Signature of interviewer, certifying that a verbal informed consent has been given, by respondent)

VERSYON KREOL

***Entrodiksyon**: "Mon non i …….. Mon pe travay pour Minister Lasante. Nou pe fer en lanket / serve nasyonal partou dan Sesel lo HIV ek SIDA. Nou anvi konpran ki mannyer HIV (SIDA) pe ganny transmet dan Sesel e ki nou kapab fer lo sa sitiasyon. Eski ou'n deza ganny "interview" pour sa letid?*

(**IF THE RESPONDENT HAS BEEN INTERVIEWED BEFORE, DO NOT INTERVIEW THIS PERSON AGAIN.)**

***Konfidansialite e konsantman:** "Mon pou demann ou plizyer kestyon personel ki ou kapab vwar difisil pour reponn. Ou bann larepons i konpletman konfidansyel – savedir ou non pa pe ganny ekri lo sa form oubyen ganny asosye avek sa form dan okenn fason. Ou non ek ou idantite pa pou ganny servi an koneksyon avek bann lenformasyon ki ou donn mwan. Tou lenformasyon ki nou pou kolekte dan sa plis 1, 600 pou ganny analize ansanm pour nou ganny en porter kler lo sitiasyon dan pei an antye. Ou pa oblize reponn okenn kestyon ki ou pa anvi reponn. Ou kapab aret sa interview nenport ki moman si ou oule. Par kont (Selman) ou bann larepons onnet pour sa bann kestyon pou ed nou konpran pli byen sa ki dimoun pe mazinen, pe dir e pe fer konsernan serten kalite konportman. Nou pou vreman apresye ou led ler ou partisip dan sa lanket / serve. Sa bann kestyon pou pran apepre 60 minit pour reponn. Eski ou anvi partisip dan sa serve / lanket?"*

_____
(Signature of interviewer, certifying that a verbal informed consent has been given, by respondent)

1.2 Biological Surveillance Informed Consent Form – use the same form for minors and replace words where necessary.

Participant ID number: _____

Introduction

Hello, my name is (_____). We are following up on the survey on knowledge, attitudes, practices and behaviour in relation to HIV, AIDS and other STIs. This time, we want to find out how much HIV there is in the general population. You are (***Your _____ is***) being invited to take part in this study. Before you decide to participate, it is important for you to understand why we are conducting the study and how you will take part, if you agree to do so.

I will explain the study to you and give you time to think about it. At any point, ask me if something is not clear or if you want more information.

What is the purpose of the study?

We wish to learn about the level of HIV in our population, as a whole. We also want to learn why some people are at risk. The study will help Seychelles learn more about its HIV. It also helps the government to give better services to the community, as a whole. This work will be carried out by the National AIDS Council in collaboration with the Ministry of Health and funded by Seychelles Government through the National AIDS Trust Fund, Ministry of Health and the United Nation Fund for Population Activities (UNFPA)

Do I have to take part?

It is entirely up to you to decide if you want to take part or not in this study. If you decide to take part you are still free to stop at any time and you will not have to give a reason.

What will happen to me if I take part?

You will first be asked to give consent to take part in the study. Consent means you understand all parts of the study and can make a decision to be part of the whole exercise.

Tests

If you agree, we will take a little blood from your arm. Before we take blood, I will counsel and give you information about HIV you. We will test the blood for HIV.

After you give blood, you can get your HIV test results two weeks from today at CDCU (***explain where it is, if necessary***). It is your choice to receive your test results. If you have HIV, the staff where you collect your results will counsel you and give you advice on care and treatment.

If you agree, we will keep left-over samples at our laboratory for 5 years. Later, we may do some more tests on your samples to know more about HIV and any other infections or medical conditions and for the development of new laboratory tests for HIV, STIs and any other medical conditions. Your name will not be on any of the left over samples, so we cannot contact you and inform you of the results of any future tests.

Risks

If you take part in the survey, it may hurt a little bit to give your blood and this may cause bruising.

If you choose to get your test results, you may find out you have HIV, which may cause worry and confusion. You will be told your test results by a trained counselor who can answer questions and give you information about how to stay healthy and prevent infection to your partners.

Benefits

If you take part in this survey you will get free counseling and testing for HIV. We will give you information about HIV as well as condoms.

Confidentiality

We will not use your name, address or any other personal information on any of the documents associated with this study. All samples will be labeled only with a number. After the survey, all forms and test results will be kept in a locked cabinet in a private room where only survey staff will have access.

What will happen to the results of the study?

The results of the study will be written in a report, which will be published by the National AIDS Council and the Ministry of Health. The results will help design programs to improve health and prevent the further spread of HIV in Seychelles.

Contact information of survey investigators

If you have any questions about the study, what your rights are if you take part in this survey, or your concerns, you may talk to (*Rosie BISTOQUET*). The phone number is: (_____). I can also give you contact numbers for the main investigator (*Benjamin VEL*) of the survey: **250 63 48**

Thank you for taking the time to learn about this study. It is up to you to decide if you want (will let your _____) to take part. If you decide to (let your _____) take part, we would like to get your consent. You (Your _____) are still free to withdraw at any time and without giving a reason.

Please tick boxes (Pay attention to Box 3 and 4)

1. ☐ The respondent confirms that s/he have been read the informed consent sheet for the study and have understood the content. He or she also confirms that s/he have had the opportunity to ask questions. (***The parent / guardian confirms that s/he have been read the informed consent form and have understood the content. S/he hereby gives consent for his/her _____ to take part in this study.)***

2. ☐ The respondent understands that his or her participation (***the participation of his or her _____***) is voluntary and that s/heis free to withdraw at any time, without giving any reason, without his /her medical care or legal rights being affected.

3. ☐ The respondent agrees to (***let his or her _____)*** take part in the above study by giving a blood sample for HIV.

4. ☐ The respondent (***The parent or guardian***) does not agree to (***let his or her _____)*** take part in this study.

_____ _____

Name of Person taking consent Date Signature

VERSYON KREOL– Servi menm form pour bann miner e ranplas bann mo kot fodre

Participant ID number: _____

Entrodiksyon

*Bonzour, mon non i (_____). Nou pe kontinny nou travay lo sa lanket / serve lo konesans, latitid, pratik e konportman an relasyon ek HIV (SIDA) e lezot maladi transmit par seks. Sa voyaz, nou anvi konnen ki kantite HIV (SIDA) i anna dan popilasyon an zeneral. Avan ou deside (**les ou _____**) partisipe, i enportan pour ou konnen akoz nou pe fer sa letid e ki mannyer ou pou pran par, si ou dakor.*

Mon pou donn ou lenformasyon lo sa letid e donn ou letan pour reflesir. A nenport ki moman, si en keksoz pa kler, aret mwan si ou anvi plis lenformasyon.

Ki bi sa serve?

Nou anvi konnen ki kantite SIDA i annan dan nou popilasyon zeneral. Nou anvi konnen akoz en bann dimoun i annan risk ganny HIV (SIDA). Sa letid pou ed Sesel konn plis lo HIV (SIDA). I ed gouvernman pour donn servis nou kominote. Konsey nasyonal SIDA avek Minister Lasante ki per fer sa letid e Gouvernman Sesel ki pe peye a traver Fond nasyonal SIDA, Minister Lasante e Fon Nasyon Zini Pour Popilasyon (UNFPA).

Eski mon bezwen pran par?

*I antyerman depann lo ou pour deside si ou pou (**les ou _____**) partisipe. Si ou dakor pour pran par, ou (_____) ankor kapab arete a nenport ki moman san donn okenn rezon.*

***Ki pou arive ek mwan si mon deside partisipe*?**
(Ki pou arive ek mon_____si mon les li partisipe?)

*Nou pou demann ou pour donn ou konsantman pour (**les _____**) partisip dan sa letid. Konsantman savedir ou konpran tou keksoz dan sa letid e ou kapab pran en desizyon si ou pou partisipe.*

Tes

*Si ou dakor, mon pou pran en pe ou / **son** disan. Avan mon tir ou disan, mon pou konsey e donn ou lenformasyon lo HIV (SIDA). Nou pou teste ou / **son** disan pour HIV (SIDA).*

Apre ki ou'n donn disan, ou kapab ganny ou rezilta dan 2 semenn depi dat ozordi kot CDCU twa zonm kot Minister Lasante. I ou swa si ou anvi ganny ou rezilta. Si ou annan HIV, ners kot ou pou al sers ou rezilta pou konsey ou e diskit tretman ek swen ek ou.

Si ou dakor, nou pou gard ou disan ki reste dan laboratwar pour ankor 5 an. Pli tar, nou kapab teste ou disan ek bann nouvo tes e pour konn plis lo HIV (SIDA) e lezot kalite lenfeksyon e kondisyon medikal. Ou non pa pou lo okenn sa bann tib disan ki'n reste e nou pa pou kapab kontakte ou e enform ou pour okennn rezilta.

Risk

Si ou partisip dan sa lanket, letan nou pou tir disan, ou pou ganny en pti pe douler e i kapab reste en pti mark.
Si ou swazir pour al rod ou rezilta, ou kapab dekouver ki ou annan HIV (SIDA). Sa i kapab fer ou per e konfize. En ners kalifye ki pou donn ou rezilta. Li, i pou kapab reponn ou bann kestyon e donn ou lenformasyon lo fason ki ou (_____) kapab reste an bonn santé e anpes pas lenfeksyon ek lezot dimoun.

Benefis

Si ou (_____) partisip dan sa letid, bann konsey ek tes HIV (SIDA) I pou nanryen. Ou pou ganny lenformasyon lo HIV (SIDA) e kapot.

Konfidansyalite

Nou pa pou demann ou ou non, ladres oswa okenn lezot lenformasyon personnel ki kapab idantifye ou. Tou disan pou annan en limero. Apre sa letid, tou bann dokiman pe ganny enfermen dan en lofis kot zis bann dimoun konserne pou ganny akse.

Ki pou arive avek rezilta sa letid?

Apre sa resers, Konsey Nayonal SIDA ek Minister Lasante pou publiy rezilta dan en rapor nasyonal. Sa bann rezilta pou ede donn bann servis, prepar e fer bann progranm pour amelyor lasante e anpes HIV (SIDA) propaze dan Sesel.

Kontakt

*Si ou annan okenn kestyon e konsern lo sa letid, ki ou bann drwa si ou pran par, ou kapab koz ek (**Rosie BISTOQUET**), sa asistan anketer. Son limero telefonn i _____. Mon kapab osi donn ou limero telefonn sa dimoun ki ansarz resers an antye (**Benjamin VEL – 250 63 48**).*

Mersi pour letan ki ou'n donnen pour aprann plis lo sa letid. Ou ki deside si ou (_____) pou pran par. Si ou deside (les ou _____) partisipe, nou pou demann ou konsantman. Ou kapab arete a nenport ki moman san donn okenn rezon.

Met en tik (✓) dan bwat (Vey byen bwat 3 ek 4)

1. ☐ *Partisipan i konfirmen ki i'n ganny lir sa form konsantman pour sa letid e ki i'n konpran sa bann lenformasyon. I konfirmen ki i'n ganny sans demann kestyon. **Paran oubyen gardyen sa miner i konfirmen ki i'n ganny lir sa form konsantman e ki i'n konpran sa bann lenformasyon. I'n pare pour les son _____ partisip dan sa letid.***

2. ☐ *Partisipan (**Paran oubyen gardyen**) i'n konpran ki son partipasyon (**son _____**) i volonter e ki i lib pour arete a nenport ki moman, san perdi son drwa ganny swen medikal oubyen ki son drwa legal i ganny afekte.*

3. ☐ *Partisipan (**Paran oubyen gardyen**) i'n dakor pour (**les son _____**) partisip dan sa letid e tir disan pour teste HIV (SIDA).*

4. ☐ *Partisipan pa'n dakor pour partisip dan sa letid.*
   Paran oubyen gardyen sa miner pa'n dakor pour les son _____ partisip dan sa letid.

_____	_____	_____
Name of Person taking consent	**Date**	**Signature**

1.3 Informed Consent Form for Minors

INFORMATION NOTE FOR INTERVIEWERS

A parent, for purposes of consent, means either a minor's biological or adoptive parent. In some instances, the consent of a guardian may be used instead of parental consent. A guardian is an individual who is authorized under national law to consent on behalf of a minor(15 to 17 years) to important decisions, such as general medical care.

For the purposes of this research a ***guardian*** is:

1. A person appointed guardian of a minor, according to the Children Act as documented by a valid court order;

2. A person having legal custody of a minor and as documented by court order;

3. A person (sister, brother, uncle, aunt, godfather, godmother, grandparents, parents-in-law) above 18 years, acting *in loco parentis*, regardless of whether such is documented by a court order. A person acts*in loco parentis* of a minor where the individual voluntarily assumes responsibility for the minor's custody, care, and maintenance even though no court order exists formally appointing the person as the guardian, legal custodian, or adoptive parent of the minor.

Introduction: "My name is …… I'm working for the Ministry of Health, and we are interviewing people all over the Seychelles as part of a national survey on HIV and AIDS. We want to get a picture of how HIV might be spreading in Seychelles, and what we can do about it. The study covers people aged 15 to 64 years. So, some minors (people under 18 years of age) may be selected to participate in this study.

Hasthe minor been interviewed already for this study?

(**IF THE RESPONDENT HAS BEEN INTERVIEWED BEFORE, DO NOT INTERVIEW THIS PERSON AGAIN.**
Tell them you cannot interview them a second time, thank them, and end the interview). If they have not been interviewed before, continue:

Explanations: "You are making a decision whether or not to have your ……(State the relationship) participate in this study. I will sign this document to show that you have verbally given your consent. This is done because we do not want your name or that of your _____ to be associated in any way with this research.

Would you like me to go on?

(**IF THE PARENT OR GUARDIAN SAYS YES, PROCEED.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

Your**_____** has been selected by the computer to take part in this study. I amasking you for your permission to allow your _____ to take part in this study. I am going to ask him or her some personal questions that may he or she may find difficult to answer. His or her answers are

completely confidential- that means his or her name will not be written on this form or associated with it in any way, and his or her name or identity will never be used in connection with any of the information he or she tells me.

All the information we collect from over 1600 interviews will be analysed together to give us a general picture of the situation in the country as a whole. Your_____ does not have to answer any questions that he or she does not want to answer, and he or she may end this interview at any time he or she wants to. However, his or her honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviours. We would greatly appreciate your help in allowing your child to respond to this survey. The survey will take about 60 minutes to ask the questions.

Your _____ will be interviewed alone to allow for his or her answers to remain confidential. I will not be able to share his or her answers with you as this is not the purpose of this study.

Would you like me to go on?

(**IF THE PARENT OR GUARDIAN SAYS YES, PROCEED.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

Do you have any questions you would like to ask me?

(QUESTIONS AND ANSWERS. SEE GUIDE)

Would you be willing to let your (_____) participate?

(**IF THE PARENT OR GUARDIAN SAYS YES, THANK THEM AND ASK TO BEGIN INTERVIEWING THE CHILD. GO OVER THE INSTRUCTIONS PRIVATELY WITH THE CHILD.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

_____	_____	_____
Name of Person taking consent	**Date**	**Signature**

VERSYON KREOL

***Entrodiksyon**: "Mon non i …… Mon pe travay pour Minister Lasante. Nou pe fer en lanket / serve nasyonal partou dan Sesel lo HIV ek SIDA. Nou anvi konpran ki mannyer HIV (SIDA) pe ganny transmet dan Sesel e ki nou kapab fer lo sa sitiasyon. Sa resers pe fer ek dimoun aze ant 15 a 64-an. Alors pou annan en pe miner, dimoun ki anba 18-t-an ki pou ganny swazir pour partisip ladan.*

Eski ou _____ i'n deza ganny "interview" pour sa letid?

***Eksplikasyon: "**Ou pou deside si ou _____ pour partisip dan sa letid / lanket. Mwanpou sinny dan ou plas si ou dir wi / ou dakor / ou aksepte. Mon pou fer sa akoz sa resers i konpletman konfidansyel / sekre e nou pa oule ou non e non ou _____ aparet dan okenn sa bann dokiman.*

Ou tia kontan plis lenformasyon?

(**IF THE PARENT OR GUARDIAN SAYS YES, PROCEED.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

***Konfidansialite e konsantman:** "Mon pou demann ou _____plizyer kestyon personel ki kapab difisil pour li reponn. Son bann larepons i konpletman konfidansyel – savedir son non pa pe ganny ekri lo sa form oubyen ganny asosye avek sa form dan okenn fason. Son non ek son idantite pa pou ganny servi an koneksyon avek bann lenformasyon ki i donn mwan. Tou lenformasyon ki nou pou kolekte dan sa plis 1, 600 form pou ganny analize ansanm pour nou ganny en portre kler lo sitiasyon SIDA dan Sesel.*

I pa oblize reponn okenn kestyon ki i pa anvi reponn. I kapab aret sa interview nenport ki moman si i oule. Par kont (Selman) son bann larepons onnet pour sa bann kestyon pou ed nou konpran pli byen sa ki dimoun pe mazinen, pe dir e pe fer konsernan serten kalite konportman. Nou pou vreman apresye ou led si ou les li partisip dan sa lanket / serve. Sa bann kestyon pou pran apepre 60 minit pour reponn.

Ou (_____) pou ganny interview li tousel akoz i enportan ki son larepons i reste konfidansyel. Mon pa pou dir ou sa ki i'n dir nou. I

Ou tia kontan plis lenformasyon?

(**IF THE PARENT OR GUARDIAN SAYS YES, PROCEED.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

Eski ou annan okenn kestyon pour demande?

(QUESTIONS AND ANSWERS. SEE GUIDE)

Eski ou aksepte ou (_____) partisip dan sa serve / lanket?")

(**IF THE PARENT OR GUARDIAN SAYS YES, THANK THEM AND ASK TO BEGIN INTERVIEWING THE CHILD. GO OVER THE INSTRUCTIONS PRIVATELY WITH THE CHILD.**

IF THE PERSON SAYS NO, THEN STOP THE MEETING, THANK HIM OR HER OR THEM AND LEAVE)

_____	_____	_____
Name of Person taking consent	**Date**	**Signature**

Appendix 2 – Study Team Composition

Technical Working Group:

1. Vincent Okullo, Joint UN Volunteer
2. Dr. Cornelia Atsyor, WHO Liaison Officer for Seychelles
3. Ms. Rosie Bistoquet, Co-investigator, Director Family Health and Nutrition and NAC Coordinator
4. Joachim Didon – Senior Statistician
5. Helena Delétourdie from National Bureau of Statistics
6. Mr. Prosper Kinabo, Director Clinical Laboratory
7. Mr. Rodney Philo – Director National Institute of Health and Social Studies
8. Georgette Furneau, Nurse Manager Communicable Diseases Control Unit
9. Dr. Meggy Louange, Director Communicable Diseases Control Unit
10. Judie Brioche, Nurse Manager Youth Health Centre
11. Dr. Anne Gabriel, Chaiperson Technical Advisory Committee, Chief Medical Officer, Community Health Services
12. Nicholas Shamlaye, Public Health Officer, Ministry of Health
13. Sabrina Mousbe, National AIDS Control Programme Manager, Ministry of Health
14. Myra Bijoux, Secretary, Health Promotion Office, AIDS Control Programme

Study team:

1. Benjamin Vel, Lead investigator, consultant (Seychelles)
2. Rosie Bistoquet, Co-investigator, Director Family Health and Nutrition and NAC Coordinator
3. Joachim Didon, Statistician, Senior Statistician of the Ministry of Health
4. Sabrina Mousbe, National AIDS Control Programme Manager, Ministry of Health

Types of personnel:

Enumerators (29)	HTC Nurses (29)	Laboratory technicians (5)
Regional Supervisors (6)	Co-Investigator (1)	Principal Investigator (1)
Data Manager (1)	Data entry clerks (3)	Logistical & Administrative Coordinator (1)
Transport Supervisor (1)	Administrative Officer (1)	Treasurer (1)
TWG (6)		

Roles and Responsibilities:

This survey will be led by the **Lead Investigator** (LI), assisted by a Co-Investigator (CI) who will be overseen by the Technical Working Group. The LI will be the main technical person and responsible for finalizing a survey protocol, developing questionnaires and other tools, ensuring the protocol has been reviewed and granted ethical approval, overseeing data collection, analysis and dissemination of results. In collaboration with the Ministry of Health, he will identify and recruit survey personnel as indicated above.The LI and CI will also be responsible for the training, pretesting of survey tools, data collection and quality assurance.

The LI will also organize an initial training of survey methodology, tools and data collection processes for the enumerators, HTC nurses and laboratory technicians.

The Site Supervisors will lead the field work and they will be closely assisted by PI, CI and Statistician who will be responsible for ensuring appropriate sampling strategy, data quality mechanism, data storage and analysis systems using recommended statistical software are in place.

Data collectors or enumerators (E) for the behavioural survey will be health workers preferably HTC nurses, clinical assistants or laboratory workers or NIHSS students. For the biological survey, only HTC nurses will be used.

For biological sample analysis, only qualified laboratory technicians will be used.

It is assumed that 90 working days will be needed to complete the work and that 29 ES will be needed.

2.1 Terms of Reference

2.1.1 Technical Working Group

Purpose:

TECHNICAL AND ADVISORY ROLES
To provides oversight and technical guidance in the HIV Prevalence and Behavioural Survey design, implementation, analysis, and dissemination throughout the study. The group consists of eight to ten members, including investigators, drawn from research institutions, National Statistic Bureau, UN Joint team, HIV/AIDS experts, with specific relevant technical expertise

Specific tasks will involve:

Provide technical support to the formulation, implementation and monitoring of the KAPB Study

KEY Responsibilities:

- Provide oversight on the preparation of the research protocol, for presentation to the ethical committee in Seychelles
- Advise the principal investigation on the development of survey design, methods including appropriate methods for 'HIV prevalence survey ', research tools including behavioural Survey questionnaire design.
- Support the drafting of the research plan, protocol outlining the key epidemiological and behavioral surveys, impact evaluations, or programs reviews.
- Advise a responsive budget, costing and financing plan for the study
- Assist into the capacity building of survey team based on qualification and expertise.
- Monitor the planning and implementation of integrated HIV Prevalence and Behavioral Survey activities.
- Advise in identification and recruitment of study population including piloting study procedures and survey tools/instrument
- Review and provide opinion of data collection, data management, data analysis, and report writing
- Provide technical support in developing appropriate procedures for collecting sample HIV testing and sample collection management
- Assist and review the data analysis report
- Monitor and review progress and communicates regularly through regular meetings to ensure successful completion of all activities

Members should be (or representatives of):

TC Chairperson, epidemiologist, NAC Coordinator, CDCU Representative, Statistician, AIDS Control Programme, Clinical Laboratory, NGOs, Joint UN Team, SBS Representative, Youth Health Centre Representative.

IT IS RECOMMENDED THAT MEMBERS OF THIS GROUP HAVE DEMONSTRATED EXPERIENCE AND EXPERTISE IN RESEARCH METHODOLOGY AND HIV & AIDS RESPONSE.

2.1.2 Lead Investigator

The main roles and responsibility of Principle Investigator will include the following:

1. The development of research design, methods, tools, data collection, storage, entry, cleaning, analysis and report writing.

Specific tasks in under guidance of TWG will involve:

2. Preparation of the research protocol, including consent forms in close consultations with TWG and seek ethical approval for ethical committee in Seychelles;
3. Development of survey design, methods including appropriate methods for 'HIV prevalence survey ', research tools including Behavioral Survey Questionnaire design;
4. Planning and implementation of integrated HIV Prevalence and Behavioral Survey activities ;
5. Support identification and recruitment of study population;
6. Piloting study procedures and survey tools/instrument;
7. Overall supervision of data collection, data management, data analysis, and report writing;
8. Provision of technical support in developing appropriate procedures for collecting sample HIV testing and sample collection management;
9. Advice and monitoring of data quality including data cleaning and verification of information from the study;
10. Preparing data analysis plan and techniques including a coding system and data screen input format either in Stata or SPSS for analysis;
11. Preparing data analysis report;
12. Provision of technical support to the analysis process and how to reconcile the results obtained from national surveys with those obtained from sentinel surveillance to produce an estimate of HIV prevalence in a country;
13. Reports on progress and communicates regularly with TWG on emerging needs among the field teams to ensure successful completion of all activities

COORDINATION SUPPORT ROLES

He will be responsible for coordinating the different research activities on a day to day basis and some tasks include:

- Providing technical assistance to TWG and NAC in recruitment and training of research supervisors, research assistants and interviewers/enumerators
- Ensure effective communication among different teams and persons at different levels.
- Work in collaboration with TWG to support supervision of field teams ensuring high quality data collection, adherence of implementation to study protocol and procedures
- He is expected to contribute to budget and operations planning to ensure smooth day to day operations
- Write Report and present final findings on the 06th November to the NAC for validation
- Dissemination workshop on 01st of December 2012 at the occasion of the World AIDS Day 2012.

SUPERVISION

The Principal Investigator will be based at the Ministry of Health offices, reporting to the Steering Research committee and NAC secretariat and working closely with Technical Working Group.

2.1.3 Co-Investigator

Purpose

LEARDERSHIP/ ADVISORY / COORDINATION ROLES

Assist the Principal Investigator for the HIV Prevalence and Behavioural Survey to ensure the development of research design, methods, tools, data collection, storage, entry, cleaning, analysis and report writing are undertaken based on the approved timeframe

Specific tasks:

1. LEADERSHIP roles before the recruitment of principal investigator

1. Revived the research committee for guidance of the best protocol to be implementing in the Seychelles context.
2. Produce the concept note for the study.
3. Define and propose the activities and timeframe for survey
4. Prepare and produce accurate budget breakdown for the pilot and the main study.
5. Advocate and seek potential funders.
6. Present the proposed the concept note for approval by the TAC and the research committee.
7. Develop the terms of reference for the recruitment of the national consultant
8. Seek the approval of the TAC and research committee for the consultancy
9. Advertise for recruitment of the consultancy in the local written media.
10. Set up panel for selection of consultancy
11. Sit on panel of recruitment
12. Recruitment national consultant
13. Develop Terms of reference for the Coordinating team TWG, enumerators, Nurse, supervisors, laboratory technicians, Data managers, Admin& logistics Coordinators, and Treasurer
14. Nomination of Survey team

2. ADVISORY ROLES

- Provide Technical and administrative inputs on the various tools and methodology of the survey
- Ethical consideration
- Implementation plan
  - Re adjust the Timeframe and budget as necessary

3. CORDINATION AND SUPPORT ROLES

- Overall coordination of the pilot study
- Overall coordination of the main study on Mahe and the Inner Islands
- Prepare and convene weekly meetings with the TWG to report on the progress
- Prepare and assist with preliminary two days training of the team on both Mahe and the inner islands
- Prepare and assist with the one day post "pilot survey" re-training of the survey team in preparation for the main study.
- Prepare and coordinate meetings with the research Committee at least three times on the progress of the survey
- Assist with training component and facilitate training based on training
- Provide technical input of the analytical report of the survey.
- Prepare validation meeting of the survey results with the Ministry of Health Central Management Committee
- Prepare and assist with the one day multisectoral consultative forum
- Prepare and coordinate the Validation meeting with the NAC
- Ensure the dissemination of the survey results to all stakeholders including publishing.

4. RESPONSIBLE

The Co-Investigator will be based at the Ministry of Health offices, reporting to the Principal Investigator and the Steering Research committee and NAC secretariat.

2.1.4 Statistician / Data Manager

Purpose

Data will be managed by the survey data manager who will provide an oversight to the methodology and tool to be used in the survey including data collection, data management and analysis. Will be responsible for ensuring appropriate sampling strategy, data quality mechanism, data storage and analysis systems using recommended statistical software are in place.

Key responsibilities

1. Devise the sample frame and sample size of the study
2. Assist the main investigator with the sampling list using simple random sampling as per district age and sex
3. Assist with the establishment of the database for the study after finalizing the questionnaire
4. Assist with the pretesting of survey tools and data quality assurance
5. Facilitate with the training of enumerators and supervisors
6. Ensure with the regional supervisors that the data entered on the filled questionnaires are consistent, accurate and of quality.
7. Assist with the coding of open-ended questions and the coding list.
8. Train the data entry persons on the usage of the database SPSS 16.0
9. Ensure data quality is continually monitored from the stage where data collectors are
    a. recruited until the database is complete and ready for analysis
10. Supervise the data entry persons to ensure data quality
11. Oversee the cleaning after computer data entry and validation programs and will provide feedback to carry out appropriate corrective actions.
12. Run relevant tables as per research objectives for the main investigator

Responsible to:

The data manager will fall under the responsibility of the main investigator

2.1.5 Regional Supervisor

Purpose

The main responsibility of Regional Supervisors will provide ongoing supervision of data collection teams and check for data completeness and consistency at the end of each day. He/She will be examine and test the data collectors everyday for any technical problems. He/She will also act as the driver for questionnaire and specimen collections including regional staff to sites.

Key responsibilities

1. Responsible for the enumerators and nurses in the districts that fall under his/her due restrictions
2. Ensure that the enumerators are supplied with all the tools they need e.g. pens, pencils, sharpeners, clip boards, name tags and questionnaires during the data collection
3. Meet with enumerators and nurses at regional sites prior to collection of data at demarcated district.
4. Ensure that all questionnaires are well filled by the enumerators and discuss with them on a daily basis
5. Submitting all completed questionnaire to the headquarters Central level
6. Ensure that all blood samples with forms are submitted to the lab and questionnaires to Central level on a daily basis
7. Drive and drop the enumerators and nurses to their area of enumeration
8. Attend weekly meeting with survey team on a weekly basis to discuss related issues
9. Ensure transport allocated are well maintained and re-fuelled periodically
10. Keep records of vehicle mileage as recommended by transport supervisors

Responsible to:

The regional supervisors are responsible to co-investigator data collection/blood specimens and transport supervisor for any transportation technical issues.

2.1.6 Enumerators

Purpose

Enumerators are responsible for carrying out interview with individuals selected for the specific survey. An enumerator has the task of delivering first had information from the community therefore it is important that the information being gathered is as accurate as possible.

Key responsibilities

1. Study and understand all instructions included in the enumerators guide and trainings provided;
2. Coordinate with the supervisor on how to to carry out the survey and to report daily work done;
3. Check that material necessary to carry out the survey is sufficient and appropriate;
4. Introduce yourself, explaining who you are and for who you are working in a manner that facilitates the participation of individuals in the survey;
5. Ask questions in a clear and kind manner, and ask all the questions exactly as worded:
6. Probe to clarify unclear answers;
7. Write down the answer in an ordinate and clear way, recording responses accurately;
8. Double check and revise the survey at the end of the survey in order to correct mistakes and sign off on completed surveys as verification of the accuracy of the survey.
9. Ensure adherence to the Code of Conduct for Enumerators

Responsible to:

The Enumerators will report to the regional supervisor, and in his/her absence will report to the Co – Investigator.

2.1.7 Qualified Nurses

Purpose

Nurses are responsible for pre and post councelling, blood specimen collection of individual selected specific for the survey, using standard guidelines and procedureswhilst observing Universal precautions during blood specimen collection.

Key Responsibilities

1. Have at hand all necessary medical equipments, items and for collection of blood samples.
2. Conduct pre counseling
3. Ensure participant is clear on the methodology of the specimen collection
4. Complete and ensure consent form is signed by participant
5. Complete form for participants who opted out.
6. Collect Seven milliliters (7 ml) of venous blood will be collected from participants using venipuncture
7. After the specimen is collected, label the specimen container with a lab number and record the lab number in the 'specimen log book' and linked with the participant's unique identifier code
8. Conduct post councelling
9. Store blood collected in accordance with set laboratory guidelines and procedures.
10. Hand over specimen to the supervisors for transportation to the Ministry of Health clinical Laboratory

Responsible to:

The nurses will report to the Co – Investigator.

2.1.8 Laboratory Technicians

Purpose

Laboratory Technician will ensure proper collection of samples in the laboratory and ensure that all test required to be conducted are conducted to the highest of standard and in the timeframe given.

Key responsibilities

1. Ensure samples collected according to set standards and are usable;
2. Conduct all tests related to the survey
3. Keep proper records of sample collected and results reported

Responsible to:

The laboratory technician will report to the senior laboratory Technician, who in turn reports to the Co– Investigator.

2.1.9 Data Entry Clerks

Purpose

The data entry clerk will be responsible to enter data received from data collectors into special tools designed for that purpose.

Key responsibilities

1. Assist with the coding of open-ended questions and coding list.
2. Entering of the filled questionnaires in the SPSS data base
3. Ensure all entries correspond with data obtain from questionnaire

Responsible

- The clerk data will fall under the responsibility of the Data Manager

2.1.10 Office Assistance

Purpose

The main tasks of the Office assistance is to p ensure the smooth running of the team office by providing clerical, secretarial duties assigned by the Logistic and administrative Coordinator.

Key Responsibilities

1. Undertake basic clerical, typing or office assistant tasks associated with the survey
2. Carry out basic photocopying tasks
3. Response to all communication to and from the survey team
4. Convey communications received promptly and efficiently
5. Records all correspondence received or to be dispatched.
6. Undertake copy and printing tasks allocated
7. Bok and confirm logistics for trainings and meeting
8. Collect and produced invoices from services providers
9. Purchasing items necessary for the survey
10. Deliver items/ materials/ to training/meeting facilities.

Responsible to:

Office assistant is responsible to logistic and administrative coordinator

2.1.11 Treasurer
Terms of Reference for Treasurer

Purpose
The treasurer has the role of overseeing all financial aspect of the study while working closely with other members of the study team.

Key responsibilities

- Oversee and present budgets, accounts and financial statements to the study team
- Liaise with designated staff about financial matters
- Ensure that appropriate financial systems and controls are in place
- Ensure proper record-keeping
- Ensure use of funds complies with conditions set by funding bodies
- Set up appropriate systems for book-keeping, payments and petty cash
- Ensure everyone handling money keeps proper records and documentation
- Ensure compliance with relevant legislation.
- Collect relevant proforma/ invoices pertaining to the study
- Ensure all payment made are timely

Responsible

The treasurer will report to the Logistic& Admin Coordinator.

2.1.12 Driver

Purpose

Provision of transport facilities to personnel to and from sites and completed questionnaires and blood specimens are transported to the clinical laboratory.

Key Responsibilities

1. Ensuring that proper maintenance of the assigning vehicle is taken place on day-to-day and report on any problem on time.
2. Drive vehicle for transportation of authorized personnel and delivery/collection of specimen and questionnaires.
3. Transportation of support staff to their home after completion of work on a daily basis
4. All specimen and questionnaire are handed over to the administrative coordinator on a daily basis after collection.
5. Perform all other related duties as per assigned by administrative coordinator
6. Make distribution of the materials or documents to appropriate persons.
7. Provide logistical support to office assistant to the organization and preparation of all workshops, meetings etc…
8. Make field trips as per allocated schedule.
9. Maintain all vehicles in good conditions
10. Ensure that the steps required by rules and regulations are taken in case of involvement in accident.
11. Transport should be at the Ministry of Health premise by 10pm and keys should be handed over to the administrative coordinator on a daily basis.

Any intended change in Rota must be done in consultation and authorization of the administrative coordinator.

Responsible to:

All drivers are responsible to theLogistic and Administrative Coordinator

2.1.13 Transport Supervisor

Purpose

Ensure the availability of transport fleet throughout the study period to personnel to and from sites with minimum risks and the provision of all transportation.

Key Responsibilities

- Hiring of fleet of transport required throughout the survey
- Hand over vehicles to drivers with appropriate monitoring tools on a daily basis
- Improvise for alternative transportation in cases of breakdown
- Ensure all drivers maintain vehicles assigned to them and monitor on a daily basis.
- Ensure drivers transport authorized personnel and delivery/collection of specimens and questionnaires.
- Refuel transport in accordance with the Ministry of health regulations.
- Ensure all drivers replenish all clinical items and other materials needed for the survey on a daily basis
- Replace drivers when necessary
- Resolve and report on any problem encountered by drivers on report sheet on a daily basis
- Perform all other related duties as per assigned by administrative coordinator
- Ensure transport to the inner islands are maintained and drivers reports to you
- Maintain all vehicles in good conditions
- Ensure that the steps required by rules and regulations are taken in case of involvement in accidents.
- Make sure all drivers and transports are at the Ministry of Health premise- Blue Roof Building by 8am in the morning and by 10pm on a daily basis.
- Any intended change in Rota must be done in consultation and authorization of the administrative coordinator.

Responsible

Responsible to administrative coordinator

3.1.14 Logistics & Adminitration Coordinator

Purpose

Provide day to day managerial operation throughout the survey composed of transportation, and other logistics and supervision of staff undertaking administrative tasks.

Key Responsibilities

Supportive roles

- Assist the team with efficient coordination of the survey
- Coordinate the nurses into the specimen collection
- Assist with the dissemination of survey results.
- All minutes of meetings are compiled and distributed to members.
- Provide technical support to survey team

Human Resources

- Devise work plan for all staff undertaking administrative and logistics
- Supervise transport supervisors and Office assistance
- Ensure all stationeries and other tools (questionnaires, forms, to be used are available.
- All medical equipments items made available and distributed accordingly
- Keep tract and records of attendances of implementing team
- Respond to queries and provide information and advice to staff on related matters related to study

- Guarantee all records are kept and filed in an orderly manner
- Disseminate relevant information to staff from the headquarters

Facilities and Funds

- Ensure venues for meetings and training are booked and confirmed
- Ensure all items, meals, are available for trainings
- Partake into the budget plan of the survey
- Provide up to date information and necessary directions to the treasurer for budget disbursement

Responsible

The Administrative and logistic coordinator reports to the Co – Investigator

Appendix 3 – Behavioural Surveillance Questionnaire

Questionnaire identification number |___|___|___|___| Respondent number |___|___|___|
Sub-district / Enumeration Area _____ _/ _____ **District** _____
Region _____

Introduction: "My name is …… I'm working for the Ministry of Health, and we are interviewing people all over the Seychelles as part of a national survey on HIV and AIDS. We want to get a picture of how HIV might be spreading in Seychelles, and what we can do about it. Have you been interviewed already for this study? / **(*Entrodiksyon*: *"Mon non i …… Mon pe travay pour Minister Lasante. Nou pe fer en lanket / serve nasyonal partou dan Sesel lo HIV ek SIDA. Nou anvi konpran ki mannyer HIV (SIDA) pe ganny transmet dan Sesel e ki nou kapab fer lo sa sitiasyon. Eski ou'n deza ganny "interview" pour sa letid?)*

(**IF THE RESPONDENT HAS BEEN INTERVIEWED BEFORE, DO NOT INTERVIEW THIS PERSON AGAIN.**
Tell them you cannot interview them a second time, thank them, and end the interview). If they have not been interviewed before, continue:

Confidentiality and consent: "I am going to ask you some personal questions that you may find difficult to answer. Your answers are completely confidential- that means your name will not be written on this form or associated with it in any way, and your name or identity will never be used in connection with any of the information you tell me. All the information we collect from over 1600 interviews will be analysed together to give us a general picture of the situation in the country as a whole. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviours. We would greatly appreciate your help in responding to this survey. The survey will take about 60 minutes to ask the questions. Would you be willing to participate?" / ***(Konfidansialite e konsantman:** "Mon pou demann ou plizyer kestyon personel ki ou kapab vwar difisil pour reponn. Ou bann larepons i konpletman konfidansyel – savedir ou non pa pe ganny ekri lo sa form oubyen ganny asosye avek sa form dan okenn fason. Ou non ek ou idantite pa pou ganny servi an koneksyon avek bann lenformasyon ki ou donn mwan. Tou lenformasyon ki nou pou kolekte dan sa plis 1, 600 pou ganny analize ansanm pour nou ganny en porter kler lo sitiasyon dan pei an antye. Ou pa oblize reponn okenn kestyon ki ou pa anvi reponn. Ou kapab aret sa interview nenport ki moman si ou oule. Par kont (Selman) ou bann larepons onnet pour sa bann kestyon pou ed nou konpran pli byen sa ki dimoun pe mazinen, pe dir e pe fer konsernan serten kalite konportman. Nou pou vreman apresye ou led ler ou partisip dan sa lanket / serve. Sa bann kestyon pou pran apepre 60 minit pour reponn. Eski ou anvi partisip dan sa serve / lanket?"*)

_____
(Signature of interviewer, certifying that a verbal informed consent has been given, by respondent)

Interviewer visit

	Visit 1	Visit 2	Visit 3
Date	____ / ____ / _____	____ / ____ / _____	____ / ____ / _____
Interviewer code			
Result			

Result codes:

1	Completed	**2**	Respondent not available
3	Refused	**4**	Partially completed
5	Others		

INTERVIEWER: Code [____|____]
Name of interviewer _____

DATE OF INTERVIEW: ____ / ____ / _____

CHECKED BY SUPERVISOR: Signature _____ **Date** ____ / ____ / _____

The questionnaire includes the following sections:

Section	Number of Questions
0: Questionnaire Identification Data	
1: Background characteristics	16 (Q1 to Q16)
2: Knowledge, opinions, and attitudes towards HIV/AIDS	22 (Q17 to 38)
3: Knowledge, opinions, and attitudes towards STIs	11 (Q39 to Q49)
4: Marriages & live-in relationships	8 (Q50 to 57)
5: Sexual history: numbers and types of partners	30 (Q58 to Q87)
6: Sexual history: regular partners	4 (Q88 to Q91)
7: Sexual history: commercial partners	5 (Q92 to Q96)
8: Sexual history: non-regular partners	5 (Q97 to Q101)
9: Female and Male condoms	17 (Q102 to Q118)
TOTAL NUMBER OF QUESTIONS	**118**

Section 1: Background characteristics

No.	Questions and filters	Answers	Codes
1.	Sex of the respondent / ***Seks partisipan***	Male / ***Zonm***	1
		Female / ***Fanm***	2
2.	By the end of 2012, how old would you be? / ***Lafen 2012, ki laz ou pou annan?***	Age (in years) / ***Laz (an lannen)***	☐☐
		Don't know / ***Pa konnen***	88
		No response / ***Napa larepons***	99
3.	Have you ever attended school? ***Eski ou'n deza al lekol?***	Yes /***Wi***	1
		No / ***Non***	2 → **Q5**
		No response / ***Napa larepons***	99

Section 1: Background characteristics

No.	Questions and filters	Answers	Codes
4.	If yes, what is the highest level of school you have completed? ***Si wi, dan ki laklas ou ti fini lekol?*** **CIRCLE ONLY ONE.** **IF RESPONDENT HAS STOPPED AND THEN STARTED AGAIN AND COMPLETED ANOTHER LEVEL, USE THIS LEVEL AS THE LAST ONE COMPLETED. (e.g., stopped in secondary, then did evening classes and reached O or A'Levels)** **Skip to Q7**	Primary (Standard) / ***Primer*** Secondary (Form) / ***Segonder*** Post-secondary (technical) / ***Pos-segonder lekol teknik*** Post-secondary (academic) / ***Pos-segonder lekol akademik*** 'A' Levels Diploma Bachelor Masters Doctorate No response / / ***Napa larepons***	1 2 3 4 5 6 7 8 9 99
5.	What is your current employment status? ***Eski ou pe travay konmela?***	Unemployed & looking for work / ***Pa travay e pe rod en travay*** Unemployed & not looking for work / ***Pa travay e pa pe rod en lanplwa*** Employed full time / ***Anploye a plen tan*** Employed part time / ***Anploye part-"time"*** Student / ***Etidyan*** Retired / ***A la retret*** Self-employed / ***Travay pour mwan menm*** No response / / ***Napa larepons***	1 → **Q7** 2 → **Q7** 3 4 5 → **Q7** 6 → **Q7** 7 99 → **Q7**
6.	What is your current occupation? / ***Ki ou metye oubyen ou profesyon konmela?***	_____	
7.	What is your religion? / ***Ki ou larelizyon?***	_____ No religion / ***Napa larelizyon*** 0 No response / ***Napa larepons*** 99	

8.	What is your nationality? / ***Ki ou nasyonalite?***	Seychellois / ***Seselwa*** 1 Others: **(please state) / *Lezot (Dir lekel)***_____ 2 No response / ***Napa larepons*** 99	
9.	Do you drink alcohol? / ***Eski ou bwar lalkol?***	Yes / ***Wi*** 1 No / ***Non*** 2	**→Q12**
10.	If yes, during the last 4 weeks how often have you drunk alcohol? ***Si wi, pandan sa dernye 4 semenn, ki kantite fwa ou'n bwar lalkol?*** **"WOULD YOU SAY "** **READ OUT** **CIRCLE ONLY ONE**	Every single day of the week / ***Toulezour*** 1 Every weekend / ***Tou le wikenn*** 2 At least once a week / ***Omwen 1 fwa par semenn*** 3 Less than once a week / ***Mwens ki 1 fwa par semenn*** 4 Two to three times this month / ***De a trwa fwa dan sa dernyen 4 semenn*** 5 Did not drink at all during last 4 weeks / ***Pa'n bwar ditou pandan sa dernye 4 semenn*** 6 Once a month / ***Enn fwa par mwan*** 7 Don't know / ***Pa konnen*** 88 No response/ ***Napa larepons*** 99	
11.	How much alcohol do you drink at any one time? ***Ki kantite lalkol ou konsonmen letan ou pe bwar?*** **USE THE METHOD BY WHICH THE ALCOHOL IS DRUNK AS MEASURES, WHETHER IT IS A GLASS OR A MUG OR A PINT.** **PROBE IF THE RESPONDENTS SAY " SMALL OR BIG GLASSES"**	A single drink (pint, glass, mug or tot) / ***En sel "drink" (en ver, en sopin, en tot)*** 1 2 drinks / ***2 "drinks"*** 2 3 drinks / ***3*** 3 4 drinks / ***4*** 4 5 drinks / ***5*** 5 > than 5 drinks / ***Plis ki 5*** 6 Don't know/ ***Pa konnen*** 88 No answer / ***Napa larepons*** 99	

12.	Sometimes, people take drugs for a variety of reasons. Have you ever tried any of the following drugs? / ***I annan dimoun ki pran drog pour diferan rezon. Eski ou'n deza sey okenn sa bann drog swivan?*** **READ LIST** **DRUGS ARE NOT THOSE PRESCRIBED BY A DOCTOR.**	Does not use drugs at all / ***Pa servi drog ditou*** _____ 3 **Yes No DK NR** Marijuana / herbal cannabis / ***Mariwana*** 1 2 88 99 Ecstasy / ***Ekstazi*** 1 2 88 99 Heroin / ***Eroin*** 1 2 88 99 Cocaine (powder) / ***Kokain (lapoud)*** 1 2 88 99 Crack (crystal-form cocaine) / ***Kokain (laform Kristal)*** 1 2 88 99 Hashish / resin cannabis / ***Asis*** Others **(state) /** ***Lezot (Dir lekel)*** _____ **DK = Don't know** **NR = No response**	**→Q17**
13.	Have you taken any drugs during the **last 4 weeks**? / ***Dan sa dernye 4 semen, eski ou'n pran okenn drog?*** **EXCLUDE TOBACCO**	Yes 1 No 2 Don't know / remember 88 No response 99	
14.	Some people have tried injecting drugs using a syringe. Have you ever-injected drugs recreationally in last 12 months? **DRUGS INJECTED FOR MEDICAL PURPOSES OR TREATMENT OF AN ILLNESS DO NOT COUNT.** ***I annan dimoun ki sey pik drog dan lavenn. Dan sa dernye 12 mwan eski ou'n deza pik drog dan ou lavenn?***	Yes 1 No 2 Don't know 88 No response 99	**→ Q17** **→ Q17** **→ Q17**
15.	If yes, at what age did you start injecting drugs? / ***Si wi, ki laz ou ti annan letan ou ti premye pik drog dan ou lavenn?***	_____	
16.	How often did you inject drugs in the last 12 months? / ***Dan sa dernye 12 mwan, ki kantite fwa ou'n pik drog dan lavenn?***	Every day / ***Toulezour*** 1 Every weekend / ***Tou le wikenn*** 2 At least once a week / ***Omwen 1 fwa par semenn*** 3 Less than once a week / ***Mwens ki 1 fwa par semenn*** 4 Don't know / ***Pa konnen*** 88 No response / ***Napa larepons*** 99	

Section 2: Knowledge, opinions and attitudes			
No.	**Questions and filters**	**Answers**	**Codes**
17.	Have you ever heard of HIV or the disease called AIDS? ***Eski ou'n deza tann nonm HIV (VIH) oubyen sa maladi ki apel SIDA?***	Yes / ***Wi*** No / ***Non*** No response / ***Napa larepons***	1 2 → **Q21** 99 → **Q21**
18.	If yes, what was the source? ***Si wi, kote ou ti tann sa lenformasyon?*** **CIRCLE ALL ANSWERS GIVEN.** **DO NOT READ LIST**	Ministry of Health / ***Minister Lasante*** NGOs / ***Bann NGOs (bann lasosiasyon)*** Other Ministries / ***Lezot minister*** Newspapers, magazines / ***Zournal, magazin*** Radio, television / ***Radyo, televizyon*** Friends, Relatives, Peers / ***Zanmi, manm fanmiy, bann dimoun ki dan ou laz*** Private Health Institutions / ***Bann lenstitisyon lasante prive*** Internet / ***Internet*** Traditional healers / ***Erbalis*** Witchdoctor / ***Bann bonnonm dibwa*** Others / ***Lezot*** _____	1 → **Q19** 2 → **Q20** 3 → **Q20** 4 → **Q20** 5 → **Q20** 6 → **Q20** 7 → **Q20** 8 → **Q20** 9 → **Q20** 11 → **Q20**
19.	**IF IT IS MOH**, Where exactly did you hear about HIV or AIDS? / ***SI OU'N TANN NONM HIV (VIH) OUBYEN SIDA KOT MINISTER LASANTE, kote ou ti tann sa ezakteman?***	Health centre / ***Klinik*** ANC / ***Kot konsiltasyon*** CDCU / Wards / ***Dan bann ward*** SOPD / Occupational health / Other: **(state)** _____ Don't know / ***Pa konnen*** No response / ***Napa larepons***	1 2 3 4 5 6 7 88 99

Section 2: Knowledge, opinions and attitudes

No.	Questions and filters	Answers	Codes
20.	Do you think condoms can protect you from getting HIV? ***Eski ou kwar ki servi kapot i kapab protez ou kont viris HIV (VIH)?***	Yes No Don't know No response	1 2 88 99
21.	What diseases can you get by sharing needles and syringes? ***Ki bann maladi ou kapab gannyen si ou servi menm sereng e zegwiy ki en lot dimoun i'n deza servi?*** **CIRCLE ALL ANSWERS GIVEN**	HIV / ***HIV (VIH)*** Hepatitis / ***Epatit*** Others ---------- Don't know No answer	1 2 88 99
22.	What are the ways you can get HIV? ***Ki bann fason ou kapab atrap viris HIV (VIH)?*** **READ LIST ONE BY ONE** **CIRCLE ALL ANSWERS GIVEN AS WAYS OF GETTING HIV.** **IF THE ANSWER IS NO, DO NOT CIRCLE.**	Mosquito bites / ***Letan moustik i pik ou*** Sharing plates / ***Manz dan menm lasyet*** Sharing needles / ***Servi menm zegwiy*** Sexual intercourse / ***Fer seks*** French Kissing (on the mouth, lips) / ***Met lalang dan labous (tete lalang)*** Tattoo and Body piercing with infected needles / ***Met bann tatou e pers bann parti ou lekor avek zegwiy ki'n ganny enfekte*** Sharing a bus seat / ***Asiz lo menm sit bis*** Buying meat from a HIV positive butcher / ***Aste lavyann kot en bouse ki annan SIDA*** Sending your child to a HIV positive teacher / ***Anvoy ou zanfan lekol ek en ansennyan ki annan SIDA*** Mother to child transmission / ***Manman ansent oubyen ki donn tete i pas viris ek son zanfan*** Blood transfusion / ***Transfizyon disan*** Public toilets / ***Lo twalet piblik*** Don't know No response	1 2 3 4 5 6 7 8 9 11 22 33 88 99

Section 2: Knowledge, opinions and attitudes			
No.	**Questions and filters**	**Answers**	**Codes**
23.	Can you protect yourself from the HIV virus by having **ONE uninfected and faithful sexual partner*?*** ***Eski ou kapab protez ou lekor kont SIDA si ou annan en SEL partner ki senser e ki pa enfekte?***	Yes No Don't know No response	1 2 88 99
24.	What do you understand by the practice of abstinence? ***Ki ou konpran par sa pratik abstinans?***	No sex at all / ***Pa fer seks ditou*** Periodic abstinence / ***Pa fer seks de tanzantan*** Says anything else / ***Dir okenn lezot keksoz*** Don't know No answer	1 2 3 88 99
25.	Can you protect yourself from the HIV virus by abstaining from all sexual activities? ***Eski ou kapab protez ou kont viris HIV (VIH) si ou pa fer seks ditou?***	Yes No Don't know No response	1 2 88 99
26.	**Don't tell me who**, but do you know anyone personally who is infected with HIV or who has died of AIDS? ***Pa dir mwan lekel, me eski ou konn okenn dimoun ki'n atrap viris HIV (VIH) oubyen ki'n mor ek SIDA?***	Yes No Don't know No response	1 2 88 99
27.	What can a HIV positive pregnant woman do to reduce the risk of transmitting HIV to her unborn child? **DO NOT READ LIST** ***Ki en madanm ansent ki annan viris HIV (VIH) i kapab fer pour redwir risk transmet sa viris avek son baba ki pa ankor ne?***	Take medication (anti-retrovirals) / ***Pran latisann kont viris HIV (VIH)*** Other / ***Lezot***: **(state / *Dir lekel*)** _____ Don't know No response	1 2 88 99

Section 2: Knowledge, opinions and attitudes			
No.	**Questions and filters**	**Answers**	**Codes**
28	Do you think HIV tests are confidential? ***Eski ou kwar ki bann tes SIDA i konfidansyel ?***	Yes No Don't know No response	1 → **Q30** 2 88 99
29.	If no, please explain ***Si non, eksplike*** **DO NOT READ THE LIST.** **PROBE IF NOT CLEAR ABOUT WHICH PERSONNEL OF THE MINISTRY OF HEALTH. EXAMPLE: "WHICH STAFF DO YOU FEEL IS NOT CONFIDENTIAL?"** **CIRCLE ALL ANSWERS GIVEN**	Doctors not confidential with results / ***Dokter pa gard rezilta sekre*** Nurses not confidential with results / ***Ners pa gard rezilta sekre*** Laboratory results not confidential / ***Rezilta laboratwar pa sekre*** Site of tests is known to the public / ***Manm piblik i konn bann landrwa kot i fer tes*** I have relatives working in the health sector / ***Mon annan fanmiy ki travay dan lasante*** I have acquaintances in the health sector / ***Mon annan zanmi ki travay dan lasante*** I am a well-known person / ***Dimoun i konn mwan byen*** There is no privacy / ***Keksoz pa fer an prive*** Other reasons / ***Lezot rezon*** _____ Don't know No response	1 2 3 4 5 6 7 8 9 88 99

Section 2: Knowledge, opinions and attitudes			
No.	**Questions and filters**	**Answers**	**Codes**
30.	Where can you get tested for HIV? ***Kote ou kapab fer tes HIV (VIH)?*** **DO NOT READ LIST** **RECORD ALL ANSWERS GIVEN.**	Health centre / ***Dan klinik***	1
		ANC / ***Kot konsilte***	2
		CDCU	3
		Private health facilities / ***Dokter peye / prive***	4
			5
		Overseas / ***Dan pei deor***	6
		Wards / ***Lopital***	7
		SOPD /	8
		Occupational health	9
		Outreach posts / ***Bann progranm kont SIDA dan aktivite distrikt***	11
		At home / ***Dan lakour***	
		Others / ***Lezot kandrwa***: **(state / *Dir lekel*)** _____	88
		Don't know	99
		No response	
31.	I don't want to know the result, but have ***you ever*** had an HIV test? / ***Mon pa anvi konn ou rezilta, me eski ou'n deza fer en tes HIV (VIH)?***	Yes	1
		No	2 → **Q34**
		Don't know	88
		No response	99
32.	Did you voluntarily undergo the HIV test, or were you required to have the test? ***Eski ou ti fer sa tes volonterman oubyen ou ti bezwen fer li ?***	Voluntary / ***Volonterman***	1
		Required / ***Mon ti bezwen fer li***	2
		Don't know	88
		No response	99
33.	Please do not tell me the result, but did you ever find out the result of your test? ***Pa dir mwan rezilta, me eski ou ti ganny rezilta ou tes ?***	Yes	1
		No	2
		No response	99

Section 2: Knowledge, opinions and attitudes			
No.	**Questions and filters**	**Answers**	**Codes**
34.	Would you be willing to live with a close relative, who is infected with HIV? ***Eski ou pare pour viv ek en manm ou fanmiy pros ki annan viris HIV (VIH)?***	Yes No Don't know No response	1 2 88 99
35.	If a student has HIV but is not sick, should he or she be allowed to continue attending school? ***Si en etidyan i annan viris HIV (VIH), me selman i pa malad, eski i devret kontinyen lekol ?***	Yes No Don't know No response	1 2 88 99
36.	If a teacher has HIV but is not sick, should he or she be allowed to continue teaching in school? ***Si en ansennyan I annan viris HIV (VIH), me selman i pa malad, eski i devret kontinyen fer lekol ?***	Yes No Don't know No response	1 2 88 99
37.	If you knew a shopkeeper or food seller had the HIV virus, would you buy food from them? ***Si ou konnen ki en boutikye oubyen en vander manze i annan viris HIV (VIH), eski ou pou aste manze ek li ?***	Yes No Don't know No response	1 2 88 99
38.	If a member of your family became ill with HIV, the virus that causes AIDS, would you want it to remain secret? ***Si en manm ou fanmiy i tonm malad ek viris HIV (VIH), sa menm viris ki lakoz SIDA, eski ou ti pou oule gard sa en sekre?***	Yes No Don't know No response	1 2 88 99

Section 3: Sexually transmitted infections			
No.	**Questions and filters**	**Answers**	**Codes**
39.	Do you know about diseases that can be transmitted through sexual intercourse? ***Eski ou konn okenn maladi ki transmet par seks ?***	Yes No Don't know No response	1 2 **SKIP TO Q42** 88 99

Section 2: Knowledge, opinions and attitudes

No.	Questions and filters	Answers	Codes
40.	**IF YES**: Describe at least one sign or symptom of STIs in women? Any others? **DO *NOT* READ OUT THE SYMPTOMS** **MORE THAN ONE ANSWER IS POSSIBLE.** ***Si wi, dir mwan o-mwen en sinny ki en madanm i gannyen ler i annan enn sa bann maladi?*** ***Okenn lezot sinny?***	Abdominal pain / ***Douler dan ba vant*** Genital discharge / ***Dezarz kot parti prive*** Foul smelling discharge / ***Dezarz ki pi*** Burning pain on urination / ***Brile ler i pise*** Genital ulcers/sores / ***Boubou lo parti prive*** Swellings in groin area / ***Anfle dan kartye*** Itching / ***Grate*** Other: **(state)**_____ Don't know No response	1 2 3 4 5 6 7 88 99
41.	**IF YES**: Describe at least Can you describe at least one sign or symptom of STIs in men? …. Any others? **DO *NOT* READ OUT THE SYMPTOMS** **MORE THAN ONE ANSWER IS POSSIBLE.** ***Si wi, dekri o-mwen en sinny ler en zonm i annan enn sa bann maladi?***	Genital discharge / ***Dezarz kot parti prive*** Burning pain on urination / ***Brile ler i pise*** Genital ulcers/sores / ***Boubou, ilser lo parti prive*** Swellings in groin area / ***Anfle dan kartye*** Other: **(state)**_____ Don't know No response	1 2 3 4 88 99
42.	Have you had an unusual and abnormal genital discharge during the past 6 months? ***Dan sa dernye 6 mwan, eski ou'n ganny okenn dezarz abnormal sorti dan ou parti prive?***	Yes No Don't know No response	1 2 88 99
43.	Have you had a genital ulcer / sore during the past 6 months? ***Dan sa dernye 6 mwan, eski ou'n ganny en boubou dan ou parti prive?***	Yes No Don't know No response	1 2 88 99
	FILTER: CHECK **If YES to Q42 and / or Q43** Had genital discharge and/or genital ulcer in last 6 months |__| ↓	**If NO to both Q42 and Q43** No genital discharge and no ulcer in last 6 months	[__] → **Q50**

Section 2: Knowledge, opinions and attitudes			
No.	**Questions and filters**	**Answers**	**Codes**
44.	Did you seek advice from a health worker in a clinic or a hospital or traditional healers? ***Eski ou'n rod konsey avek en travayer lasante dan en klinik oubyen dan en lopital oubyen al kot en erbalis?***	Yes No No response	1 2 → **Q50** 99 → **Q50**
45.	**IF YES FOR NO 44**, how long after first experiencing symptoms did you seek advice from a health worker in a clinic or hospital or traditional healer? ***SI WI POUR Q44, konbyen letan apre ki ou'n eksperyans sa bann sinny ki ou'n al vwar en travayer lasante dan klinik oubyen lopital oubyen en erbalis?***	1 week or less / ***En semen ou mwens*** Less than 1 month but more than 1 week / ***Mwens ki en mwan me plis ki en semenn*** One month or more / ***En mwan ou plis*** Don't know No response	1 2 3 88 99
46.	If yes, did you receive a prescription for medicine? ***Eski ou ti ganny en preskripsyon pour pran latizann?***	Yes No Don't know No response	1 2 → **Q50** 88 → **Q50** 99 → **Q50**
47.	Did you obtain the medicine prescribed? ***Eski ou ti gannyen sa latizann?***	Yes / ***Wi*** I obtained some but not all / ***Mon ti ganny enpe, me pa tou*** I did not obtain the medicine / ***Mon pa ti ganny sa latizann*** Don't know No response	1 2 3 → **Q50** 88 → **Q50** 99 → **Q50**
48.	Did you take all of the medicine prescribed? ***Eski ou ti pran tou latizann ki ou ti gannyen?***	Yes No Don't know No response	1 → **Q50** 2 88 → **Q50** 99 → **Q50**

Section 2: Knowledge, opinions and attitudes

No.	Questions and filters	Answers	Codes
49.	If not, why did you not take all of the medicine prescribed? ***Si non, akoz ou pa ti pran tou?*** **DO NOT READ LIST** **CIRCLE ALL THAT APPLY.**	Experienced side effects / ***Mon ti ganny bann lefe endezirab***	1
		Worried about side effects / ***Mon ti per bann lefe endezirab ki mon kapab gannyen***	2
		Used another method / ***Mon ti servi lezot metod***	3
		Forgot / ***Mon oubliye pran***	4
		Felt better / ***Mon ti'n fini santi mwan pli byen***	5
		Was drinking alcohol / ***Mon'n ti bwar lalkol***	6
		Other:(**state)**_____	
		Don't know	88
		No response	99

Section 4: Marriage and live-in relationships (BANN RELASYON MARYAZ OUBYEN MENAZ)

No.	Questions and filters	Answers	Codes
50.	Have you ***ever*** been married or lived with a man or woman with whom you had a sexual relationship? ***Eski ou', deza marye oubyen reste ek en fanm oubyen en zonm avek ki ou ti annan en relasyon seksyel?***	Yes	1
		No	2
		No response	99
51.	What type of ***sexual relationship*** do you currently have? ***Ki kalite relasyon seksyel ou annan la konmela?*** **PROBE IF NOT SURE ABOUT MEANING OF QUESTION:**	currently married, living with spouse / ***Mon'n marye e mon pe viv mon fanm / mari***	1
		currently married, living with other sexual partner / ***Mon'n marye, me mon pe viv en lot dimoun***	2
		currently married, not living with spouse or sexual partner / ***Mon marye, me mon pa pe viv ek personn***	3
		not married, living with sexual partner / ***Mon pa'n marye, mon pe viv ek en dimoun***	4
		not married, not living with sexual partner (single) / ***Pa'n marye, pa pe viv avek sa dimoun ki i annan relasyon avek***	5
		Others _____	99
		No response	

Section 2: Knowledge, opinions and attitudes			
No.	**Questions and filters**	**Answers**	**Codes**
52.	Do you have children? ***Eski ou annan zanfan?***	Yes No No response	1 2 → **56** 99 → **56**
53.	What age were you when you had your first child? ***Ki laz ou ti annan ler ou ti ganny ou premye zanfan?***	_____ Don't know No response	 88 99
54.	Were any of your children ever breastfed? ***Okenn ou zanfan ti tete?***	Yes No Don't know No response	1 2 → **59** 88 → **59** 99 → **59**
55.	What is the longest period that your child (ren) was (were) breastfed? / ***Ki pli long letan ou zanfan ti tete?***	1 – 3 months 3- 6 months 6 months – 1 year I year and above Don't know No response	1 2 3 4 88 99
56. **ASK BOTH MEN & WOMEN & ALL MINORS**	Have you ever used any contraceptives? ***Eski ou'n deza pran okenn kontraseptiv?***	Yes No No response	1 2 → **Q58** 99 → **Q58**

Section 2: Knowledge, opinions and attitudes

No.	Questions and filters	Answers	Codes
57.	What contraceptive methods have you ever used? ***Ki metod kontraseptiv ou'n deza servi?***	Oral / ***Pilil***	1
		Injection / ***Pikir***	2
		IUD/	3
		Condoms/ ***Kapot zonm***	4
		Natural / ***Metod natirel***	5
		Others / ***Lezot***	6
		Don't know	88
		No response	99

Section 5: Sexual history: numbers and types of partners

No.	Questions and filters	Answers	Codes
58.	At what age did you first have sexual intercourse? ***Ki laz ou ti annan letan ou ti fer seks pour premye fwa?*** **FOR THE PURPOSE OF THE SURVEY 'SEXUAL INTERCOURSE' IS <u>VAGINAL</u> AND / OR <u>ANAL</u> SEX**.	***CIRCLE 1 FOR MINORS AND ADULTS WHO HAVE NEVER HAD SEX BEFORE AND THEN SKIP TO Q60***	
		Age (in years)	|__|__|
		Never had sex before	***1*** → **Q60**
		Don't know	88
		No response	99
59.	In what circumstances did you have your first sexual intercourse? ***Dan ki sirkonstans / sitiasyon ou ti fer seks pour premye fwa ?*** **DO NOT READ LIST**	Mutual consent / ***Tou le de ti dakor***	1
		Peer Pressure / ***Mon ti ganny forse***	2
		Rape / ***Mon ti ganny peze***	3
		Sexual Abuse / ***Mon ti ganny abize***	4
		Family Pressure / ***Fanmiy ti met presyon***	5
		Alcohol / ***Mon ti'n bwar lalkol***	6
		Drugs / ***Mon ti'n pran drog***	7
		Others _____	
		Don't know	88
		No response	99

60. 	Have you ever had oral sex? ***Eski ou'n deza fer seks dan labous?***	Yes No No response	1 2 99	**SKIP TO Q102 IF NEVER HAD SEX AND NEVER HAD ORAL SEX**
61.	Have you ever accepted gift or money or other material goods or favours for sex? ***Eski ou'n deza aksepte kado / larzan / okenn byen materyel / okenn faver pour seks?***	Yes No Don't know No response	1 2 88 99	**→ Q63**
62.	If yes, in the **last 12 months**, how often has it happened? ***Si wi, dan sa dernye 12 mwan, konbyen fwa sa i 'n arive ?***	Once / ***1 fwa*** Twice / ***2 fwa*** More than 3 times / ***plis ki 3 fwa*** Don't know No response	1 2 3 88 99	
63.	Have you ever had anal sex? ***Eski ou'n deza fer seks dan deryer?***	Yes No Don't know No response	1 2 88 99	
64.  **ANAL & / OR VAGINAL SEX**	Have you had sexual intercourse in the last 12 months? ***Dan sa dernye 12 mwan, eski ou'n fer seks ?***	Yes No No response	1 2 99	 **→ Q102** **→ Q102**
65. 	(**ASK MEN Q65 TO Q76, OTHERWISE GO TO Q77 FOR FEMALE RESPONDENTS**) How many were your spouse(s) or live-in female sexual partners ("regular" partners)? ***Parmi sa bann dimoun, konbyen ki ti ou fanm marye ouswa en fanm ki ou ti pe reste avek dan lakaz (menaz) (bann partner labitid)?***	Number of regulars Don't know No response	|__|__| 88 99	 **→Q67** **→Q67**

66.	If yes, how often in a month on average? ***Si wi, konbyen fwa ou fer seks, an zeneral, dan en mwan?***			
67.	How many were ***"regular"*** sexual partners that you; • are not married to • have **never** lived with ***Konbyen ladan ki ti bann partner labitid, me ki ou'n pa'n marye avek e ki ou pa'n zanmen reste ek zot dan lakaz?***	Number of regulars Don't know No response	|__|__| 88 99	 → **Q69** → **Q69**
68.	If yes, how often in a month on average? ***Si wi, konbyen fwa ou fer seks, an zeneral, dan en mwan?***			
69.	*How many were* ***"Commercial"*** (partners with whom you had sex in exchange for money) ***Konbyen parmi sa bann dimoun ki ou'n fer seks avek pour larzan?***	Number of commercials Don't know No response	☐☐ 88 99	 → **Q71** → **Q71**
70.	If yes, how often in a month on average? ***Si wi, konbyen fwa ou fer seks, an zeneral, dan en mwan?***			
71.	How many were ***"non-regular"*** sexual partners that you; • are not married to • have never lived with • did not pay ***Konbyen parmi, ki ou'n pa'n marye ek zot, pa'n zanmen viv ek zot dan lakaz e ki ti napa okenn peyman pour fer seks?***	Number of non-regulars Don't know No response	|__|__| 88 99	 →**Q73** →**Q73**
72.	If yes, how often in a month on average? ***Si wi, konbyen fwa ou fer seks, an zeneral, dan en mwan?***			
73.	We've just talked about your female sexual partners. Have you ever had any male sexual partners? ***Nou'n fek koz lo ou bann partner madanm. Eski ou'n deza annan okenn partner zonm?***	Yes No No response	1 2 99	 →**Q86** →**Q86**

74.	Have you had sexual intercourse with any of your male partners **in the past 12 months**? (sexual intercourse defined as penetrative anal sex) ***Dan sa dernye 12 mwan, eski ou'n fer seks avek en zonm?***	Yes No No response	1 2 99	 **→Q86** **→Q86**
75.	If yes, how often in a month on average? / ***Si wi, konbyen fwa ou fer seks, an zeneral, dan en mwan?***	_____		
76.	How many male partners have you had anal intercourse with in the last 12 months? / ***Dan sa dernye 12 mwan, avek konbyen zonm ou'n fer seks?***	Number of male partners Don't know No response	|__|__| 88 99	 **→Q90** **→Q90**
77.	**(ASK WOMEN QUESTION 77 TO QUESTION 86)** How many were your spouse(s) or live-in male sexual partners **("*regular" partners)***? / ***Konbyen ki ti ou partner labitid (mari marye oubyen partner ki ou pe reste ek li?***	Number of regulars Don't know No response	|__|__| 88 99	 **→Q79** **→Q79**
78.	If yes, how often in a month on average? / ***Si wi, konbyen fwa ou fer seks, an zeneral, dan en mwan?***			
79.	How many were ***"regular"*** sexual partners that you; • are not married to • have never lived with ***Konbyen ti bann partner labitid, me ki ou'n pa'n marye avek e ki ou pa'n zanmen reste ek zot dan lakaz?***	Number of regulars Don't know No response	|__|__| 88 99	 **→Q81** **→Q81**
80.	If yes, how often in a month on average? / ***Si wi, konbyen fwa ou fer seks, an zeneral, dan en mwan?***			
81.	*How many were* ***"Commercial"*** (partners with whom you had sex in exchange for money) / ***Konbyen ki ou'n fer seks avek, ki ou'n pey zot ouswa zot ti pey ou?***	Number of commercials Don't know No response	|__|__| 88 99	 **→ Q83** **→ Q83**
82.	If yes, how often in a month on average? / ***Si wi, konbyen fwa ou fer seks, an zeneral, dan en mwan?***			

83.	How many were ***"non-regular"*** sexual partners that you are not married to, have never lived with & did not pay? / ***Konbyen ki bann partner seksyel, ki ou'n pa'n marye ek zot, ou pa'n zanmen viv ek zot dan lakaz e ki ti napa okenn peyman pour fer seks?***	Number of non-regulars Don't know No response	|__|__| 88 → **Q86** 99 → **Q86**
84.	If yes, how often in a month on average? / ***Si wi, konbyen fwa ou fer seks, an zeneral, dan en mwan?***		
85.	Have you ever had a sexual relationship with a woman? / ***Eski ou'n deza annan relasyon seksyel ek en madanm?***	Yes No No response	1 2 99
86.	**(ASK MEN AND WOMEN):** During the past 12 months, did any of your sexual partner(s) force you to have sex with them even though you did not want to? / ***Dan sa dernyen 12 mwan, eski okenn ou ban partner seksyel i'n fors ou fer seks ek zot?***	Yes No No response	1 2 99
87.	How many female / male partners have you had anal intercourse with in the last 12 months? / ***Dan sa dernye 12 mwan, konbyen partner zonm oubyen fanm ki ou fer seks avek, dan deryer?***	Female _____ Male _____	

Section 6: Sexual history, REGULAR partners

No.	Questions and filters	Answers	Codes
	FILTER: CHECK **QUESTION 65 FOR MALES** **QUESTION 77 FOR FEMALES** Had sex with regular partner during **past 12 months** [___] ↓	Did not have sex with regular partner during **past 12 months**	[__] →**Q92**
88.	**THE LAST TIME** you had sex with a regular partner, did you and your partner use a condom? / ***DERNYE FWA ou ti fer seks ek ou partner labitd, eski zot ki servi en kapot?***	Yes No Don't remember / ***Pa mazinen*** No response	1 2 →**Q90** 77 →**Q91** 99 →**Q91**

89.	Who suggested using a condom that time? / ***Lekel ki ti sizer servi en kapot?***	Myself / ***Mwan menm***	1
		My partner / ***Mon partner***	2
		Joint decision / ***Nou toulede***	3
		Don't remember / ***Pa mazinen***	77
		No response	99
90.	**IF QUESTION 88 IS NO**: Why didn't you and your partner use a condom that time? ***Akoz zot pa ti servi en kapot sa fwa la?*** ⚑ **DO NOT READ OUT THE OPTIONS.** **CIRCLE ALL ANSWERS GIVEN.**	Not available / ***Ti napa***	1
		Partner objected / ***Partner pa ti oule***	2
		Don't like them / ***Pa kontan servi kapot***	3
		Used other contraceptive / ***Nou ti servi lezot metod kontraseptiv***	4
		Didn't think it was necessary / ***Pa ti neseser***	5
		Didn't think of it / ***Pa'n mazinen***	6
		Other **(state)**_____	
		Don't know	88
		No response	99
91. ⚑	In general, with what ***frequency*** did you and your regular partner(s) use a condom during the past 12 months? ***<u>Dan sa 12 dernye mwan</u>, ki kantite fwa ou ek ou partner labitid i'n servi kapot?*** **READ OUT SLOWLY AND GIVE TIME TO ANSWER** **CIRCLE ONLY ONE**	Every time / ***Toultan***	1
		Almost every time / ***Preski toultan***	2
		Sometimes / ***Parfwa***	3
		Rarely / ***Rar***	4
		Never / ***Zanmen***	5
		Don't know	88
		No response	99

Section 7: Sexual history, <u>COMMERCIAL</u> partners

No.	Questions and filters	Answers	Codes
⚑	**FILTER: CHECK** **QUESTION 69 FOR MALES** **QUESTION 81 FOR FEMALES** Had sex with commercial partner during **<u>past 12 months</u>** [___] ↓	Did not have sex with commercial partner during **<u>past 12 months</u>**	[__] → **Q97**
92.	How many commercial partners you had sexual intercourse with over the last **<u>30 days</u>**? / ***<u>Dan sa dernye 30 zour</u>, konbyen partner ki ou'n peye ouswa ki'n pey ou pour fer seks?***	Number of commercial partners	|__|__|
		Don't know	88
		No response	99

93.	The **LAST TIME** you had sex with a commercial partner, did you and your partner use a condom? / ***DERNYE FWA ou ti fer seks ek ou partner ki ou peye oubyen ki ti pey ou, eski zot ti servi en kapot ?***	Yes No Don't remember / ***Pa mazinen*** No response	1 2 → **Q95** 77 → **Q96** 99 → **Q96**
94.	Who suggested using a condom that time? / ***Lekel ki ti sizer servi kapot?***	Myself / ***Mwan menm*** My partner / ***Mon partner*** Joint decision / ***Nou toulede*** Don't remember / ***Pa mazinen*** No response	1 2 3 77 99
95.	Why didn't you and your partner use a condom that time? ***Akoz zot pa ti servi kapot?*** **DO NOT READ OUT THE OPTIONS.** **CIRCLE ALL ANSWERS MENTIONED**	Not available / ***Ti napa*** Partner objected / ***Partner pa ti oule*** Don't like them / ***Pa kontan servi kapot*** Used other contraceptive / ***Nou ti servi lezot metod kontraseptiv*** Didn't think it was necessary / ***Pa ti neseser*** Didn't think of it / ***Pa'n mazinen*** Other **(state)**_____ Don't know No response	1 2 3 4 5 6 88 99
96.	In general, with what ***frequency*** did you and your commercial partner(s) use a condom during the past 12 months? / ***An zeneral, ki kantite fwa ou ek ou partner peye zot i'n servi kapot dan sa 12 dernye mwan?*** **READ OUT** **CIRCLE ONLY ONE**	Every time / ***Toultan*** Almost every time / ***Preski toultan*** Sometimes / ***Parfwa*** Rarely / ***Rar*** Never / ***Zanmen*** Don't know No response	1 2 3 4 5 88 99

Section 8: Sexual history, NON-REGULAR partners

No.	Questions and filters	Answers	Codes

	FILTER: CHECK **QUESTION 71 FOR MALES** **QUESTION 83 FOR FEMALES** Had sex with **non-regular partner** during **past 12 months** [___] ↓	Did not have sex with non-regular partner during **past 12 months**	[__] →**Q102**
97.	How many times did you have sexual intercourse with casual partners, that is non-regular, non-paying sexual partner over the **last 30 days**? / ***Pandan sa dernye 30 zour, konbyen fwa eski ou'n fer seks avek en partner ki pa ou partner labitid, ki ou pa'n peye oubyen i pa'n pey ou?***	Number of times / ***Kantite fwa*** Don't know No response	|__|__| →**Q98** →**Q98**
98.	The last time you had sex with a non-regular partner, did you and your partner use a condom? / ***Dernye fwa ki zot ti fer seks, eski zot ti servi en kapot?***	Yes No Don't remember / ***Pa mazinen*** No response	1 2 → **Q100** 77 → **Q101** 99 → **Q101**
99.	Who suggested using a condom that time? ***Lekel ki ti sizer servi enn?***	Myself / ***Mwan menm*** My partner / ***Mon partner*** Joint decision / ***Nou toulede*** Don't remember / ***Pa mazinen*** No response	1 2 3 77 99
100.	Why didn't you and your partner use a condom that time? ***Akoz ou pa ti servi en kapot?*** **DO NOT READ OUT THE OPTIONS.** **CIRCLE ALL ANSWERS GIVEN.**	Not available / ***Ti napa*** Partner objected / ***Partner pa ti oule*** Don't like them / ***Pa kontan servi kapot*** Used other contraceptive / ***Nou ti servi lezot metod kontraseptiv*** Didn't think it was necessary / ***Pa ti neseser*** Didn't think of it / ***Pa'n mazinen*** Other **(state)** _____ Don't know No response	1 2 3 4 5 6 88 99

101.	In general, with what ***frequency*** did you and your non-regular partner(s) use a condom **during the past 12 months**? **READ OUT AND CIRCLE ONLY ONE** ***Dan sa dernye 12 mwan, ki kantite fwa zot i'n servi en kapot ?***	Every time / ***Toultan*** Almost every time / ***Preski toultan*** Sometimes / ***Parfwa*** Rarely / ***Rar*** Never / ***Zanmen*** Don't know No response	1 2 3 4 5 88 99

Section 9: Male and female condoms

No.	Questions and filters	Answers	Codes
	FILTER: CHECK IF NO TO QUESTION 88 AND 93 AND 98 Condoms not used……[___] ↓	**IF YES TO QUESTION 88 OR 93 OR 98** Condoms used	 |___| → **Q105**
102. 1	Have you ***ever heard*** *of* a male condom? ***Ou'n deza tann nonm en kapot zonm?*** (**SHOW PICTURE OR SAMPLE OF ONE.)**	Yes No Not sure No response	1 2 → **Q105** 88 → **Q105** 99 → **Q105**

103.	If **yes**: Indicate the source of information ***Si wi, dir mwan kote ou'n tann nonm kapot zonm***	Television / Radio / ***Televisyon / Radyo***	1
		Print media / ***Zournal, magazin***	2
		MOH / ***MInister Lasante***	3
		Private health facilities / ***Fasilite lasante prive***	4
		NGOs / ***NGOs, bann lorganizasyon saritab***	5
		Other Ministries / ***Lezot minister***	6
		Workplaces / ***Landrwa travay***	7
		Schools / ***Lekol***	8
		Internet / ***Internet***	9
		Leisure places & sites / ***Landrwa pour lwazir***	11
		Others / ***Lezot*** _____	
		No response	99
104.	Have you and a sexual partner ***ever*** used a male condom? ***Eski ou ek en partner seksyel i'n deza servi en kapot zonm?***	Yes	1
		No	2
		Don't know	88
		No response	99
105.	Do you know of any place or person from which you can obtain male condoms? ***Eski ou konn okenn landrwa oubyen dimoun kot ou kapab ganny en kapot zonm?***	Yes	1
		No	2 → **Q107**
		No response	99

106.	If yes to **Q105,** from which places or persons can you obtain male condoms? ***Kote ou kapab ganny kapot zonm?*** **DO NOT READ LIST.** **PROBE AND RECORD *ALL* ANSWERS** **ANY OTHERS?**	Shops / ***Laboutik***	1
		Private Health facilities / ***Fasilite lasante prive***	2
		Health centre / ***Klinik***	3
		Hospital pharmacy / ***Farmasi lopital***	4
		Family planning clinic / ***Klinik Planing Familyal***	5
		Outreach Post / ***Bann landrwa ki annan aktivite kont HIV (VIH) /SIDA***	6
		CDCU	7
		Bar/guest house/hotel / ***Bar, pti lotel, guest house, gran lotel***	8
		Peer educator / ***Bann edikater / peer educator***	9
		Friend / ***Zanmi***	22
		Vending machines / ***Bann masin otomatik***	33
		Other / ***Lezot*** **(state / *Dir lekel*)**_____	
		Don't know	88
		No response	99
107.	How easy would it be for you to get a new supply of condoms now? ***Eski i fasil pour ou ganny en kapot zonm la konmela ?***	Very easy / ***Tre, vreman fasil***	1
		Easy / ***Fasil***	2
		Difficult / ***Difisil***	3
		Very difficult / ***Tre, vreman difisil***	4
		Impossible / ***Enposib***	5
		Don't know	88
		No response	99
108.	**REFERENCE: QUESTION 64 - HAD SEXUAL INTERCOURSE IN PAST 12 MONTHS,"SEXUAL INTERCOURSE", IS DEFINED AS VAGINAL OR ANAL SEX** Did you **ever** have sexual intercourse without using a condom? / ***Eski, a okenn moman dan sa dernyen 12 mwan, ou'n fer seks san en kapot?***	Yes	1
		No	2 → **Q110**
		Don't remember	77 → **Q110**
		No response	99 → **Q110**

109.	**IF YES FOR Q108**, can you explain why you did not use a condom? ***Si wi, eski ou kapab eksplike akoz?*** **DO NOT READ.** **CAN TICK AS MANY AS GIVEN**	No feelings / ***Napa feelings***	1
		Not available / ***Napa***	2
		Too small / ***Tro pti***	3
		Too big / ***Tro gran***	4
		Smelly / ***I pi, mon pa kontan son loder***	5
		Rashes, allergies / ***I donn mwan lagratel, mon alerzik***	6
		Partners did not want to /***Partner pa ti oule***	7
		Noisy / ***Fer tapaz***	8
		Don't like it / ***Pa kontan kapot***	9
		Other reasons _____	
		Don't know	88
		No response	99
110.	Where would you prefer to buy or collect males and females condoms? ***Kote ou ti ava prefere aste oubyen kolekte kapot zonm ouswa kapot fanm?***	Shops / ***Laboutik***	1
		Private Health facilities / ***Fasilite lasante prive***	2
		Health centre / ***Klinik***	3
		Hospital pharmacy / ***Farmasi lopital***	4
		Family planning clinic / ***Klinik Planing Familyal***	5
		Outreach Post / ***Bann landrwa ki annan aktivite kont HIV (VIH) /SIDA***	6
		CDCU	7
		Bar/guest house/hotel / ***Bar, pti lotel, guest house, gran lotel***	8
		Peer educator / ***Bann edikater / peer educator***	9
		Friend / ***Zanmi***	11
		Vending machines / ***Bann masin otomatik***	22
		Other / ***Lezot*** **(state** ***/ Dir lekel*****)** _____	
		Don't know	88
		No response	99
111.	Have you ***ever heard*** *of* a female condom? ***Eski ou'n deza tann nonm kapot fanm?*** **(SHOW A CONDOM)**	Yes	1
		No	2 → **Q113**
		Don't know	88 → **Q113**
		No response	99 → **Q113**

112.	If yes, where did you get the information on the female condoms from? ***Si wi, kote ou ti ganny lenformasyon lo kapot fanm?*** **CIRCLE ALL ANSWERS GIVEN**	Television / Radio / ***Televisyon / Radyo*** 1 Print media / ***Zournal, magazin*** 2 MOH / ***MInister Lasante*** 3 Private health facilities / ***Fasilite lasante prive*** 4 NGOs / ***NGOs, bann lorganizasyon saritab*** 5 Other Ministries / ***Lezot minister*** 6 Workplaces / ***Landrwa travay*** 7 Schools / ***Lekol*** 8 Internet / ***Internet*** 9 Leisure places & sites / ***Landrwa pour lwazir*** 11 Others / ***Lezot*** _____ No response 99	
113.	Have you and a sexual partner ***ever*** used a female condom? ***Eski ou ek en partner i'n a okenn moman servi en kapot fanm ?***	Yes 1 No 2 Don't know 88 No response 99	
114.	Do you know of any place or person from which you can obtain female condoms? ***Eski ou konn okenn landrwa oubyen dimoun kot ou kapab ganny kapot fanm?***	Yes 1 No 2 **SKIP TO Q117** No response 99 **SKIP TO Q117**	

115.	Which places or persons do you know where you can obtain female condoms? ***Ki landrwa oubyen ek ki dimoun ou kapab ganny kapot fanm?*** **DO NOT READ LIST.** **PROBE AND RECORD *ALL* ANSWERS** **ANY OTHERS?**	Shops / ***Laboutik*** 1 Private Health facilities / ***Fasilite lasante prive*** 2 Health centre / ***Klinik*** 3 Hospital pharmacy / ***Farmasi lopital*** 4 Family planning clinic / ***Klinik Planing Familyal*** 5 Outreach Post / ***Bann landrwa ki annan aktivite kont HIV (VIH) /SIDA*** 6 CDCU 7 Bar/guest house/hotel / ***Bar, pti lotel, guest house, gran lotel*** 8 Peer educator / ***Bann edikater / peer educator*** 9 Friend / ***Zanmi*** 11 Vending machines / ***Bann masin otomatik*** 22 Other / ***Lezot*** **(state *I Dir lekel*)**_____ Don't know 88 No response 99	
116.	How easy would it be for you to get a new supply of female condoms now? ***Eski i fasil pour ou ganny enpe kapot fanm la konmela ?*** **READ LIST AND LET RESPONDENT CHOOSE ONLY ONE ANSWER**	Very easy / ***Tre, vreman fasil*** 1 Easy / ***Fasil*** 2 Difficult / ***Difisil*** 3 Very difficult / ***Tre, vreman difisil*** 4 Impossible / ***Enposib*** 5 Don't know 88 No response 99	
117.	Between the male and female condom, Which will you prefer to use? ***Ant kapot zonm ek fanm, lekel ki ou prefere servi ?***	**Male** 1 **Female** 2 No preference / ***Napa preferans*** 3 Don't know 88 No response 99	**→ 118** **→ 118** **End int.** **End int.** **End int.**

118.	Why do you prefer this type of condom ***Akoz ou prefer sa enn?***	It is more accessible / ***I pli fasil gannyen*** 1 It is easier to carry / ***I pli fasil mars avek*** 2 It is lighter / ***I pli leze*** 3 It is easier to use / ***I pli fasil servi*** 4 I am more familiar with it / ***mon pli abitye*** 5 It is easier to remove / ***I pli fasil tire*** 6 It is cheaper / ***I pli bon marse*** 7 There are different sizes / ***I annan diferan grander*** 8 There are different colours / ***I annan diferan kouler*** 9 There are different flavours / ***I annan diferan flavour, gou*** 11 It is less noisy / ***I fer mwens tapaz*** 22 It is safer to use / ***I annan plis sekirite*** 33 Others / ***Lezot rezon*** _____ Don't know 88 No response 99	

That is the end of our questionnaire.

Thank you very much for taking time to answer these questions.

We appreciate your help.

Appendix 4: - Survey Forms

5.1 – Behavioural Surveillance Handing-Over Forms

Name of Site Supervisor:	**Date:**
Time:	**Site:**
Name of Enumerator:	**No. of questionnaires collected:**

List of questionnaires' ID number collected and returned:

Questionnaire ID	Collected	Returned	Completed	Require 2nd Visit	Require 3rd Visit	No consent given

Signature: _____ **Signature: _____**

Site Supervisor **Enumerator**

Date: _____ **No. of questionnaires collected: _____**

List of questionnaires' ID number collected and returned:

Questionnaire ID	Collected	Returned	Completed	Require 2nd Visit	Require 3rd Visit	No consent given

Signature: _____ **Signature: _____**

Site Supervisor **Enumerator**

Appendix 5.2: Form for biological surveillance

Name of Site Supervisor: **Date:**

Time: **Site:**

Name of Nurse:

ITEMS	QUALITY	QUANTITY	STATUS ON RECEIPT	STATUS ON RETURN	REMARKS
Syringes - Auto Disabled	5 mls	10			
Disposable Gloves	Large	2			
Disposable Gloves	Medium	2			
Disposable Gloves	Small	1			
Sharp Box	Small medium	1			
Cotton wool pack	Sterile	2			
Surgical Tape		1			
Elastoplast		1			
Sterilising Bag	No. 5	2			
Sterilising Bag	No. 7	2			
Sterilising Crepe Wrapping	Pieces	3			
Methylated Spirit bottle	100mls	1			
Scissors	small	1			
Condom Male		2			
Condom Female		2			
Laboratory form		4			
KLEENEX	Handwipes	3 weekly			

INSTRUCTIONS:

Tick if the items have been received in the quantity and quality required.Write a remark if there are any types of gaps in quantity and quality.

State condition in which materials are returned in column: **status on return**

Signature: _____ **Signature: _____**

Site Supervisor **HTC Nurse**

Appendix 5 - Time-Line for the research

The time-line for the research is as follows. It is important to note that many tasks will be conducted simultaneously. The total number of days for the whole study is 120 days, 75 days preparatory work undertaken by the secretariat staff and 90days from recruitment of Principal investigator

START DATE: Friday 06th August 2012 **END DATE:** Friday 07th December 2012

Table 3: Time-Line

Task No.	Deliverables	Deadlines	Number of days
1.0	**Phase 1 Preparation – Prior of recruitment of consultant**		**75**
1.1	Revival of research Committee	01st June	1
1.2	Organize and facilitate weekly meetings with research Committee	07th June	6
1.3	Develop concept note	19th -09th July	10
1.4	Seek approval of concept form TAC & research Committee	10th -15th July	6
1.5	Seek partial funding from Ministry of Health	15th -24th July	10
1.6	Develop TOR for National consultancy	17th 23th July	4
1.7	Advertise post in national written media	24th–30th July	7
1.8	Develop TORs for survey team	26thJuly-07th Aug	10
1.9	Develop TOR for Technical Working Group	06th Aug	1
1.10	Develop first draft of sampling method	4th -15th Aug	10
1.11	Draw up selection panel	30th July	1
1.12	Meet with various heads of section for advocacy & awareness	4th – 10th Aug	5
1.13	Select national consultant with panel based on TOR	03th Aug	1
1.14	Recruit consultant	16th Aug	1
1.15	Mobilize partial funds under the NATF	06th Aug	1
1.16	Introduce consultant & discuss on project to Research team through one day meeting	17th Aug	1
2.0	**PHASE 2: Research Protocol** **START DATE**: Monday 06th August 2012 - **END DATE:** Friday 07th December 2012 for Principal investigator is 90 working days	**21st August**	**16**
2.1	Research design	17th August	2
2.2	Methodology	17th August	2
2.3	Sampling method finalised	17th August	2
2.4	First draft of questionnaire	17th August	3
1.5	Draft protocol for biological surveillance	18th August	3
1.6	Ethical issues and how they will be addressed	19th August	2
1.7	Data analysis plan	20th August	2
3.0	**PHASE 3: Health Research and Ethics Committee Application and Approval**	**17th September**	**10**
3.1	Application to the Health and Research Ethics Committee completed and approval obtained	17th August	8
3.2	Application submitted to the HREC	24th August	1
3.3	Presentation done to the HREC	06th September	1

Task No.	Deliverables	Deadlines	Number of days
4.0	**PHASE 4: Piloting of research**	**28th September**	**10**
4.1	Recruitment of enumerators	01st September	5
4.2	Recruitment of nurses	01st September	5
4.3	Recruitment of laboratory technicians	01st September	2
4.4	Media and Communication Plan for pilot & survey	01st September	1
4.5	Pre-testing of questionnaire and procedures	17th to 21st	5
4.6	Analysis of results	22nd – 23rd	2
4.7	Drafting of new questionnaire	22nd – 23rd	2
4.8	Sample collection procedures and tools for HIV prevalence survey developed	17th – 21st	5
4.9	Final sample procedures adopted	22nd – 23rd	2
4.10	Review of HIV prevalence survey done	22nd – 23rd	2
4.11	Training of enumerators and supervisors (Mahé) Praslin	24th, 25th 28th9	3
4.12	Training of nurses and laboratory technicians	26th	1
5	**PHASE 5: Data Collection**	**30th Oct**	**22**
5.1	Data collection, management and analysis plan developed	24th Sep	4
5.2	Data collection begins	01stOct	21
5.3	Monitoring of data collection	01st Oct	22
6	**PHASE 5: Data Entry**	**10th Nov**	**10**
6.1	Data entry	10th Nov	10
6.2	Data clean-up	10th Nov	20
7	**PHASE 7: Data Analysis**	**23rd Nov**	**14**
7.1	Data analysis tables / data sets	25th Oct	4
7.2	Preliminary analysis report: behavioural surveillance data	20th Nov	7
7.3	Preliminary analysis report: biological surveillance data	20th Nov	7
7.4	Review of data sets	22nd Nov	7
7.5	Interpretation of data	23rd Nov	4
8	**PHASE 8: Dissemination**	**01st Dec**	**8**
8.1	Final complete research report with detailed analysis of both HIV prevalence data and behavioral data completed and associations	15th Nov	7
8.2	Presentation of results to NAC for World AIDS Day 2012	07th Dec	1
	TOTAL NUMBER OF DAYS		**120 days**

Appendix 6 - Funding

Total budget proposed for the study is SCR. SCR. 1,652,827 or USD 122,432, based on current exchange rate of SCR.13.50 per US dollar. Resourced mobilisation has been through the two main multi-lateral partners, namely WHO and UNFPA and domestic funding under the Ministry of health and the National AIDS Trust Funds (NATF).

Funding Agency	Amount (SR)	Amount ($US)
Ministry of Health	272,447	20,181
World Health Organisation (WHO)	362,460	26,849
United Nation For Population Activities (UNFPA)	135,000	10,000
National AIDS Trust Fund (NATF)	344,370	25,509
National AIDS Council the through Ministry of Finance	538,550	39,822
Total	**1,652,827**	**122,432**

6.1 Summary of budget

SEYCHELLES BUDGET FOR THE KAPB STUDY AMONGST THE GENERAL POPULATION OF 15 TO 64									
	ITEMS	**Acti-vities**	**Numbe r**	**Number of Items**	**Duratio n (days)**	**Unit cost**	**T0TAL SR**	**TOTAL $**	**Funding Agency**
2	**HUMAN RESOURCES**								
	Subtotal	Pilot& Main	84	1691	90-120	20,200	837,650	62,048	UNFPA/N ATF/ NAC
17	**TRANSPORTATION**								
	Subtotal	Pilot& Main	15	1691	33	970	196,000	14,519	NATF/ MOH
22	**CLINICAL SUPPLIES**								
24	Subtotal		1726	2000	33	570	453,045	33,559	WHO/ MOH
26	**STATIONERY**								
	Subtotal			3106	1	7,157	87,215	6,460	MOH
42	**TRAINING/MEETINGS**								
	Subtotal			473	4	3,927	43,847	3,248	MOH
53	**TRAINING/MEETINGS PRASLIN**								
	Subtotal		54		2	6,365	30,070	2,227	MOH
63	**CONTINGENCIES**						**5000**	**370**	
64	**GRAND TOTAL**					39,189	**1,652,827**	**122,432**	

Appendix 7 – Enumerators / Nurses and districts

		Number of visits			
		1	**2**	**3**	**Total**
Interviewers Names	Dinah Hibonne	52	9	5	66
	Daisy Rath	32	19	12	63
	Sarah Malbrook	46	10	5	61
	Mitla Fanny	49	5	3	57
	Vincent Mamode	55	2	0	57
	Brigitte Zelia	35	11	8	54
	Sherley Figaro	30	19	2	51
	Jim Moncherry	50	0	0	50
	Nerick Fred	49	0	1	50
	Lina Moses	30	12	6	48
	Cynthia Sanders	44	0	0	44
	Micheline Marie	36	4	4	44
	Suzel Cafrine	35	6	1	42
	Delna Julie	38	0	1	39
	Jeanette Moumou	35	2	2	39
	Maryse Hortere	22	9	8	39
	Morison Julie	29	6	3	38
	Mary Jane Maillet	32	1	4	37
	Aysha Fostel	36	0	0	36
	Sabrina Labiche	22	6	7	35
	Linda Esparon	26	6	1	33
	Dora Mousbe	31	0	0	31
	Vivianne Marie	27	1	1	29
	Christianne Jeannevole	27	0	0	27
	Hugh Mederick	17	6	4	27
	Inese Hall	24	3	0	27
	Nichole Gerry	19	0	0	19
	Maryse Hortere	9	2	3	14
	Doris Antoine	8	1	0	9
	Maria Cousin	9	0	0	9
	Yvette Sinon	1	2	0	3
	Christianne Jeannevole	2	0	0	2
	Norman Francois	2	0	0	2
		1	0	0	1
	Andrew Richard	1	0	0	1
	Mitla Fanny	0	0	1	1
Total		**961**	**142**	**82**	**1185**