PLACE in Burkina Faso: Combating AIDS at the District Level

Priorities for Local AIDS Control Efforts (PLACE) Series, No. 1

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List of Abbreviations

AIDS: Acquired Immune Deficiency Syndrome

CNLS: *Conseil National de Lutte Contre le SIDA* (Burkina Faso National AIDS Control Council)

CSPS: *Centre de Santé et de Promotion Sociale* (Health and Social Services Center)

DRS of Banfora: *Direction Regionale de la Santé de Banfora* (Banfora Regional Health Office)

DRS of Tenkodogo: *Direction Regionale de la Santé de Tenkodogo* (Tenkodogo Regional Health Office)

EDSBF-II: *Enquete Demographique et de Santé, Burkina Faso 1998-1999* (Demographic and Health Survey of Burkina Faso 1998-1999)

HIV: Human Immuno-deficiency Virus

PLACE: Priorities for Local AIDS Control Efforts

STI: Sexually Transmitted Infection

ZIP: *Zones D' interventions Prioritaires* (Priority Intervention Area)

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Executive Summary

Burkina Faso health districts need tools to plan and evaluate AIDS interventions.

The Burkina Faso National AIDS Program (CNLS) estimates that the current HIV prevalence is 7%, making it the second-most infected country by HIV/AIDS in West Africa after its southern neighbor, Côte d'Ivoire. Health districts in Burkina Faso have become the administrative units with primary responsibility for combating disease. The population of a health district ranges from about 300,000 to 400,000 people, and resources for HIV/AIDS prevention are limited. Therefore, health district officials need assessment tools to focus and monitor interventions at low cost. In June through October 2001, the PLACE (Priorities for Local AIDS Control Efforts) method for planning HIV/AIDS interventions was adapted as a health district-level tool and piloted in the Banfora and Tenkodogo Health Districts of Burkina Faso. Funding for the assessment was provided by the World Bank.

The rationale of the PLACE protocol.

Current epidemiologic models explain the HIV epidemic as determined by a complex set of viral, individual and population level factors (Anderson and May 1999). Among the most important factors at the population level are the rates and pattern of new sexual partnership formation. The PLACE method provides a description of sexual partnership and identifies where to focus AIDS-prevention programs in order to reach key members of the underlying sexual network. In the first step of the PLACE method, epidemiologic and contextual information are used to identify areas with potentially higher HIV incidence. In each of these priority areas, named *Zones D' interventions prioritaires* ("*ZIP*s") in Burkina Faso, three stages of interviews are performed. First, community informants within each study area identify key sites for sexual partnership. Next, each site is visited and a person knowledgeable about the site describes site characteristics and activities, sexual partnership at the site and the potential for on-site HIV prevention activity. Finally, at a sample of sites, interviews with individuals socializing at the sites help characterize sexual behavior and AIDS awareness.

A review of available data suggested that Banfora and Tenkodogo Health Districts are priority areas for HIV/AIDS prevention.

The Banfora and Tenkodogo Health Districts were identified by the CNLS primarily because they are important centers of migration, as the literature indicates that areas with heavy migration traffic may experience increased exposure to HIV transmission (UNAIDS 2002). Not only do both health districts experience internal migration between their urban, rural and border areas, but major international highways through both districts facilitate migration to and from other Burkina Faso provinces and across international borders. Practical concerns also informed the choice of the health districts. The Banfora Health District is home to a number of organizations that could translate study results into intervention. Meanwhile, lack of previous HIV/AIDS intervention in the Tenkodogo Health District made this area an appropriate choice.

Where do people in the two health districts meet new sexual partners? More than 400 sites and 30 different types of community events were identified.

Key informants (N=471) identified 263 unique sites in the five *study area*s of the Banfora Health District and 159 sites in the three study areas of the Tenkodogo Health District. Community events were also identified as important moments of sexual encounter. While 44% of sites were bars, taverns or nightclubs, over 30 different types of sites were identified, with differences observed among types and characteristics of sites in urban, rural and border areas. In the urban towns of both districts, key informants most frequently named formal bars, dance clubs and brothels. The semi-urban border towns in both districts were known to have a prominent sex industry based around migration traffic. Frequently named sites in these areas included brothels and bars, as well as informal public meeting areas, such as markets, customs

areas, truck stops and bus stops. Where rural areas did not have formal establishments such as dance clubs or brothels, the most frequently named sites included informal sites such as markets, streets and video clubs. Events also comprised a larger proportion of all key informant reports in the most rural areas of Banfora and Tenkodogo (14 and 35% of key informant reports, respectively).

People meet new sex partners at 85% of sites, though site type and size greatly varies. As 87% of sites have patrons from outside the study area, a high degree of sexual mixing is probable.

Interviewers visited the 422 sites identified by key informants. The site was identified in 388 cases, and at the majority of sites, a representative was interviewed about site characteristics and activities (N=379). Owing to the diversity of site types, the size of sites ranged from less than 10 individuals at some bars to over 1,000 people at certain markets. Over half of site representatives reported 30 to 100 individuals came during peak hours, with an additional 17% reporting greater than 100 individuals. Men outnumbered women by two to one, based on observation at the time of site visit. More than 50% of site representatives reported that male and female youth come to sites. About 60% of site representatives reported that drinking alcohol was a common site activity, while other common activities included eating, commerce and dancing. People meet sex partners at 85% of sites, with 13% of site representatives reporting that commercial sex also occurs on site. Large proportions of site representatives reported that people come to the sites from outside the study area (87%) and from other areas of Burkina Faso (50%).

36% of people interviewed while socializing at sites reported having met a new sex partner at the site. In some areas, more than 80% of women interviewed traded sex for money, goods or services.

In the third phase of interviews, 1,394 individuals were questioned while socializing at a sample of the 64 sites most frequently named by key informants. About 97% interviewed believe that people come to the site to meet new sexual partners, while a proportion of men and women had, themselves, met a partner at the site (34 and 41%, respectively). The highest partnership rates clustered around formal bars, clubs and brothels. Reports of sex work – selling sex for money, goods or services – were highest among women in Niangoloko (43%) and the town of Tenkodogo (81%), though significant proportions of women interviewed in other areas of the Banfora and Tenkodogo Health Districts reported sex work (17 and 31%, respectively).

Of those interviewed at the sites, 44% of men and 28% of women visit multiple sites in one day, and more than one-third of men and nearly half of all women interviewed visit the sites daily. The network in the health districts is extensive and diffuse. Therefore, site-based prevention would reach sexually active individuals more effectively than strategies targeted only to individuals that conform to a "high risk" profile.

People were unlikely to be equipped with condoms while socializing at sites.

Though about 75% of men and women interviewed reported having used a condom with a recent sex partner, less than 8% of individuals carried a condom at the site, where the potential for meeting new sex partners is high. Women, particularly those in rural areas, were less likely than their male counterparts to have ever used a condom or to carry a condom on site. In the border town of Niangoloko and the town of Tenkodogo, higher rates of condom possession were observed among individuals who reported trading sex for money, goods or services (26 and 23%, respectively) and individuals who had a new sex partner in the past week (59 and 33%, respectively).

Currently there is little on-site condom availability and HIV prevention, though managers are willing to host prevention activities at sites.

Even though condoms are accessible within ten minutes walk of 86% of sites, the majority of individuals interviewed while socializing did not carry condoms. Condoms had never been available at 73% of sites in the areas studied, and only 28% of sites had ever hosted an AIDS-prevention activity. However, the

potential for site-based prevention activity is high, as 85% of sites affirm that they are willing to host prevention activities and 65% are willing to sell condoms.

The PLACE Protocol provides health districts inexpensive, efficient tools for identifying priority areas of intervention.

The PLACE study was successfully mobilized for planning HIV/AIDS-prevention programs at the level of the health district. Health district officials must take care to assess needs in the diverse areas that comprise a district, in order that programs be best suited to variable situations. AIDS education and condom promotion at hubs of sexual activity, whether bars and brothels in urban areas or markets and weddings in rural areas, coupled with the success of PROMACO's condom distribution, will better ensure that condoms are not only in circulation but in use where they are needed.

District health officials from Banfora and Tenkodogo developed a generic "roll-out" PLACE protocol for use in other Burkina Faso health districts. This protocol minimizes time, technical assistance and cost by reducing the number of study areas within a health district. Implementation of the "roll-out" protocol requires about 6 weeks and US $4,000 for recruitment of the study team, identification of towns in the health district where the PLACE method will be implemented, interviewer training, field work and dissemination of results to appropriate community and health representatives.

Summary of Indicators for HIV Prevention in the Banfora and Tenkodogo Health Districts

	Banfora Health District		Tenkodogo Health District	
Number of *ZIP*s (study villages)	5		3	
Total population of combined study areas	44,100		106,600	
Number of sites where people meet new sexual partners, according to key informants	263 in 5 study areas		159 in 3 study areas	
Sites where people meet sex partners (%)				
• That are formal bars, clubs, hotels and brothels	34.7		30.2	
• That are informal small sites (eg., *cabarets*, street vendors)	38.4		33.4	
• That are large public places (eg., markets, stations)	26.9		36.7	
• Where alcohol is consumed	63.3		57.2	
• With commercial sex workers	11.5		15.9	
AIDS-prevention program coverage (%)				
Percent of sites in a study area:				
• That ever had an HIV/AIDS program	23.1		36.6	
• Willing to have prevention program	82.5		89.7	
• Where condoms were available at the time of the interview	3.8		4.1	
• Where condoms were never available	74.8		71.0	
• Willing to have condoms	62.4		69.0	
Characteristics of people at sites	**Men**	**Women**	**Men**	**Women**
Percent socializing at sites who:	(N=582)	(N=261)	(N=374)	(N=177)
• Are 15 to 24 years	36.2	69.0	28.4	57.1
• Visit the site every day	27.7	39.5	44.7	60.5
• Will visit multiple sites that day	40.9	27.6	47.6	28.8
• Met a new sex partner at the site	29.2	38.3	42.0	44.1
• Had a new sex partner in past month	25.5	33.0	44.1	47.4
• Involved in sex work*	28.5	22.6	48.0	47.9
• Had AIDS prevention in past 3 months	44.0	35.3	39.0	31.1
• Ever used a condom	77.2	69.7	78.3	63.3
• Used a condom with recent new partner**	78.8	71.9	73.5	72.9
• Carried condom at interview	7.9	5.4	9.1	7.9

*Have given (if men) or received (if women) money, goods, services for sex

**Among people with at least one partner in last three months

Section 1. Burkina Faso General Context and the HIV Epidemic

1.1 Country context

Burkina Faso is a country of the Sahel that comprises roughly 274,200km^2 and is land-locked by neighboring Côte d'Ivoire, Ghana, Togo and Benin to the south, Niger to the east and Mali to the northwest. Burkina Faso is home to 10 million inhabitants, with a demographic profile of a typical developing country. According to the latest Demographic and Health Survey of Burkina Faso, *Enquete Demographique et de Santé, Burkina Faso 1998-1999* (EDSBF-II), nearly half the population is under 15 years of age and 71% is less than 30 years old.

About 55% of the population is of reproductive age (Sangare et al. 1997), and fertility rates are high (6.8 TFR). High fertility rates are in part due to early childbearing. About a quarter of female adolescents aged 15-19 years and half of all females aged 18 years have had at least one child. Age at first sex for women just precedes age at first union (17.4 and 17.6, respectively), falling earlier than men's age at first sex (20.5). If the current growth rate of 2.4% is sustained, its population is expected to double in 29 years (EDSBF-II 2000).

Burkina Faso ranks 172nd out of 174 countries in the 2000 Human Development Index, and about 45% of the population lives below the national poverty level. The poverty is reflected in the sparse economic development of the country. Nearly 90% of the population lives in rural areas, less than 30% has access to adequate sanitation and only 42% has access to safe water

Figure 1.1 Map of Burkina Faso

(UNICEF 2001, The World Bank Group 2002). The poor economic situation is reflected in staggeringly low education rates. The majority of men and women have received no education (72 and 84%, respectively) and are unable to read (66 and 86% of those 15 years or older) (EDSBF-II 2000, The World Bank Group 2002). Poverty underlies high rates of morbidity and mortality in Burkina Faso. The country has among the highest rates in the world for infant mortality and under-five child mortality (105 and 127 per 1000, respectively) as well as maternal mortality (484 per 100,000).

The country's health care system has been decentralized to 53 health districts, each with a population of about 300,000 inhabitants. Each village is served by a health clinic, called the *Centre de Santé et de Promotion Sociale* (CSPS), which is staffed by a certified nurse or midwife who provides primary care, including family planning (Auregan 2001). Rates of health coverage remain poor despite improvement of the health care system since the mid-1980's. As of 1997, there was one medical doctor for every 29,000 people, one midwife for every 28,500 women and one nurse for every 8,500 inhabitants (EDSBF-II 2000). In the Banfora Health District, for example, the majority of the population lives more than 10km from a CSPS, and poor road conditions further prohibit access to the CSPS. The Banfora Regional Health Office, *Direction Regionale de la Santé de Banfora* (DRS of Banfora) estimates that only about 40% of the Banfora Health District population is covered by health services, 82% of births are unattended by a trained medical professional, and 49% of children are vaccinated (DRS of Banfora, 1999).

1.2. The HIV epidemic in Burkina Faso

HIV prevalence data indicate a generalized epidemic.

Burkina Faso has the second highest rate of infection in West Africa after its southern neighbor, Côte d'Ivoire. According to the National AIDS Program, the *Conseil National de Lutte Contre le SIDA* (CNLS), HIV prevalence in Burkina Faso is about 7%. Prevalence rates for high risk groups, such as sex workers and patients presenting with sexually transmitted infection (STI) symptoms are much higher (57.2 and 41.8%, respectively) (UNAIDS 2002), as is the rate in tuberculosis patients (33.6%) (Malkin and Yamengo et al. 1997). While some sources suggest that prevalence will be 10% by 2000 (SIDA Retro 2000 in Auregan 2001), there is also evidence to suggest a stabilization among pregnant women in Burkina Faso's second largest city, Bobo-Dioulasso (Meda et al. 2001). Regardless, all estimates indicate that the country is experiencing a "generalized" epidemic in which infection is well established in the general population.

Migration facilitates the spread of HIV.

Burkina Faso historically has substantial internal and international migration, and evidence suggests that migration may facilitate the spread of sexually transmitted infections (STIs) and HIV (UNAIDS 2001). For example, about 602,000 people have migrated internationally between 1988-92, most often to Côte d'Ivoire or Ghana in search of work (EDSBF-II 2000). Seasonal internal migration is another factor that may increase the spread of HIV between Burkina Faso's urban and rural areas and between its provinces, as Burkinabé move to the more fertile southern region of the country for agricultural work during the harvest season. Migration is facilitated by a train route and a national highway which link Burkina to Côte d'Ivoire, as well six major highways within the country.

Poverty underlies disease transmission.

Though the crude death rate has steadily decreased since the '60s, it remains at about 15 per 1000 according to 1996 estimates, and life expectancy is only 45 years. Common diseases include tuberculosis, malaria, acute respiratory infection and diarrheal disease. Poor sanitary conditions, inadequate access to health services and high rates of illiteracy contribute to disease in general, and AIDS in particular (EDSBF-II 2000, The World Bank Group 2002).

Cultural factors could contribute to disease transmission.

Certain cultural practices may have an impact on HIV transmission. The tradition of widow remarriage, a practice in Burkina Faso, is of particular concern if a woman's husband has died of AIDS (Sangare et al. 1997). Polygyny is a widespread practice in Burkina Faso, involving 55% of women and 32% of men (EDSBF-II 2000). Whether polygyny further increases HIV transmission has not been demonstrated, though data indicate that similar percentages of men in monogamous and polygamous partnerships have non-marital partners (16 and 18%, respectively) (Nnko S. et al. 2001). Therefore, these similar rates of infidelity would impact a greater number of individuals in polygynous unions, as STIs move easily through the system of multiple and concurrent partnerships (Pebley et al. 1988).

Response to HIV/AIDS in Burkina Faso has increased over time.

The CNLS was formed in 1990, headed by the Ministry of Health and supported by the Ministry of Communication to govern and integrate all HIV/AIDS intervention activities. The first stage of plans devised by the CNLS, conducted from 1990 to 1992, focused on further intensification of IEC activities, particularly targeting high risk groups and strengthening the sentinel serosurveillance system to monitor HIV rates in pregnant women, STI patients, FSW and tuberculosis patients. The condom social marketing campaign also was launched with the aid of Population Services International (PSI) to advertise condoms and subsidize condom sales. The second phase of CNLS activities, from 1993 to 1995, focused on STI treatment, care for those infected with HIV/AIDS, and mobilizing support from other development sectors, including other government ministries, the military and non-governmental organizations (Meda 1998).

Since 1996, governmental and donor support of the national HIV/AIDS effort has markedly increased and become better coordinated. UNAIDS and UNDP has supported the government in developing the Strategic Framework for HIV/AIDS Control 2001-2005 and the National Multisectoral Program for HIV/AIDS Control Action Plan (Meda N. 1998). In 2001, the CNLS was moved from the Ministry of Health in order to facilitate a multisectoral response (UNDP 2001, Aegis 2001). In addition, access to resources for AIDS programs has improved due to additional grants from donor agencies such as the UNDP, loans from the World Bank and increased governmental contribution.

1.3 Description of the PLACE method in Burkina Faso

Because resources for HIV prevention programs are extremely limited, there is an urgent need to focus interventions where they are most cost-effective. Areas with higher incidence of HIV infection are priority areas for intervention, and AIDS-prevention programs should focus resources in these areas in order to be cost-effective.

The PLACE (Priorities for Local AIDS Control Efforts) protocol is a new rapid assessment tool to identify high transmission areas and the specific sites within these areas where AIDS-prevention programs should be focused. It is an alternative to population-based serosurveys that aim to empirically identify areas with high HIV incidence but are rarely conducted due to cost, feasibility, loss to follow-up, and ethical concerns.

This approach takes advantage of the fact that contextual factors can signal increased risk of HIV in lieu of seroprevelance data. Such factors include:

- Poverty and unemployment
- Lack of health care services
- Alcohol consumption
- High population mobility
- Urbanization and rapid growth
- High male-to-female ratio

Consequently, the first step in the PLACE method is to use available epidemiologic and contextual information to identify areas likely to have a higher incidence of HIV transmission. Subsequent steps use rapid field methods to identify and characterize sites within these areas

Table 1.1. The five steps of the PLACE method

Step	Objective
1	Identify high transmission areas in the city or district
2	"Key Informant" Interviews: Ask community members who know the area well, "key informants," to identify sites in study areas where people meet new sex partners
3	Site Verification Interviews: Visit sites named by key informants, interview someone at the site to characterize sites in each area and map sites
4	Interviews with Individuals Socializing at Sites: Describe the characteristics of people socializing at sites
5	Use findings to inform interventions

where people with many new sex partners can be reached for prevention interventions. Characteristics of people socializing at sites are also obtained. Finally, the information is used to inform interventions in the area (see Table 1.1).

The method focuses on places where new sexual partnerships are formed because the pattern of new partnerships in a community shapes its HIV epidemic.

A place-based approach has programmatic advantages. Approaches based on risk group status, such as being a trucker or sex worker, can be stigmatizing and are often inadequate in generalized epidemics. Clinic-based approaches miss most people with high rates of new sex partner acquisition. This method was developed at the University of North Carolina and pilot tested in 1999 in Cape Town, South Africa in collaboration with the University of Cape Town. USAID has supported development of the method through the MEASURE/*Evaluation* Project. The method has subsequently been implemented in Tanzania, three townships in South Africa, five parishes in Uganda, St. Petersburg, Russia, and two border towns in Mexico.

The current project aims to develop a tool useful to Burkina Faso health districts, with funding from the World Bank HIV/AIDS Disaster Response Project. Appraised in March 2001, this project aids Burkina Faso governmental, non-governmental and community institutions in improving program planning, implementation and evaluation of HIV/AIDS programs.

In collaboration with the CNLS, representatives of the Regional Health Offices of the Banfora and the Tenkodogo Health Districts – the *Direction Regionale de la Santé de Banfora* (DRS of Banfora) and the *Direction Regionale de la Santé de Tenkodogo* (DRS of Tenkodogo) – the Centre Muraz of Bobo-Dioulasso and the MEASURE *Evaluation* Project at University of North Carolina at Chapel Hill and Tulane University adapted the PLACE method for the purposes of Burkina Faso health districts.

While the PLACE method has been implemented primarily in urban centers, the present study examined the use of the protocol in a variety of urban and rural settings within the health districts. The protocol was first fully implemented in five key areas of the Banfora Health District, including one urban, three rural and one semi-urban border area. Findings from implementation of the PLACE method informed the development of a shorter version of the protocol, better for Burkina Faso health districts because it requires less technical assistance and less money. This "roll-out" version was then implemented in three areas of the Tenkodogo Health District, including one urban, one rural and one semi-urban border area. A general

Table 1.2. Timeline of preparation, implementation and analysis of the PLACE method in two Burkina Faso health districts

Month and Year	Activity
April 2001	Funding granted by World Bank to MEASURE Evaluation Project to adapt and test the PLACE method as a district level tool for planning HIV/AIDS programs in Burkina Faso
June–July 2001	PLACE methodology adapted to Burkinabé context and implemented in Banfora Health District
August–September 2001	Meetings with the DRS, Banfora, the DRS, Tenkodogo, the CNLS and Centre Muraz held to modify PLACE method to make it less expensive and more rapid
October 2001	Modified PLACE methodology implemented in Tenkodogo Health District
November 2001	Meetings with the DRS, Banfora, the DRS, Tenkodogo, the CNLS and Centre Muraz held to finalize PLACE methodology protocol and study instruments to be used in other health districts in Burkina Faso

timeline of preparation, implementation and analysis is presented here (see Table 1.2), with a more detailed version found in Appendix A.

In each of the health districts, the study team included a principal investigator from the Centre Muraz in Bobo-Dioulasso, Burkina Faso, a field coordinator, eight interviewers and representatives from the DRS of Banfora and the DRS of Tenkodogo. The five major steps of the PLACE method were implemented, and findings have been disseminated to the CNLS, the DRS of Banfora and the DRS of Tenkodogo. Representatives from the DRS of Banfora and the DRS of Tenkodogo have been involved in developing a generic protocol and questionnaires so that other Burkina Faso health districts also can determine areas with increased vulnerability to HIV/AIDS and assess the possibility for intervention. If additional Burkina Faso health districts implement the PLACE method in the future, members of the Banfora and Tenkodogo study teams will be available to give technical assistance. Implementation of the "roll-out" protocol by health district officials requires about 6 weeks and US $4,000.

Section 2. How Were the Banfora and Tenkodogo Health Districts Selected for a PLACE Method Assessment?

2.1 Why the Banfora Health District? Heavy migration facilitates HIV transmission

The Banfora Health District is one of the largest in Burkina Faso, comprising 16,000 km² of the southwestern corner of the country and inhabited by about 300,000 people (see Figure 2.1). Despite a lack of HIV seroprevalence data for the Banfora Health District – this district does not have one of the national HIV sentinel surveillance sites – the importance of the district as an area of heavy internal and international migration may suggest increased vulnerability to STIs and HIV (UNAIDS 2001). It shares a long border with Côte d'Ivoire and is located near Ghana, countries with relative economic prosperity, and it is close to Bobo-Dioulasso, the country's second largest city and economic capital. Therefore, the Banfora Health District is an important crossroads for Burkinabé seeking work abroad and for truckers working among the three countries. A railway line and a major international highway connect it with Côte d'Ivoire (DRS of Banfora 1999).

Not only does traffic move through the district en route to other countries, but the relative wealth makes Banfora a destination for Burkinabé from drier regions in the north to live and work. Banfora's land becomes particularly fertile during the rainy season, which extends from May through October. Favorable land and climate conditions also permit the development of tourist and industrial economies. Therefore, while about 45% of Burkinabé live below the national poverty level, it is probable that a smaller proportion who live in the Banfora Health District are affected by extreme poverty. Though development is sparse and the majority of the population lives in rural areas (70%), this proportion is less than that of the country as a whole (nearly 90%). The health district has ten public schools, and though education rates are low, a smaller proportion in the Banfora Health District have received no schooling (74%) than at the national level (86%) (DRS of Banfora 1999, EDSBF-II 2000).

Based on the important geographic position of the district and the resulting migration, the DRS of Banfora estimates that the rate of HIV is equal to or greater than the national average. Though no seroprevalence data exist, health workers report an increase in STI cases from 1996 to 1999 based on syndromic surveillance of STIs (DRS of Banfora 1999).

Identification, selection and description of study areas in Banfora

In June 2001, the DRS of Banfora held a group discussion to identify key towns in the district with a potentially increased risk of HIV transmission. The group chose five towns representing different settings in the health district: the urban town Banfora, the border area Niangoloko, the semi-urban factory town Bérégadougou, and two rural towns, Sidéradougou and Mangodara. These five towns were slightly more developed than the majority of other areas in the district. The towns of Banfora, Niangoloko and Bérégadougou have village-wide electricity, a sanitation system and running water. The rural areas are less developed, though Mangodara and Sidéradougou both have latrines and solar electricity at certain municipal buildings. In both rural areas, good quality water is available via wells and pumps (Direction Régional de la Santé du District de Banfora 1999). The justification for choosing each town is given below.

1. Town of Banfora (population 17,000) is the largest town in the health district, a center of commerce and tourism with numerous establishments such as hotels, bars, dance clubs and restaurants. Due to the nightlife, the town is a place where people from throughout the district come to recreate and meet people.

2. Niangoloko (population 11,432) is a semi-urban border town that shares a border with Côte d'Ivoire and hence sees a great deal of migration traffic. An established professional sex industry serves truck drivers and travelers that come through the town. Though a majority of its neighborhoods are poor, there is a municipal infrastructure, including electricity, running water and a sanitation system. Economic development common in urban areas has brought establishments such as bars with dancing, brothels and restaurants.

3. Bérégadougou (population 8,125) is a semi-urban town built around two major factories. People from throughout Burkina Faso migrate to the town for work, with and without their families. The factories enable a degree of economic development, and establishments such as bars and restaurants serve the working population. It is located about 10 km from Banfora, so there is a constant migration between the two towns.

4. Sidéradougou (population 3,963) is one of the larger rural villages in the health district. It is situated on a major road extending from the town of Banfora to another tourist attraction, the town of Gaoua, therefore the town experiences increased mobility due to tourism. Traditional culture and religion characterize this area, with rites such as polygamy and female genital cutting commonly practiced. Despite a potential increased risk of HIV transmission, the town has not been able to fund HIV/AIDS-prevention efforts due the depressed economic situation.

5. Mangodara (population 3,589) is also one of the largest villages in the district. Situated on the border with Côte d'Ivoire, it is a center of mobility. It also has an important market that attracts numerous vendors, making it a small center of commerce.

2.2 Why the Tenkodogo Health District? Migration and heightened poverty signal increased risk of HIV transmission

The Tenkodogo Health District is the largest in the Tenkodogo Health Region, inhabited by 398,009 people and extending 5,232 km^2 in southeastern Burkina Faso. Similar to the Banfora Health District, the geographic position of the Tenkodogo Health District facilitates international and internal migration. It borders Togo and is located 11 km from Ghana, two countries that supply a large proportion of Burkina Faso's imported goods. A major international highway connects Tenkodogo with Togo. Other international destinations include Côte d'Ivoire, Gabon and Italy, either due to commercial sector trade or migration for better employment prospects (DRS of Tenkodogo 2000).

Burkinabé move through the Tenkodogo Health District from rural to urban areas, or to visit tourist attractions and areas where people can mine gold. A major highway traversing the Tenkodogo Health District enables movement within the district and to other districts (DRS of Tenkodogo 2000).

Limited HIV prevalence data are available for the Tenkodogo Health District. The town of Tenkodogo is one of the five locations comprising Burkina Faso's national HIV surveillance system, which is based in antenatal care clinics. HIV prevalence among pregnant women in Tenkodogo is lower (3.8%) than the official national average reported by the CNLS (7.2%). In addition, HIV estimates among blood donors at Central Regional Hospital (CHR) of Tenkodogo were lower (2.9%) than among blood donors at Burkina Faso's national hospital in Ouagadougou, Centre Hospitalier National Yalgado Ouedraogo (5%) (CHR de Tenkodogo 2001, UNAIDS 2000). Though prevalence of HIV appears low compared with the national average, there is an increase in the number of HIV/AIDS cases, with HIV/AIDS among the leading causes of hospitalization at the Tenkodogo central regional hospital in 1998.
The Tenkodogo Health District may be at greater risk of HIV than the data suggests because it is one of the poorest in the country. The majority of the population lives under the national poverty line in rural areas that are less developed than in the Banfora Health District. Three towns have piped drinking water, while the remainder of the district gets water from pumps, wells or rivers and streams. Both urban

and rural areas lack septic systems, contributing to poor hygiene conditions. Despite such poverty, this health district receives few resources for health and AIDS prevention compared with other health districts (DRS of Tenkodogo 2000).

Identification, selection and description of Tenkodogo study areas

In September 2001, the DRS of Tenkodogo held a group meeting and identified key towns in the district that potentially have increased risk of HIV transmission. As was done in the Banfora Health District, the group chose three towns representing diverse settings: the urban town of Tenkodogo, the border town Bittou, and the rural area comprised of two adjacent towns Beguedo and Niaogho. Of the three towns, the towns of Tenkodogo and Bittou have electricity, while only the town of Tenkodogo has running water. The justification for choosing each town is given below.

1. The town of Tenkodogo (population 35,258) is the largest town in the district and an important center of transit and commerce owing to its strategic position on a major route leading to Togo. Consequently, there are numerous commercial establishments such as hotels, bars, restaurants, etc. It is also known as a leading destination for women from Togo who come to work as bar servers and/or sex workers.

2. Bittou (population 37,053) is a semi-rural border town about 11 km from Ghana and 20 km from Togo. Relative to other border towns in Burkina Faso, there is very little economic development. While agriculture and animal husbandry are major sources of revenue, an important aspect of the economy is tied to customs-related activity at the border. Bittou's commercial establishments, some of which are the center of sex work, include two hotels for lodging travelers in transit, bars with dancing, and numerous informal restaurants.

3. Beguedo/Niaogho (population 34,334) is 42 km northwest of the town of Tenkodogo. This rural area is comprised of two adjacent villages, situated about 2 km from one another and separated by a river. Beguedo is a large village with relatively modern development. Relatives of many villagers who have emigrated to Italy are able to support villagers back home, so the living conditions in this area are better than many other villages in the district. In addition, the presence of organizations such as the Association for the Development of Beguedo (ADB) and the non-governmental organization Born Fonden offer further support. Niaogho is less modernized, with a slightly smaller market, though it shares many of the same characteristics as Beguedo.

Agriculture, animal husbandry and fishing are major sources of revenue for Beguedo/Niaogho. In addition, there is a tradition of commerce that has greatly intensified over the past decade, its markets are visited by people coming from a variety of locations. As Islam has a strong presence, hard alcohol has a limited presence in the village and there are no modern bars.

Figure 2.1. Map of Banfora and Tenkodogo Health Districts

2.3 Preparation activities for implementation of the PLACE method in the health districts

Community support

Representatives of the DRS of Banfora and the DRS of Tenkodogo were selected to remain involved during the fieldwork of the PLACE protocol, aiding the interviewing team by introducing them to important villagers and helping to solve problems in the field. They assumed the responsibility of contacting the administrative leaders of the ZIPs to explain the PLACE protocol, garnering support for the PLACE method and notifying the village populations that fieldwork would take place.

Interviewer selection and training

In both the Banfora and Tenkodogo Health Districts, interviewers were chosen based on interest in the PLACE protocol, previous interviewing experience, experience with sexual behavior studies and education level. Interviews would be conducted in French and/or the local language of the health districts. Therefore, it was necessary for interviewers to be fluent in French and either Dioulla, if working in the Banfora Health District, or Mooré, if working in the Tenkodogo Health District. All interviewers in the Banfora Health District were male, because previous experience with the PLACE Method assessments suggested that both men and women feel more comfortable speaking frankly about sexual behavior with men than with women. However, it was decided that both men and women would comprise the interviewing team in the Tenkodogo Health District.

Interviewers received a one-week training on the rationale, objective and methods of the PLACE protocol. During the training, interviewers read the data collection manual and questionnaires, role-played interviews, field-tested the questionnaires, and discussed study methodology, study ethics and sensitivity regarding the sexual behavior studies.

Study instruments

Study instruments, including the PLACE Method protocol, interview guide and questionnaires, were translated from English to French at Tulane University. In Burkina Faso, representatives from the DRS of Banfora, the Centre Muraz of Bobo-Dioulasso, the University of North Carolina at Chapel Hill, USA and the Banfora interviewing team reviewed the questionnaires and made appropriate changes. Though questionnaires remained in French, interviewers reached a consensus about which Dioulla and Mooré words would be used during the interviews to best explain certain concepts.

Section 3. Where Do People Go to Meet New Sexual Partners? Findings from Key Informant Interviews

3.1 Methods of key informant interviewing

A sexual network site is a place or an event in a study area where people with high rates of partner acquisition meet to form new sexual partnerships. We focus on new partnerships because individuals with high rates of new partner acquisition are more likely to transmit infection. Typical sites include bars, dance clubs and brothels. However, the method seeks to identify all sites in a study area, which can include markets, soccer fields, places of worship and community events.

Key informant interviewing was the primary method used to identify sites where people from the health districts go to meet new sexual partners. This is a rapid method for obtaining sensitive data not otherwise available. In this study, key informants are members of the study area who may be particularly knowledgeable about where people meet sexual partners, because they are mobile or because their work allows them to witness people socializing. Key informant reporting yields a list of site and event reports.

Numerous types of key informants were chosen in each area to ensure a diversity of perspectives regarding locations of sexual encounter. Because this list is based on reports from many key informants, bias from any individual informant is reduced. Self-presentation bias is minimized because key informants report others' sexual behavior rather than their own. Further, key informants' reports can be verified in the second stage of interviewing, when the sites that key informants identify are visited.

In each of the five study areas, local health workers aided the study team in identifying people who would serve as suitable key informants. Between 50 and 80 key informants were

Figure 3.1. Key informants types, Banfora Health District, 2001

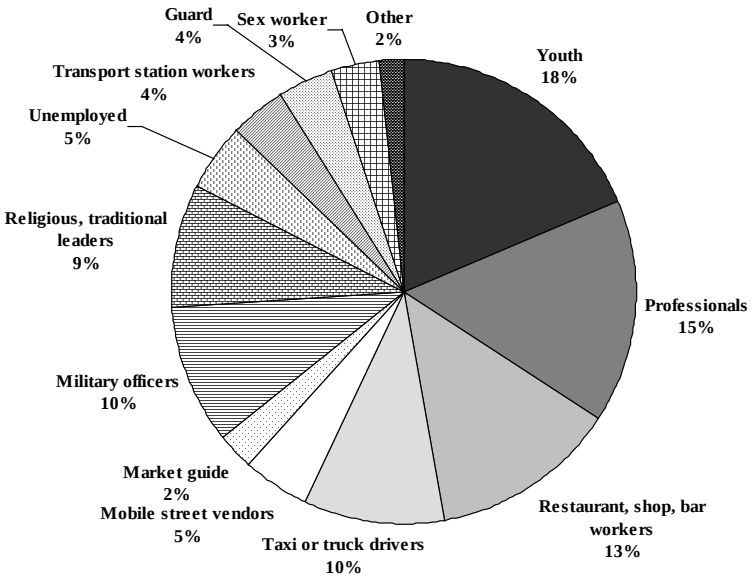
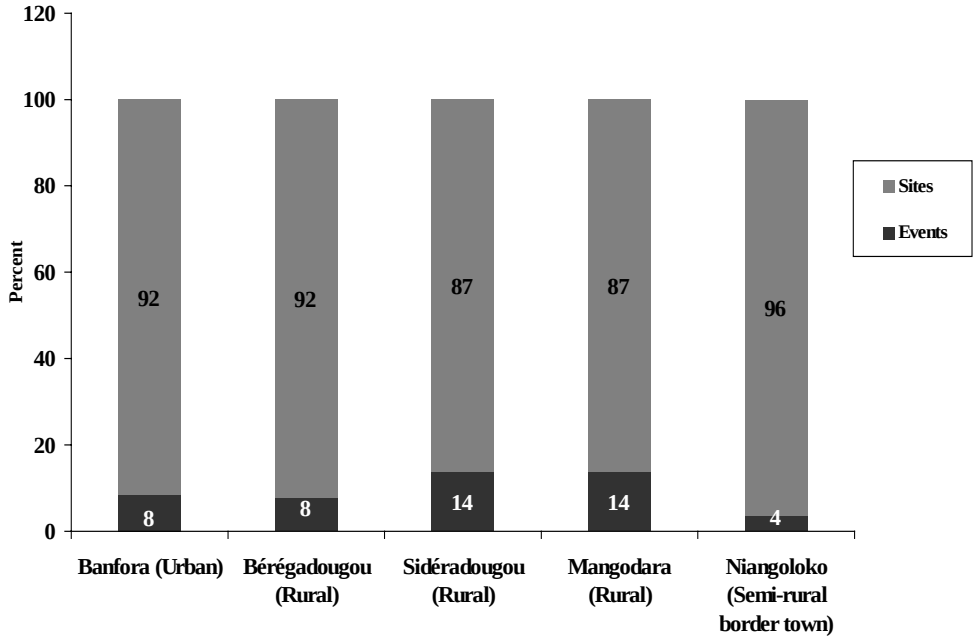


Figure 3.2. Proportion of key informant reports that are geographically located sites versus temporally situated events, by study area, Banfora Health District, 2001



chosen in each study area, depending on the village size. In past studies using the PLACE method, site reports most pertinent for HIV/AIDS interventions came from community members who were mobile and who therefore were exposed to a variety of people and places, such as taxi and truck drivers. Therefore, the study team recruited a large proportion of mobile key informants. Professionals, restaurant and bar workers, adolescents in school and out of school, military officers, religious authorities and traditional authorities were other types of key informants that the interviewing team attempted to recruit in each study area.

Verbal consent was obtained before proceeding with the key informant interviews. The main question asked of each key informant was "Where do people go to socialize and meet new sexual partners?" Each key informant provided the following information concerning sites and/or events that they identified:

- Name of site or event
- Type of site (e.g., restaurant, bar, video store, street corner) or event (e.g., wedding, funeral)
- The precise address of the site (or a description of how to get to the site if they could not provide the address) or the time and location of the event

3.2 Results of key informant interviewing, Banfora Health District

Over the course of the five-week study period in the Banfora Health District, 5.5 days were devoted to key informant interviews. A total of 295 interviews were conducted in the five study areas by either eight or nine interviewers, depending on the size of the study area. About 95% of individuals approached for the key informant interview agreed to participate (see Appendix Table B1).

Major categories of key informant types are shown in Figure 3.1 (see Appendix Table B2 for greater detail). The study team recruited a large proportion who work in transport or who are mobile, including taxi and truck drivers (10%), mobile street vendors (5%) transport station workers (4%) and market/station helpers (2%). The youth, including students and youth out of school, also comprised a large proportion of key informants (19%), followed by education and health professionals, businessmen and those who work in non-governmental and governmental organizations (15%). Other key informants worked in the commercial sector, such as in restaurants, bars, or shops (13%), worked in the military (10%), or were religious leaders or leaders of traditional rituals (9%).

Appendix Table B3 provides the demographic characteristics of key informants. About 79% of key informants were male, the median age was about 31 years and almost all lived in the area of study (97%). The majority of female key informants were bar servers, owners of *cabarets* (traditional bars serving home-brewed beer), health or education professionals and sex workers.

Each key informant reported an average of about 5 sites and 0.5 events (see Table 3.1 and Appendix Table B4 for greater detail), with the number of sites and/or events reported by a key informant ranging from 0 to 24. Naturally, key informants within a study area named the same sites and events that are particularly popular. Of the 1,504 site reports, 264 unique geographically located sites were identified, with a greater number of sites found in the urban center (108) compared with the semi-urban border town (41) or each of the three rural villages (53, 37 and 25).

Of the 137 event reports, 27 unique types of events were identified. Common events included weddings, funerals, baptisms, end-of-school festivals, harvest festivals and community celebrations of music, dance and ritual. Figure 3.2 indicates that event reports comprised a larger proportion of key informant reports in the rural study areas, Sidéradougou and Mangodara, than in the urban commercial center of Banfora, the border town of Niangoloko and the semi-urban factory town of Bérégadougou.

Table 3.2 presents the five most common types of sites named in each of the five study areas, by urban-rural setting. In the urban town of Banfora and the semi-urban border town of Niangoloko, formal bar/dancing establishments, small modern bars (*maquis*) and brothels were the most commonly named sites. Key informants from urban and rural study areas also named informal sites such as markets, streets and informal establishments where people come to watch VCR videos (video club). Informal sites were more commonly named in rural areas, where formal commercial establishments were not as common. For example, the majority of the top five sites in the most rural areas, Sidéradougou and Mangodara, were important streets, markets and video clubs. Other sites named in the Banfora Health District included schools, churches, the waterfall near the town of Banfora, hospitals and the local health clinic.

Table 3.1. Summary of key informant fieldwork, Banfora Health District, 2001

	N
Total number of key informants	295
Number of site reports	1504
Mean number of site reports	5.1
Number of unique sites identified	264
Number of event reports	137
Mean number of event report	0.5
Number of different events identified	27

3.3 Results of key informant interviewing, Tenkodogo Health District

Eight interviewers conducted 176 interviews over a period of 5 days during the month of fieldwork in the Tenkodogo Health District (see Appendix Table B5). The participation rate was excellent (99.4%), with only one male key informant in Bittou refusing to respond to the interview.

Table 3.2. Site type of the five sites most frequently named by key informants, by ZIP, Banfora Health District, 2001

Most frequently named site	Banfora (Urban, commercial center)	Niangoloko (Semi-rural border town)	Bérégadougou (Semi-rural, factory town)	Sidéradougou (Rural)	Mangodara (Rural)
1st	Bar/dancing	Bar/dancing	Bar/dancing	Bar/dancing	Video club
2nd	Bar/dancing	Brothel	Bar/dancing	Bar/dancing	Video club
3rd	Bar/dancing	Brothel	Bar/dancing	Market	Street
4th	Bar/dancing	Street (Near customs at border with Côte d'Ivoire)	Market	Video club	*Maquis*
5th	Film cinema	Bar/dancing	*Maquis*	Street	Market

Figure 3.3. Key informants types, Tenkodogo Health District, 2001

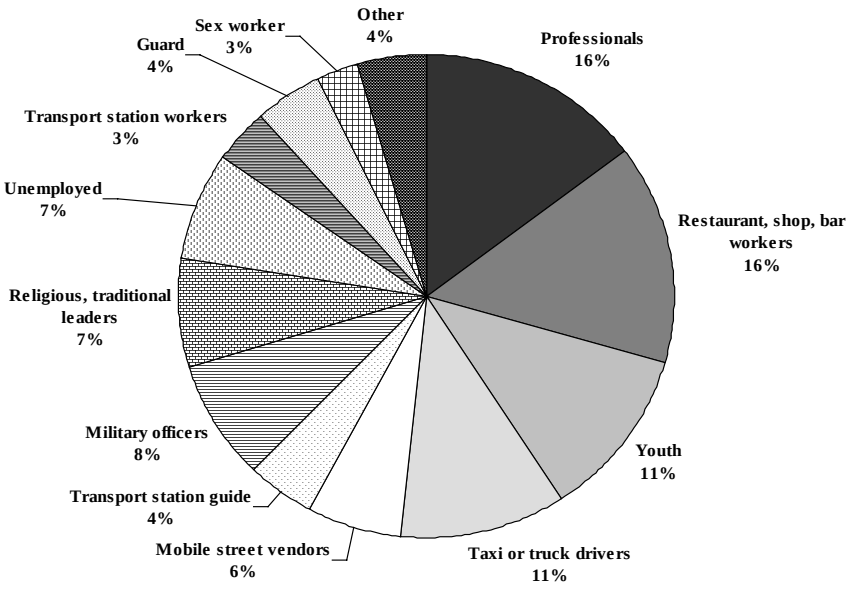


Figure 3.3 presents major categories of key informant types (see Appendix Table B6 for greater detail). As in the Banfora Health District, a large proportion of key informants were chosen for their mobility and exposure to a variety of people and places, including taxi or truck drivers (11%), mobile street vendors (6%), transport station workers (3%) and market/station helpers (4%). Large proportions of key informants in the Tenkodogo Health District were professionals (16%), restaurant, shop or bar workers (16%) and youth in or out of school (11%). Military officers, religious or traditional leaders and unemployed persons each comprised between 5 to 10% of key informants.

Appendix Table B7 provides the demographic characteristics of key informants. The majority were male (92%), and the mean age was 32.1 years, ranging from 15 to 79 years. About 90% of key informants lived in the study areas.

Each key informant reported an average of 5.2 sites (see Table 3.3 and Appendix Table B8), with the number of reports given by key informants ranging from 0 to 26. Of the 918 site reports, 159 unique sites were identified, with a greater number of sites identified in the urban town of Tenkodogo (89) than in the rural area Beguedo/Niaogho (35) or the semi-urban border town of Bittou (35).

In addition, 367 event reports were given, with an average of two event reports per key informant. As in the Banfora Health District, events included weddings, funerals, harvest festivals, school and community celebrations. Indicated in Figure 3.4, event reports comprised a larger proportion of reports given by key informants from the rural area Beguedo/Niaogho (about 35%) than key informant reports in the semi-urban border town Bittou (31%) and the urban commercial center of Tenkodogo (25%). Event reports comprised a greater percentage of key informant reports in the Tenkodogo Health District than in the Banfora Health District.

The five most frequently named sites are presented by site type for each of the three study areas in Table 3.4. Similar to the urban area town of Banfora, in the urban town of Tenkodogo, the top spots were bar/dancing establishments, brothels and *maquis*. Markets represented three of the five most commonly named sites in the rural area Beguedo/Niaogho. Key informants in the border town of Bittou most frequently cited formal hotel/brothel establishments, the customs area at the Togo border and one of the town's popular markets. Other sites named by key informants included schools, hospitals, places of cult worship and truck stops.

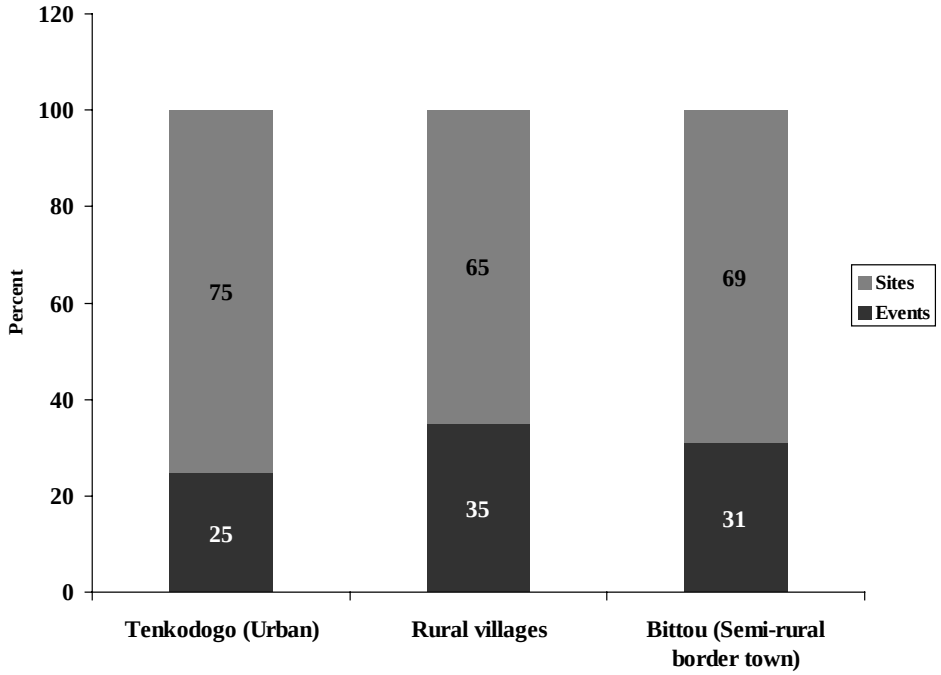
3.4 Summary of key informant reports

In both health districts, a greater number of sites were identified in the urban towns (average 99 sites) compared with the number found in each of the rural villages (average 38) or border towns (average 38) in both of the health districts. The most frequently named type of sites differed greatly by urban, rural and border areas. In urban towns of both districts, commonly named

Table 3.3. Summary of key informant fieldwork, Tenkodogo Health District, 2001

	N
Total number of key informants	176
Number of site reports	918
Mean number of site reports	5.2
Number of unique sites identified	159
Number of event reports	367
Mean number of event reports	2.1
Number of different events identified	34

Figure 3.4. Proportion of key informant reports that are geographically located sites versus temporally situated events, by study area, Tenkodogo Health District, 2001



sites included formal bar/dancing establishments and brothels. The semi-urban border towns in both districts were known to have a prominent sex industry based around migration traffic. Frequently named sites in these areas included brothels and bars, as well informal sites, such as markets, the customs area, or truck and bus stops. When rural areas did not have formal establishments such as dance clubs or brothels, the most frequently named sites were informal sites such as markets, streets and video clubs.

During preparation stages for the implementation of the PLACE method in the Banfora Health District, district health officials emphasized the importance of events in the Burkinabé context. The questionnaire was changed to include events, and interviewers were trained to elicit such events. In both health districts, results of the PLACE method assessment indicated that a variety of important events serve as moments for sexual meeting in both urban and rural areas, with many frequently named events taking place after the harvest season (from the beginning of the year through May). It is possible that events are particularly important in areas where there is less development of commercial establishments such as formal bars, dance clubs, brothels and hotels. In the most rural areas of the Banfora Health District, a slightly higher proportion of all key informant reports (site plus event reports) were comprised of event reports (about 14%) compared with the urban area Banfora (8%) and the border town Niangoloko (4%). Event reports were even more common in the Tenkodogo Health District, ranging from 25% of all key informant reports in the urban town of Tenkodogo to 35% of reports in the rural areas. Interviewers were particularly attuned to the importance of events after the experience of the PLACE method in Banfora Health District and may have been more persistent in asking key informants in the Tenkodogo Health District about events. Therefore, interviewer bias may have played a role in the increased number of events reported in the Tenkodogo Health District. However, the fact that the Tenkodogo Health District is less developed, with fewer

Table 3.4. Site type of the five sites most frequently named by key informants in the five study towns, Tenkodogo Health District, 2001

Most frequently named site	Tenkodogo (Urban commercial center)	Beguedo/Niaogho (Rural area)	Bittou (Border town)
1st	Bar/dancing	Market	Hotel/brothel
2nd	Brothel	Market	Hotel/brothel
3rd	Brothel	Bar/dancing	Street (Near customs at border with Togo)
4th	Bar/dancing	Bar/dancing	Market
5th	*Maquis*	Market	Film cinema

commercial establishments to serve as meeting places, may also explain the higher rates of event reports in this health district. Regardless, the Burkina Faso PLACE study group is pursuing further studies to better understand the extent to which events serve as moments of sexual encounter and the potential for intervention.

3.5 Assessing bias of key informant interviews

Participation rates in the Banfora and Tenkodogo Health Districts were strong (95 and 99%, respectively). The questionnaire was short, and key informants were generally willing or eager to speak about where people in their town go to meet new sexual partners. Self-presentation bias was possible if certain key informants did not report important sites of sexual encounter because they were embarrassed to reveal that they knew this type of information. However, the key informant method of eliciting sites minimizes such bias, as people are likely to be more open and frank when speaking about the sexual behavior of others. Self-presentation bias also was minimized because interviewers reassured key informants that the interview was confidential.

Selection bias may have occurred if those chosen as key informants did not report the most important sites of sexual encounter. A situation that occurred during fieldwork in the town of Banfora indicated that if a different sample of key informants had been chosen, different sites may have emerged as important. Interviewers learned through informal conversations with a group of young men that a bar/dancing establishment that had opened in the previous year was an important new place for people to meet, however this bar was only the 15th most frequently named site by key informants. Likewise, the men mentioned certain bars that had been important in the years preceding the interview but which were no longer as popular. It is possible that some of the sites most frequently named by key informants were popular in the past and had gained community-wide recognition but were no longer important for sexual partnership. The dynamic nature of sites and the phenomenon that the most important places of sexual encounter change every season or year is a challenge to key informant reporting, and it is possible that our key informants were unaware of the most current sexual meeting sites.

To minimize this selection bias we included a large proportion of mobile key informants, people privy to changes in the community, and a broad range of key informant types. Subsequent stages of the PLACE method in the Banfora and Tenkodogo Health Districts reaffirmed that sites reported during key informant interviews were places where people meet new sexual partners. Site verification interviews indicated that over 90% of sites that key informants reported still existed, and over 85% of site representatives interviewed affirmed that people came to the sites to meet sexual partners.

Section 4. What Are Characteristics of Sites Where People Go to Meet New Sexual Partners? Findings from Interviews with Site Representatives

4.1 Methods of site verification interviews

Interviewers visited each unique site reported by the key informants to verify its location and to interview a site representative about site characteristics important for AIDS prevention. Eight interviewers devoted one to two days in each study village to this "site verification" stage of interviewing, each visiting five to eight sites. Interviewers spoke with a knowledgeable person at the site, whether a manager, owner or server who had worked at the site for an extended period of time. When a person was not available for an interview on the first visit, an appointment was requested for a re-visit. Verbal consent for an anonymous interview was obtained for each completed interview. Respondents were asked the following:

- Name of the site and number of years in operation
- The types of activities occurring on site
- The estimated number of clients at peak times
- Estimates of daily amount of alcohol consumed and different cadres of staff
- Characteristics of clientele, including their residence, employment status, age and gender
- Whether people meet new and previous sex partners at the site
- The extent of AIDS/STD prevention activities on site, including condoms and posters
- Willingness to sell condoms.

Identifying each site named by key informants presented difficulties for the interviewers. Often, two different key informants referred to the same site by two different names, so it became difficult to differentiate whether the two names referred to the same site or two different sites. In addition, key informants gave imprecise directions to sites, making it difficult for interviewers to locate sites. Locating sites could be particularly difficult in rural areas, where there were fewer landmarks for identifying sites. During this process of site verification, interviewers were in communication to prevent duplication of interviews and to ensure coverage of all sites. Interviewers also often asked people in the community for help when investigating the status of sites.

4.2 Results of site verification interviews, Banfora Health District

The interviewing team devoted about 6.5 days over the course of the five week study period in the Banfora Health District to visit the 263 unique sites named by key informants (Appendix Table C1). Table 4.1 and Appendix Table C2 present the outcome of site visits. At 234 sites, interviewers managed to locate the site and interview a person knowledgeable about the site. A total of 22 sites could not be identified or were closed. Of 241 sites that were located, individuals at seven sites refused to participate in the interview (97.1% interview participation rate) (see Appendix Table C1). Among those who participated in the interview, about 62% were male. The mean age was about 30 years old, ranging from 16 to 63 years old (see Appendix Table C3).

Table 4.1. Summary of site verification field work, Banfora Health District, 2001

	%	N
Outcome of Site Verification Visits		
Site identified and person interviewed	89.0	234
Site identified but manager refused interview	2.7	7
Site not identified or closed	8.4	22
Total	100	263

Distribution of site types

Over 30 different types of sites were identified in the district. Figure 4.1 compares the most common sites found in each area of the Banfora Health District (see also Appendix Table C4). The town of Banfora and the semi-urban border town, Niangoloko, show similar distributions of the most numerous site types. The largest proportion of sites in both the town of Banfora and Niangoloko were *maquis* (small modern bars) (20%), while other important sites included *cabarets* (small traditional bars serving home brewed beer) (12% and 20%, respectively), brothels (12% and 10%, respectively) and bar/dancing establishments (10% respectively). For the rural areas, *cabarets* were the most common site type (38%), while *maquis*, brothels and bar/dancing establishments were less common (6%, 4% and 4%, respectively). The second most common site in the rural areas was the "tea club," an informal daily gathering of men who make tea and chat. The tea club comprised 17% of rural sites and 5% of sites in Banfora and Niangoloko.

In further analysis, sites were divided into three categories: "formal commercial establishments," "informal small sites" and "large public areas" (see Figure 4.2). **Site category 1**, "formal commercial establishments," included bars, bar/dancing establishments, brothels, hotels and restaurants. These comprised greater proportions of sites in the urban town of Banfora (52%) and the border town of Niangoloko (44%) than sites in the rural area (16%). **Site category 2**, "informal small sites," included *cabarets*, tea clubs, informal food vendors and shops. "Small meeting places" characterized a majority of sites in rural areas (60%), with comparably smaller proportions in Niangoloko (27%) and the town of Banfora (20%). In each geographic location, about a quarter of all sites fell into **site category 3**, "large public areas," such as schools, streets, markets, film cinemas, video clubs and bus stops.

Characteristics of sites

Age and size

Sites had been in operation, on average, for two years or less. The majority of sites were small, with a mean of 8 men and 8 women reportedly employed at the sites and a mean of 11 men and 9 women socializing at the site at the time of the interview (see Appendix Tables C5 and C6). However, a few sites were quite large, and interviewers observed hundreds or thousands of men and women at certain markets, streets or bus stations.

Greater numbers of men than women attended sites during peak hours. About 47% of all respondents reported that, during peak hours, between 20 to 100 men came to the site (see Appendix Table C7), while half of sites reported that fewer than 10 women came to the site. A greater proportion of site representatives in the town of Banfora reported that at least 100 people were present at sites (20%), compared with those in the rural areas (9%) or the border town Niangoloko (7%). The sites that attracted large numbers included formal establishments such as large bars and dance clubs, as well as at informal meeting sites such as at markets and schools.

Figure 4.1. Percent of sites that are *maquis*, brothels, *cabarets* and tea clubs, Banfora Health District, by study area, 2001

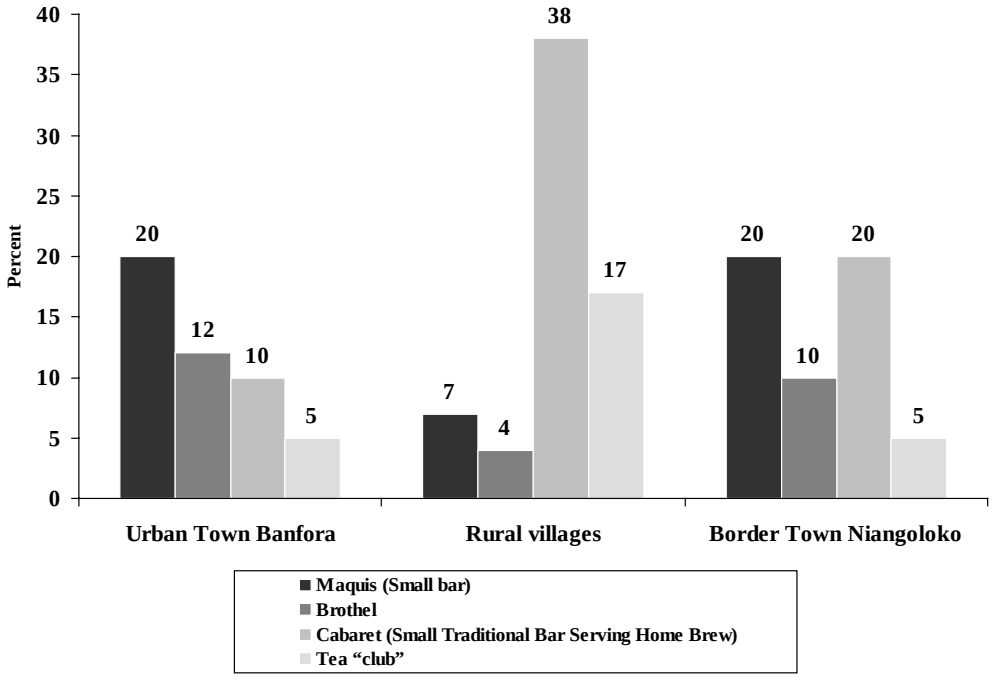


Figure 4.2. Distribution of sites by site type, Banfora Health District, 2001

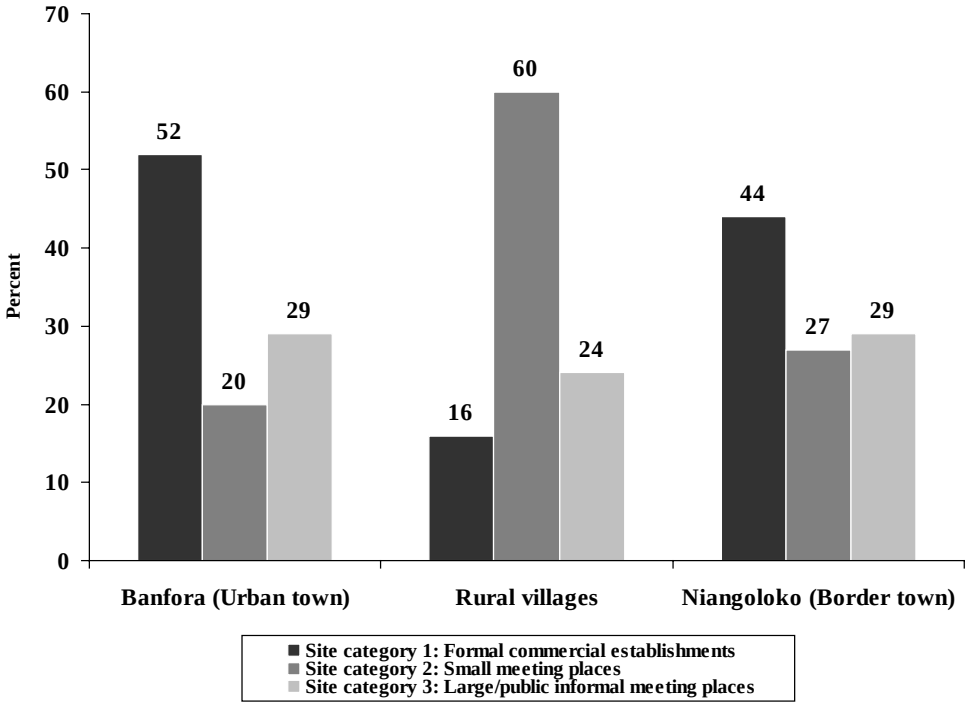
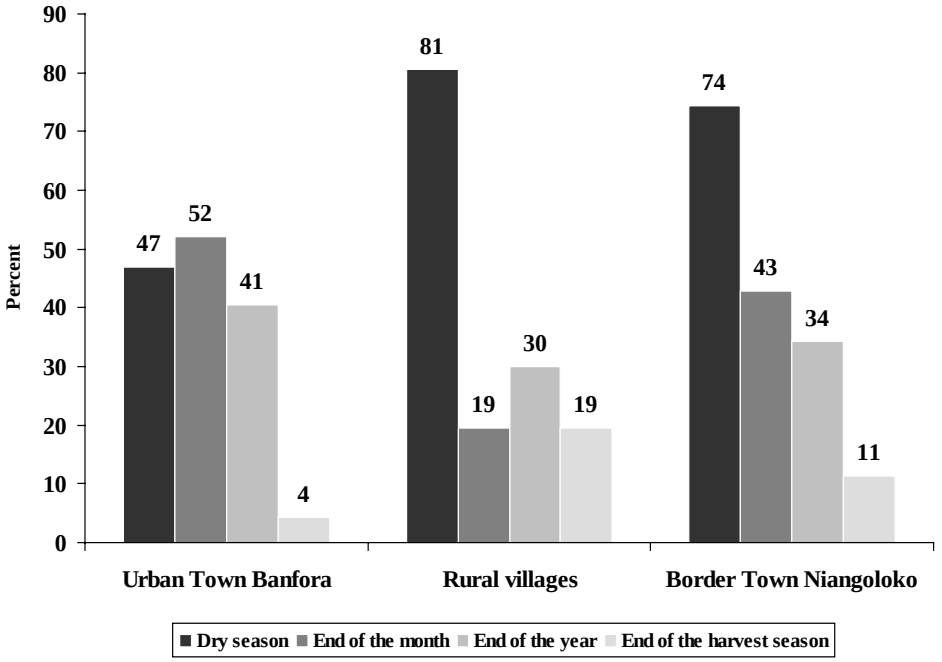


Table 4.2. Weekly calendar showing times of peak operation for different types of sites visited during the site verification, Banfora Health District, 2001

Time of the day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning: 6am-12pm	Schools → Markets, Transport Stations, Tea club (gathering of men making tea), Streets, Hospital					*Cabaret* Tea club	*Church* *Cabaret* Tea club
Afternoon: 12-4pm	Tea club	Tea club	Tea club	Tea club	*Cabaret* Tea club	*Cabaret* Tea club	*Cabaret* Tea club
Evening: 4-9pm					Brothel Bar/dancing	Brothel Bar/dancing	Bar/dancing
Late night: 9pm-12am					*Maquis* Hotel	*Maquis* Hotel	*Maquis*
Later night/early morning: 12-6am					Street Video club	Street Video club	Street Video club

Figure 4.3. Percent of site representatives reporting that sites are popular in the dry season, at the end of the month, end of the year and end of the harvest, Banfora Health District, 2001



Times of peak operation

The times and seasons of peak operation varied greatly by site type. Table 4.2 demonstrates the times during the week when certain sites were most busy. In the towns of Banfora and Niangoloko, where a large proportion of sites were formal commercial establishments such as bars, bar/dancing establishments, brothels and hotels, about 70% reported that Friday and Saturday nights were busy times. In contrast, about 30% of sites in rural areas and 50% of sites in Niangoloko reported that Friday and Saturday nights were among the busiest times. *Cabarets*, tea clubs, schools, taxi and bus stations comprised a greater proportion of sites in rural areas and Niangoloko. These operate during the day and during the week.

The peak moments at certain sites and events cannot be presented on a weekly calendar. For example, certain markets may operate daily, and others may take place on chosen days of the month. Likewise, events take place on certain days of the week or in certain seasons of the year, and therefore cannot be presented on the calendar.

Sites were busier not only during certain times of the week, but also during certain times of the month and seasons of the year (see Appendix Tables C8). Figure 4.3 presents the periods in the year when sites are most busy, indicating that different periods of time are important for the different study villages in Banfora Health District. While a larger proportion of site representatives reported that sites were most busy during the dry season (65%) than those who reported the rainy season (6%) throughout the health district, site operation in rural areas appears to be particularly susceptible to seasonal change.

Respondents in the rural villages and the semi-urban town border of Niangoloko were much more likely to name the dry season as an important time for site operation (81 and 74%, respectively) than site representatives in the town of Banfora (47%). Likewise, "after the harvest," this occurs after the rainy season, was more commonly cited as a busy time for sites in the rural villages (19%) than in the town of Banfora (4%) or Niangoloko (11%). In addition, about 10% of site representatives from the rural areas and Niangoloko cited the season of weddings and funerals, which occurs after the rainy season and harvest, as an important time for sites. More than one-third of site respondents in all areas reported that the end of the month and the end of the year were important periods of site operation, with those in the town of Banfora more likely to report these periods.

Common activities

According to site representatives, a variety of activities takes place at the sites (Figure 4.4 and Appendix Table C9). Drinking alcohol was the most commonly reported activity at sites throughout the district (63%). In keeping with the West African tradition, musical performance was a commonly reported activity at the site, particularly in Niangoloko (60%), with large proportions of site respondents in the town of Banfora and the rural area reporting musical performance as well (42% and 25%, respectively). Other activities reported by site respondents include watching TV or VCR videos, dancing and eating.

Potential for sexual encounter

Potential for meeting a partner at sites was high. About 85% of those interviewed reported that men met new female sex partners at the sites, and 73% claimed that women met new male partners (see Figure 4.5 and Appendix Table C10). Site representatives in the town of Banfora were more likely to report that people at the sites facilitated sexual partnerships (19%) compared with respondents in the rural areas (11%) and Niangoloko (9%). In Niangoloko, a larger percentage of respondents reported that sex workers solicited clients at the sites (23%) compared with the town of Banfora and the rural area (13% and 7%, respectively).

Characteristics of individuals who visit sites, according to site representatives

Though most respondents affirmed that individuals living in the study village came to

Figure 4.4. Percent of site representatives reporting drinking beer or alcohol, musical performance, TV/VCR showing, dancing and smoking marijuana occurs on site, Banfora Health District, 2001

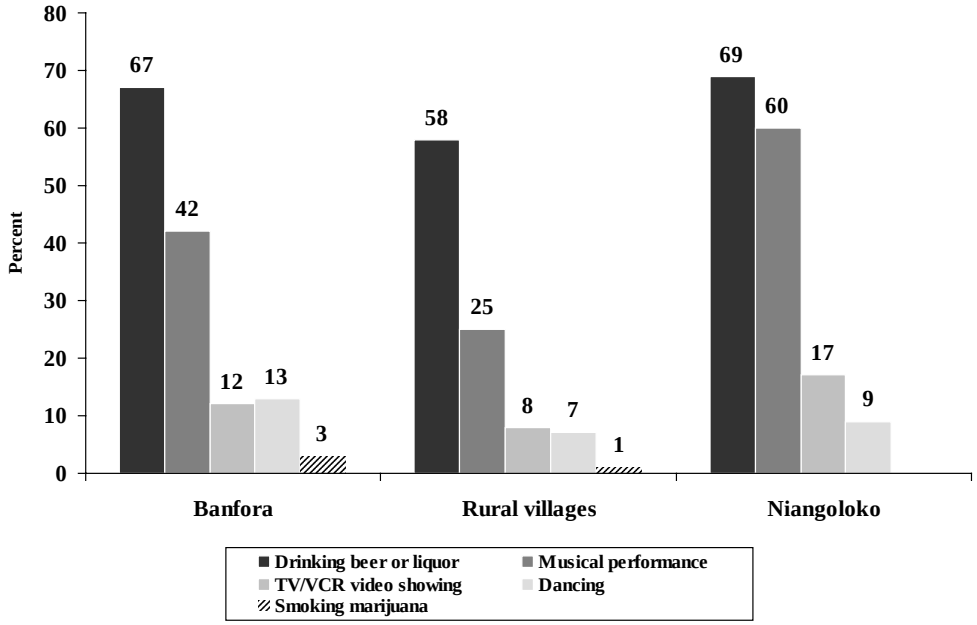


Figure 4.5. Percent of site representatives reporting sexual partnerships that occur on site, Banfora Health District, 2001

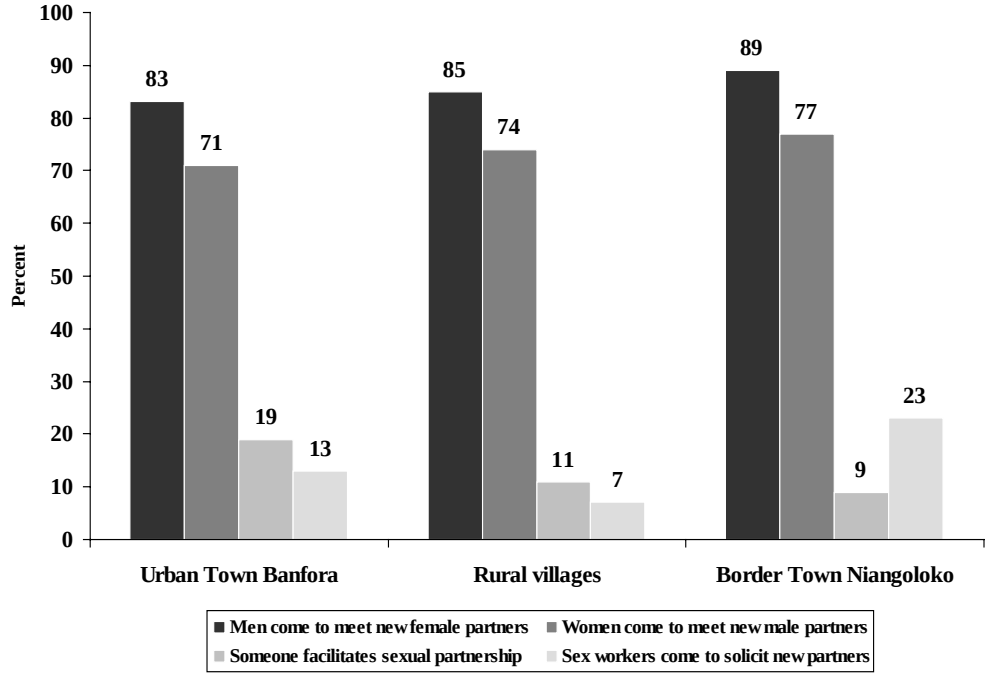
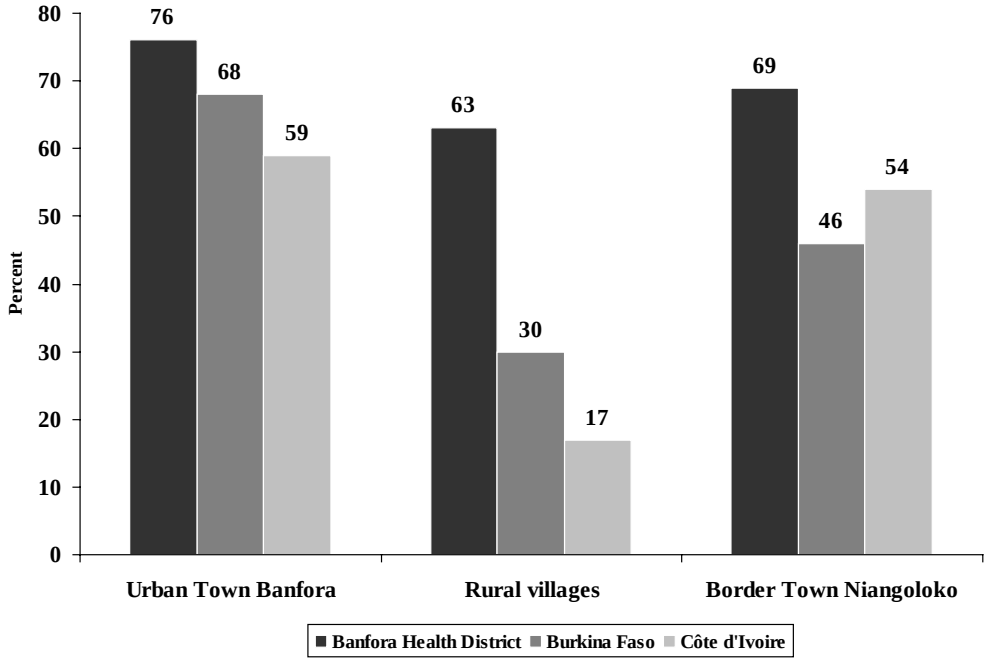


Figure 4.6. Percent of site representatives reporting people come to the site from throughout the Banfora Health District, throughout Burkina Faso or Côte d'Ivoire, 2001



the site, Figure 4.6 indicates that individuals coming to the sites were mobile (see Appendix Table C11). Large proportions of site respondents from the town of Banfora, the rural villages and the town of Niangoloko reported that individuals came to sites from elsewhere in the Banfora Health District (76, 63 and 69%, respectively). Reports that individuals from elsewhere in Burkina Faso came to sites were more common among site respondents in the town of Banfora (68%) compared with respondents in the rural villages and Niangoloko (30 and 46%, respectively). More specifically, respondents commonly reported that individuals came to sites from the capital of Burkina Faso, Ouagadougou, and the large city of Bobo-Dioulasso. More than half of respondents in Banfora and Niangoloko reported that people from Côte d'Ivoire and other countries outside Burkina Faso came to the sites.

Respondents at the sites were asked to characterize the type of people who came to the sites (see Appendix Table C12 and C13). Over 40% reported that at least some men and women who came to sites were younger than 18 years old and were students. Over half of all respondents reported that some men and women did not have employment, with respondents in rural areas more likely to report unemployment. Men and women visited the sites at least once a week at 92% of sites in the town of Banfora, 99% of sites in rural areas, and 100% of sites in Niangoloko.

Potential for site-based AIDS prevention

Condom availability is presented in Figure 4.7 and Appendix Table C14. Sites in the town of Banfora were most likely to have given or sold condoms in the past. Sites in Banfora were more likely to have had condoms at the time of the interview (23%) than sites in Niangoloko (about 26%) and the rural areas (about 16%). Despite low availability of condoms at the sites, about 86% of respondents affirmed that one could find a condom within 10 minutes walk from the site.

Figure 4.7. Percent of site representatives reporting condoms are available on site and within 10 minutes walk, Banfora Health District, 2001

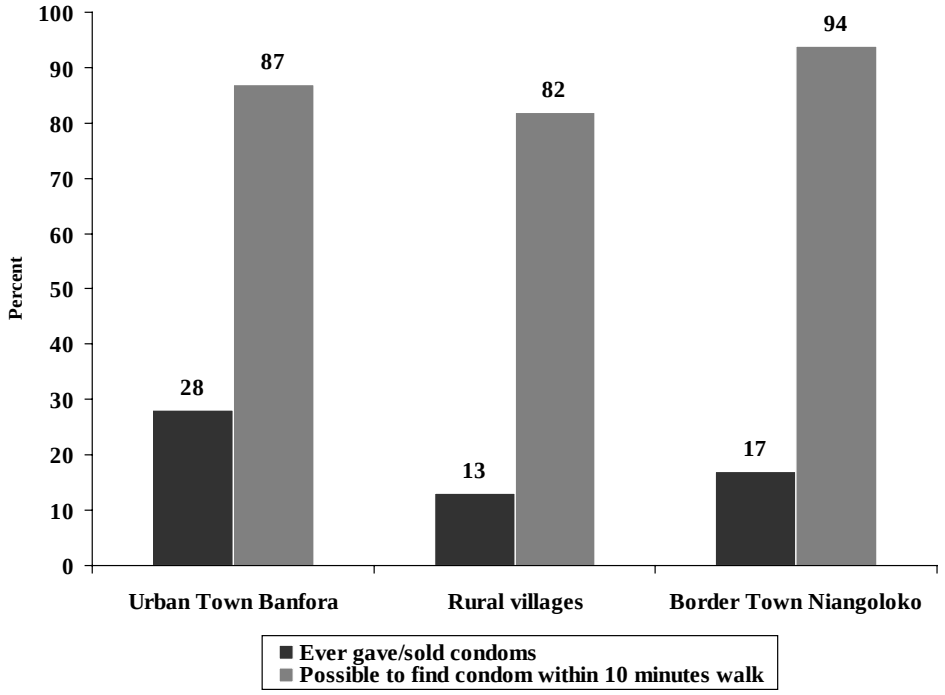
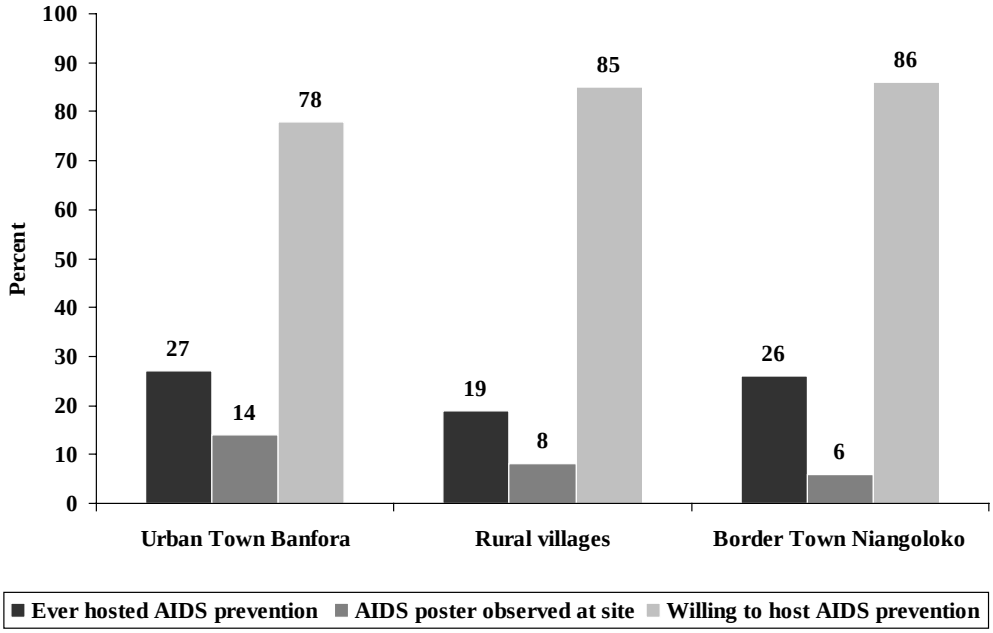


Figure 4.8. Percent of site representatives reporting past, current and potential on-site AIDS prevention, Banfora Health District, 2001



Past prevention activities at the sites were reported by less than 30% of respondents in Banfora and Niangoloko and less than 20% in the rural area. Evidence of AIDS education materials at the time of the interview, such as posters or brochures, was low in all areas. Figure 4.8 indicates that while a small proportion of sites were involved in previous AIDS-prevention activities, there was a high level of willingness to host AIDS-prevention activities at sites in the future (see also Appendix Table C14). The majority of respondents in the town of Banfora, the rural areas and Niangoloko were willing to implement an AIDS-prevention program (78, 85 and 86%, respectively), while slightly lower proportions were willing to sell condoms (72, 53 and 63%, respectively).

4.3 Results of site verification interviews, Tenkodogo Health District

Interviewers visited the 159 unique sites identified by key informants in five days over the course of the three-week period of fieldwork. Table 4.3 presents the result of site visits, with further detail given in Appendix Table C15. Interviewers located the site and interviewed the site owner at 145 sites. A total of 12 sites could not be identified or were closed. Out of 145 sites that were located, only two individuals refused to participate in the interview (98.6% participation rate) (Appendix Table C16). Among those who participated in the interview, about 70.3% were male. The mean age was about 31 years old, ranging from 17 to 75 years (see Appendix Table C17).

Distribution of site types

Over 30 different types of sites were identified in the district, with the greatest diversity in types of sites observed in the town of Tenkodogo. Figure 4.9 compares the most common sites in the urban, rural and border areas of the Tenkodogo Health District (see also Appendix Table C18). In urban Tenkodogo, small drinking establishments, including *cabarets* and *maquis*, comprised about 45% of all sites, while the remaining proportion of sites was distributed among bar/dancing establishments (6%), brothels (6%), markets (6%), hotels (4%), video clubs (4%), tea clubs (4%) and schools (4%). Other sites included streets, churches, shops, stations and sporting arenas.

In the rural area Beguedo/Niaogho, markets comprised the greatest proportion of sites (17%). *Cabarets*, bar/dancing establishments, video clubs, stores selling alcohol and informal food vendors each comprised about 10% of sites, while smaller proportions of sites were categorized as brothels, schools, empty lots and streets. Sites in the rural area also included a roadside toll collection office, a shop, a community center, a hydroelectric dam, a hospital and a Red Cross Center.

As in urban areas, *maquis* and *cabarets* comprised the greatest proportion of sites (26%) in the semi-urban border town Bittou. Key informants in Bittou did not identify nightclubs, bar/dancing establishments or brothels, but hotels that included bars, restaurants and dancing, and which served as brothels, comprised 9% of sites. Markets, video clubs and informal food vendors, sites important in the rural area, each comprised 9% of sites in Bittou.

Table 4.3. Summary of site verification field work, Tenkodogo Health District, 2001

	%	N
Outcome of Site Verification Visits		
Site identified and person interviewed	91.2	145
Site identified but manager refused interview	1.3	2
Site not identified or closed	7.5	12
Total	100	159

Figure 4.9. Percent of sites that are *cabarets*, *maquis*, brothels, market places or video clubs, Tenkodogo Health District, 2001

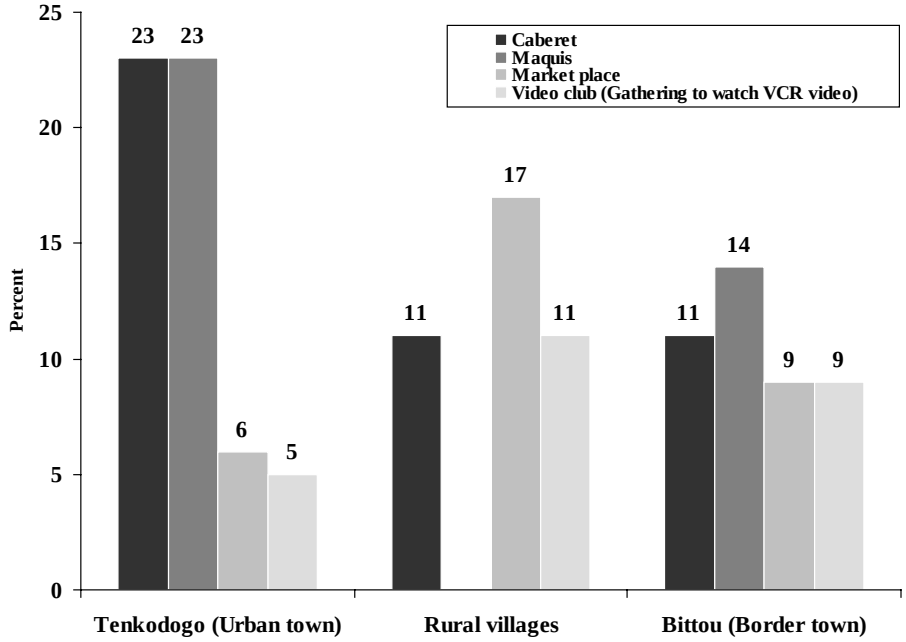
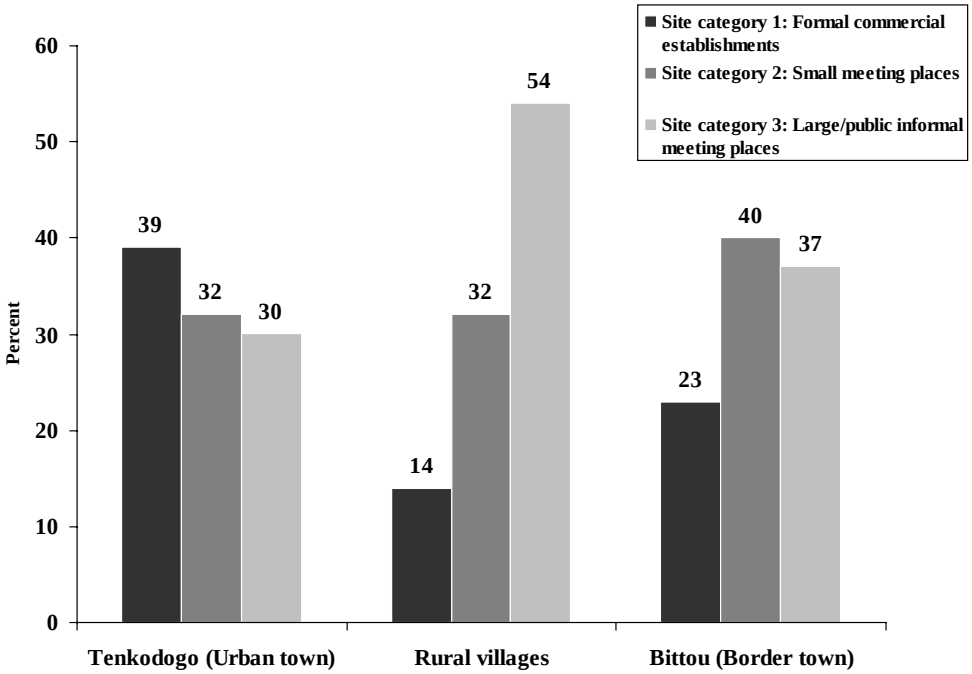


Figure 4.10. Distribution of sites by site type, Tenkodogo Health District, 2001



Distinct from the town of Tenkodogo and the rural area, a large proportion of sites in Bittou were informal restaurants or small open-air kiosks serving food (17% of sites), while other sites unique to a border town setting included transport stations, parking lots and the area near the customs officials.

As was done in the analysis for the Banfora Health District, sites were divided into three categories: formal commercial establishments, informal small sites, and large public areas (see Figure 4.10). Formal commercial establishments accounted for a smaller proportion of sites in the Tenkodogo Health District than in the Banfora Health District. The urban town of Tenkodogo was most likely to have such sites, including bars, dance clubs, brothels and hotels (39%), followed by the border area Bittou (23%) and the rural villages (14%). Small meeting places, such as *cabarets* and street food vendors, comprised the greatest proportion of sites in Bittou (40%) and 32% of sites in the town of Tenkodogo and the rural villages. Large public areas, such as schools, markets, bus stations and customs areas, comprised the greatest proportion of sites in the rural villages Beguedo/Niaogho (54%), followed by Bittou (37%) and Tenkodogo (30%).

Characteristics of sites

Age and size

Sites had been in operation, on average, for two years or less (appendix Table C19). The mean numbers of people working at the sites (27 men and 24 women) and socializing at the sites (20 men and 13 women) were higher than the numbers observed at sites in the Banfora Health District. A higher average number of people were observed in Tenkodogo than in Banfora, due to a greater proportion of sites that attract crowds of people, including schools, markets, bus stations and video clubs (see Appendix Table C20). Large informal public sites, such as markets and streets, comprised a sizeable proportion of sites in the Tenkodogo Health District.

More men than women came to sites during peak hours (see Appendix Table C21). About half of all site representatives reported between 20 and 100 men, while over 60% reported less than 20 women. In the rural areas, more than half of respondents reported that less than 10 women attended the site. Site representatives from a few formal commercial establishments such as bars and dancing clubs reported that large numbers of men (over 50 men) visited their sites, while these respondents did not report comparably large groups of women. Large numbers of both women and men (50 or more of each) were observed only at large public sites, such as markets.

Times of peak operation

The times and seasons of peak operation had a similar distribution found in Banfora (see Table 4.2). Sites in the town of Tenkodogo were more likely to report that Friday and Saturday nights were the busiest times in the week (71% of site representatives) than sites in the rural area Beguedo/Niaogho or the semi-urban border town (50% of site representatives). Sites in the urban area were more likely to be formal bars, hotels, brothels and dance clubs. Sites such as schools, markets, shops and transport stations, which were more commonly reported in rural and semi-urban areas, reported that their busiest times were during the weekdays.

Figure 4.11 presents seasons when sites are most busy, indicating urban-rural differences in seasonality (see also Appendix Table C22). The largest proportion of respondents reported that sites were busy in the dry season, with respondents in the rural area Beguedo/Niaogho and the semi-urban border area Bittou more likely to name this season (83%) than those in the town of Tenkodogo (71%). The end of the harvest was also a busy time at the majority of sites in the rural area Beguedo/Niaogho (63%), compared with about half of sites in Bittou and less than one-third of sites in Tenkodogo. Reports that sites were busy at the end of the month or during holidays were greater in the town of Tenkodogo (54 and 40%, respectively) than in the border town Bittou (37 and 33%, respectively) or the rural area Beguedo/Niaogho (17%). Specific events when sites were busy included holidays such as Christmas and

Ramadan, celebrations for the traditional leaders, birthdays, baptisms, parties to celebrate the end of the school year, market days, soccer matches and periods celebrating return to school.

Common activities

Respondents reported common activities that take place at sites (Figure 4.12 and Appendix Table C23). Though consumption of commercially produced wine, beer and liquor was less common in the Tenkodogo Health District than in the Banfora Health District, a common activity at sites in Tenkodogo was the preparation, sale and consumption of traditional wine *dolo*. Musical performance was another common activity reported at the sites in the district. Respondents in the town of Tenkodogo were more likely to report drinking and music (71 and 38%, respectively) than those in the rural area (40 and 27%, respectively) and Bittou (37 and 20%, respectively).

Respondents in Beguedo/Niaogho and Bittou were more likely to report that sites were places of commerce (33 and 27%, respectively) than respondents in Tenkodogo (17%). Markets where people dealt in selling fish and other goods comprised a large proportion of sites in the rural area and the border area. Respondents in Tenkodogo and the rural areas were more likely to report that watching TV or videos occurs at sites (about 23%) than in Bittou (17%). Small proportions in all areas reported dancing and smoking marijuana. More than half of respondents reported "other" activities occur at the site, specifically eating, commerce-related activities, teaching, praying and playing games. The diversity of these "other" activities is a further indication of the variety of sites that serve as sexual meeting places in the Tenkodogo Health District.

Potential for sexual encounter at sites

About 85% of those interviewed in the district reported that men and women met new sex partners at the site, with 90% of site representatives in Bittou reporting that people met partners (Figure 4.13 and Appendix Table C24). About 10% in the towns of Tenkodogo and Bittou reported that someone at the site facilitated sexual partnerships, compared with 3% of site respondents in the rural area Beguedo/Niaogho. Respondents at the site were asked whether sex workers came to the sites to solicit clients. Significant proportions reported sex work in Tenkodogo (17%) and Bittou (30%). In contrast, no respondents in the rural area Beguedo/Niaogho reported that sex workers come to the sites (0%).

Characteristics of individuals who visit sites, according to site representatives

About 90% of site representatives reported that people who came to the site lived in the study area. In addition, sites throughout the Tenkodogo Health District, and particularly sites in the border town Bittou, were visited by people from locations throughout Burkina Faso and bordering countries (see Figure 4.14 and Appendix Table C25). The majority of site representatives in the town of Tenkodogo, the rural villages and Bittou also affirmed that people from other parts of the Tenkodogo Health District come to the site (75, 66 and 74%, respectively). About 50% in rural area Beguedo/Niaogho and 73% in Bittou reported that people from the town of Tenkodogo came to their sites. Over half of respondents in the towns of Tenkodogo and Bittou reported that visitors from throughout Burkina Faso came to sites (51 and 57%, respectively), compared with 20% of site representatives in the rural area. Site representatives in Bittou were most likely to report that people from outside Burkina Faso came to sites. At least 60% of respondents in Bittou reported that people come from Togo, Ghana and Niger. Smaller proportions in the town of Tenkodogo and Beguedo/Niaogho reported that visitors come from abroad.

Those interviewed about sites were asked questions to characterize the type of people who came to the sites (see Appendix Tables C26 and C27). More than half reported that at least some men and women who came to the site were younger than 18 years old and were students. Greater than 60% of all respondents reported that some men and women who came to the site do not have employment, with 90% of sites in

Figure 4.11. Percent of site representatives reporting that sites are popular in the dry season, at the end of the month, during public holidays, and at the end of the harvest season, Tenkodogo Health District, 2001

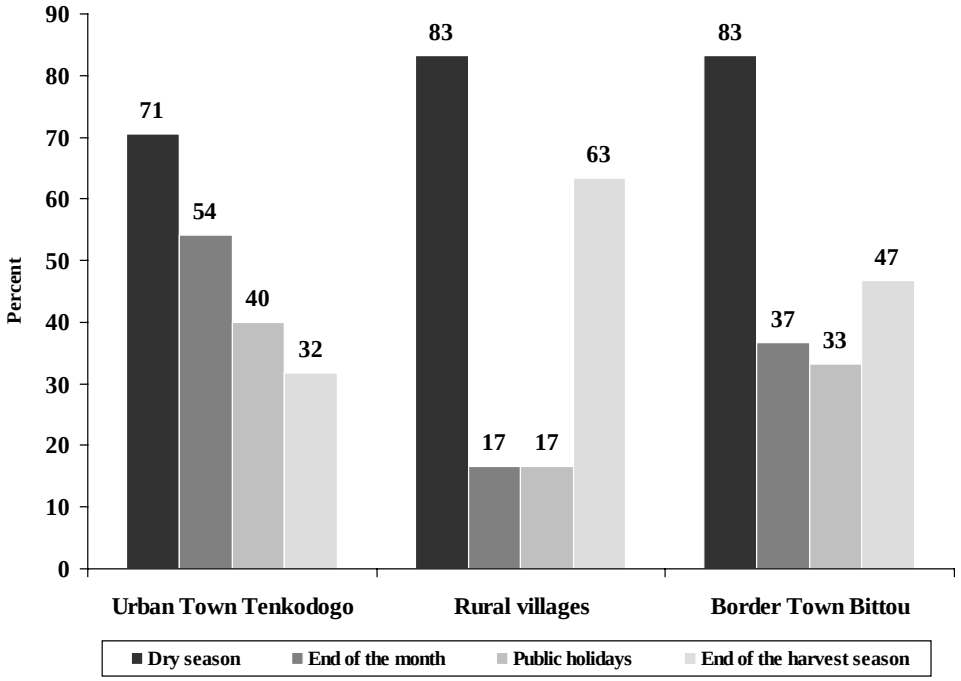
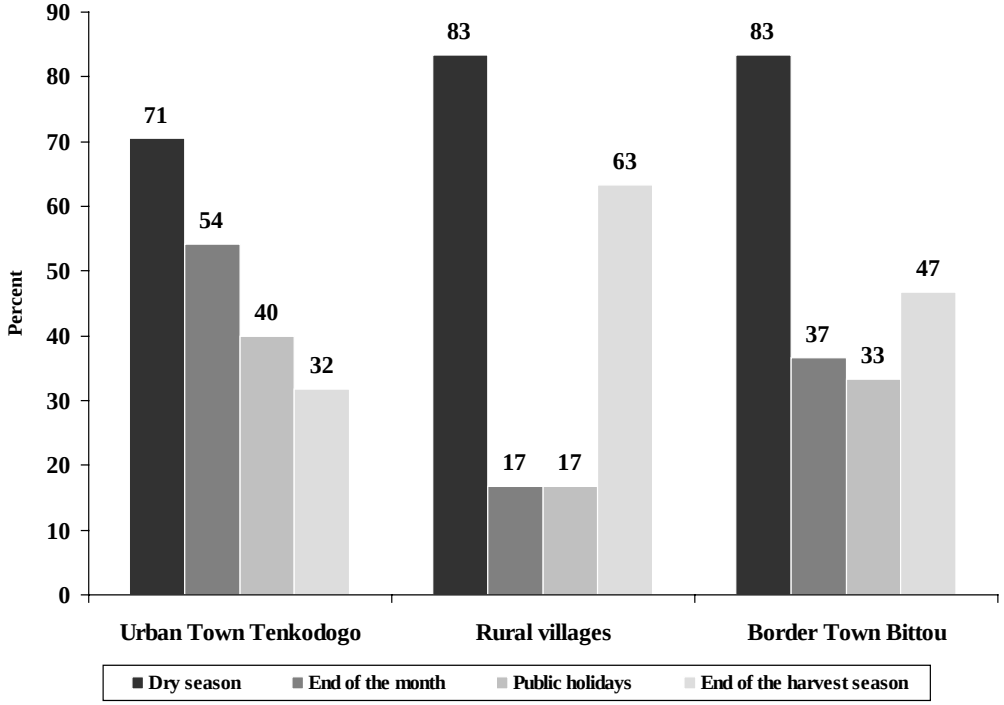


Figure 4.12. Percent of site representatives reporting drinking beer or liquor, smoking marijuana, musical performance, TV/VCR showing and commerce occurs on site, Tenkodogo Health District, 2001



Bittou reporting that at least some clients are unemployed. At least 97% of sites in each study area reported that some patrons visited the sites at least once a week.

Potential for site-based AIDS prevention

Only one-quarter of sites reported having given or sold condoms on-site in the past year, and only 13% reported giving or selling condoms in the past month. Despite low condom availability on the site itself, over 86% of site representatives reported that one could find a condom within 10 minutes walk from the site after 9pm at street vendors. Availability was reported by a smaller proportion of site representatives in Beguedo/Niaogho (77%) than in Bittou or the town of Tenkodogo (93 and 86%, respectively) (Figure 4.15 and Appendix Table C28).

AIDS-prevention activity reported in the site verification is presented in Figure 4.16 and Appendix Table C28. Nearly half of the respondents at sites in Bittou reported that their site had been involved in AIDS-prevention activity, with lower percentages reported in Beguedo/Niaogho (37%) and the town of Tenkodogo (31%). A comparatively smaller proportion of sites displayed AIDS-prevention materials, such as visible AIDS posters (10%), brochures (4%) and condoms (7%).

The interest in AIDS-prevention efforts at sites was high throughout the district at all site types, including formal commercial establishments such as bars, hotels, and dance clubs and informal sites such as markets and bus stations. High proportions of respondents in the town of Tenkodogo, the rural area, and Bittou were willing to implement AIDS-prevention programs (88, 87 and 97%, respectively), while about 70% in each area were willing to sell condoms.

4.4 Summary of site characteristics

Sites in the Banfora and Tenkodogo Health Districts were categorized into three major site categories, with the most common site categories differing by urban and rural area. Site category 1 included formal bars, hotels, brothels and dance clubs, where people went primarily to socialize, and comprised 46% of sites in urban areas and 15% of sites in rural areas. Site category 2 included informal small meeting places such as small bars which served home-brewed wine and beer, as well as street food vendors and shops. These small sites comprised over half of sites in rural areas (53%) and about one-fourth of urban sites. Site category 3 included large, public informal meeting places, such as markets, streets, schools, hospitals, etc. and comprised 31% of rural sites and 29% of urban sites.

The Tenkodogo Health District is one of the poorest in Burkina Faso and is less developed economically than the Banfora Health District. It is not surprising, therefore, that a greater density of sites was reported in the study areas of the Banfora Health District (6.5/1,000 people) than in the Tenkodogo Health District (1.5/1,000 people). There are fewer commercial establishments such as formal bars, dance clubs and restaurants, so people in Tenkodogo were more likely to seek sex partners at informal meeting sites, including markets, food stalls, schools and bus stops.

In both health districts, a greater number of sites were reported in the urban centers (average 99 sites) compared with the number reported in each of the rural villages (average 38) or border towns (average 38). The urban areas in the two districts were fairly similar regarding the distribution of sites. In both urban towns half of the sites were drinking establishments, and the most common activities reported at sites were drinking alcohol, whether liquor, beer or traditional home brew (about 70%) and watching musical performances (about 40%).

The border town in Banfora Health District, Niangoloko, was more urbanized than the border town in Tenkodogo Health District, Bittou. About 20% of sites in Niangoloko were formal bar/dancing establishments or brothels, and an additional 20% of sites were small modern bars, *maquis*. Formal sites were less common in Bittou, but included *maquis* and hotels (14 and 9%, respectively). Similar to the rural area in the

Figure 4.13. Percent of site representatives reporting sexual partnerships that occur on site, Tenkodogo Health District, 2001

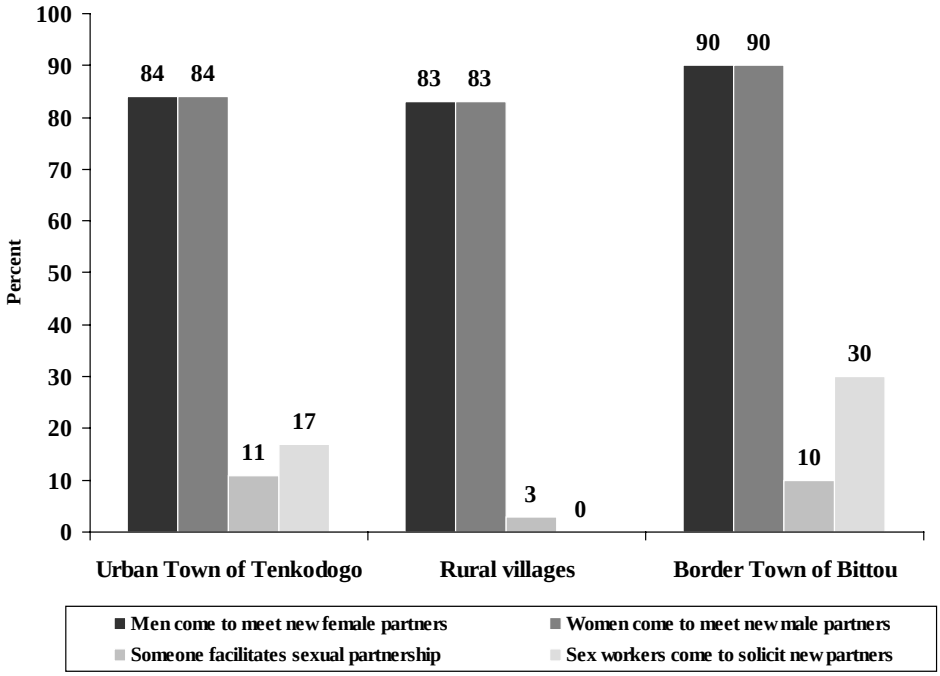


Figure 4.14. Percent of site representatives reporting people come to the site from throughout the Tenkodogo Health District, throughout Burkina Faso or Togo, 2001

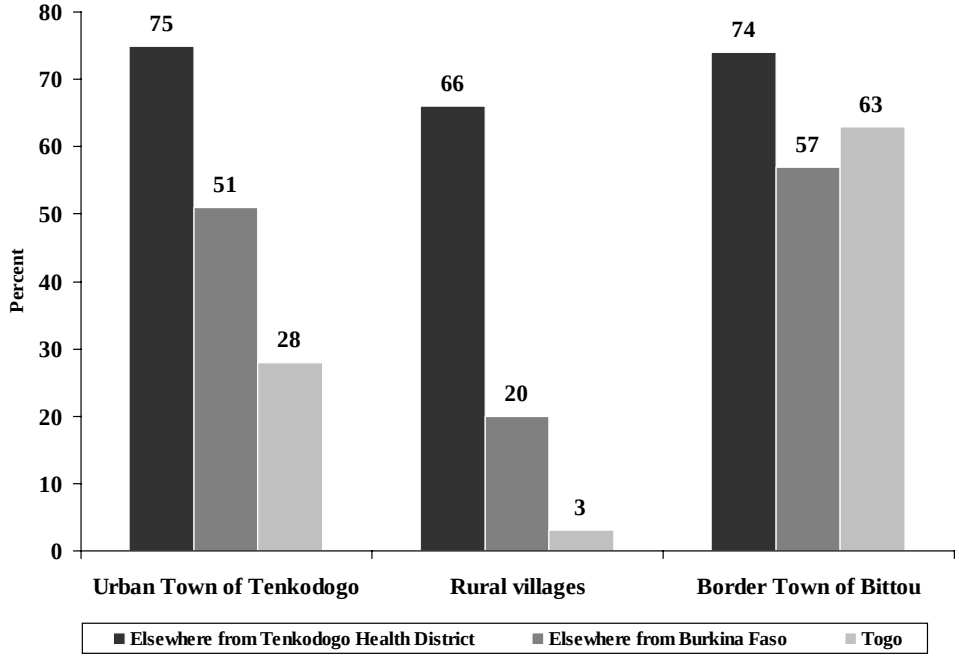


Figure 4.15. Percent of site representatives reporting condoms are available on site and within 10 minutes walk, Tenkodogo Health District, 2001

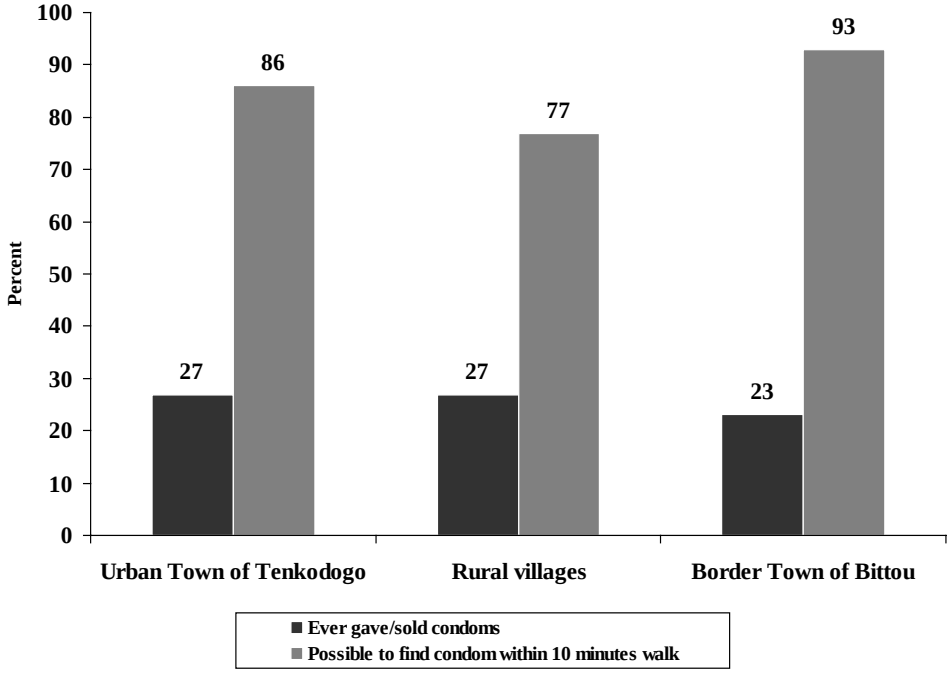
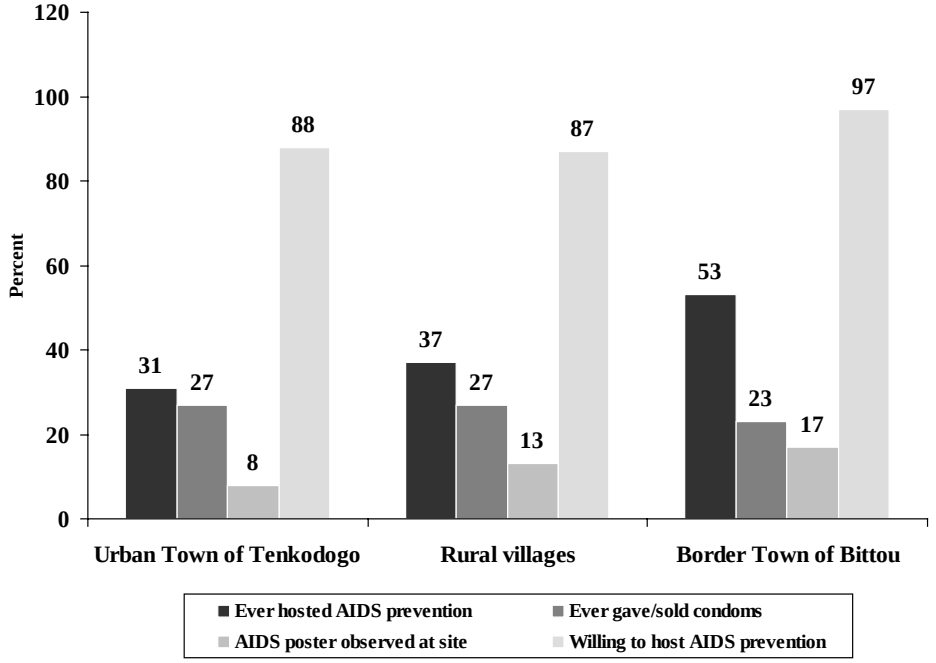


Figure 4.16. Percent of site representatives reporting past, current and potential on-site AIDS prevention, Tenkodogo Health District, 2001



Tenkodogo Health District, important sites in Bittou were informal meeting places such as food stalls (17%) and markets (9%). Differences in activities at border town sites in the two health districts reflect the difference in sites. Drinking alcohol and watching musical performances were much more commonly reported at sites in Niangoloko (69 and 60%, respectively) than in Bittou (37 and 20%, respectively), where eating was a commonly named activity at sites.

In rural areas of both health districts, which were less developed with commercial establishments, the most frequently named sites included small traditional bars, markets, streets and video clubs.

The greatest proportion of sites in Banfora Health District rural areas were small bars (45%), and the most common activity among sites in rural area of Banfora Health District was drinking alcohol (63%) and watching musical performance (37%). No modern bars were identified in the Tenkodogo Health District, owing to the strong influence of Islam. However, *cabarets*, small traditional huts serving home brewed beer or wine, were common. Another important site type in the rural areas of the Tenkodogo Health District was the market, comprising 17% of all sites. Common activities at sites in the rural area of the Tenkodogo Health District included drinking alcohol, primarily weakly alcoholic home brew (60%) and commerce at markets (33%).

The number of people present at the sites varied greatly depending on the type of site, with some small bars serving less than 10 individuals during peak hours while over 1,000 individuals were observed at certain markets. Greater numbers of men than women came to the sites during peak hours. In Tenkodogo Health District, however, women outnumbered men at some large public sites such as schools and markets.

The times when sites were most busy varied according to the day of the week. At bar/dancing establishments and brothels, weekend nights were the busiest times, while smaller bars were popular in the evenings throughout the week. Certain meeting places, such as schools and large markets, were most busy during the middle of the day and throughout the week. Certain markets did not have a set day of the week for operation, as they run every five days.

While certain days of the week are more important, specific times of the month and year also must be considered. In urban areas, the end of the month, often coinciding with pay periods, was commonly cited as a period when sites experience more business. Seasonality was an important consideration for site operation, with the dry season more important for site operation than the rainy season, particularly in rural areas of both districts. While villagers must work in the fields through the rainy season, they have free time and money after the harvest to relax and socialize. Not only do sites receive more business during the dry season, but certain events that take place during this time period, such as harvest celebrations, weddings and funerals, offer important opportunities for people to meet new partners.

Sites were most likely to be visited by people living in the study villages, though respondents in each study village reported that people from elsewhere in the health district and from elsewhere in Burkina Faso visited their sites. Sites also received international traffic, with more than 50% of sites in Niangoloko and the town of Banfora reporting visitors from Côte d'Ivoire and nearly 70% of sites in the town of Tenkodogo reporting visitors from Togo.

Interviews with people who knew the sites well confirmed that the majority of sites were places where people came to meet new sex partners (over 85%), with little variation observed between sites in urban and rural settings. Sex work was most commonly reported in the border towns of the Banfora Health District and Tenkodogo Health Districts (23 and 30% of sites, respectively) and occurred at smaller proportions of sites in urban areas (13 and 17%, respectively) and rural areas in Banfora Health District (7%). No sites in the rural area of the Tenkodogo Health District reported sex work.

Though a small proportion of sites gave or sold condoms, high proportions in urban, rural and

border areas of both health districts reported that it was possible to buy a condom within ten minutes walking distance from the site, largely with street vendors. The possibility that condoms available from such vendors have diminished quality because they have been exposed to sunlight for a prolonged period of time should be considered. Nevertheless, condoms are widely available at low cost because the condom social marketing program, PROMACO, subsidizes sales. On average, individuals interviewed at the sites reported that one could buy 4 condoms for about 50 CFA, or about 4 condoms for US $0.07.

The majority of site respondents in the Banfora and Tenkodogo Health Districts interviewed at the sites were willing to host AIDS interventions (80 and 90%, respectively) and sell condoms (62 and 69%, respectively). A diversity of site types reported interest in participating in such AIDS interventions, including night clubs, brothels, small bars, restaurants, video clubs, community centers, churches, streets, markets and shops.

4.5 Assessing bias of site verification interviews

In order to prevent disclosure of identity, interviewers did not seek out site owners as the only acceptable respondents to the questionnaire, rather the criteria for an acceptable site verification respondent were flexible. It is possible that inaccurate information about the site was given, particularly if the person interviewed had not been working at the site for a long time. However, interviewers took care to ensure that the respondent was knowledgeable about the site before beginning the interview.

In order to minimize selection bias due to non-response, interviewers reassured respondents that responses were completely confidential and that sites would not be uniquely identified in the presentation of materials to district health officials. Rates of participation in the site verification interview were high in the Banfora and Tenkodogo Health Districts (97 and 99%, respectively). While the majority of representatives were helpful and eager to participate, a few refused to participate or were openly uncomfortable during the interview. For example, in the border town of Niangoloko, where sex work is common, the impact of AIDS is evident and awareness of AIDS is heightened. Therefore, managers in this border town were particularly wary of participating, fearing that their establishments would be stigmatized as places of AIDS transmission.

As most questions were not sensitive in subject matter, and respondents were asked to describe general characteristics of the site, the potential for self-presentation bias during the interview was minimized. In regards to the most sensitive questions, fear of being stigmatized may have led to underreporting of sex work and the potential for sexual encounter. However, the fact that high proportions reported that individuals come to meet new partners (85%) may indicate that that respondents generally were comfortable with the interview and gave valid responses. Reports of sex work ranged from 30% of respondents in Bittou to 0% of respondents in the rural area of the Tenkodogo Health District. It is possible that site respondents from these rural areas, which tend to be more traditional and conservative than in semi-urban and urban areas, were hesitant to affirm that sex workers come to sites. However, respondents in rural areas may report less sex work because the commonly understood definition in rural areas is less broad than in other areas.

Section 5. How Risky is Sexual Behavior in the Health Districts? Findings from Interviews with People Socializing at Sites

A. Methods of individual interviews

Interviews with men and women socializing at sites, the third phase of interviews, allowed for estimation of the proportion of people who meet new sex partners on site. The final selection of sites where individual interviews would be conducted could only occur after the key informant interviews and site visits were conducted and the resulting list of reported sites was compiled. Individual interviews were conducted in the Banfora and Tenkodogo Health Districts (843 and 551 interviews, respectively) at the eight sites most frequently named by key informants (41 and 24 sites, respectively). The goal of the interviews was to define the characteristics and sexual behavior of people who visited sites and ascertain whether sites named by key informants were indeed hubs of sexual activity.

Though it was not generally possible to visit and conduct interviews at events, the importance of events was consistently emphasized in key informant interviews. Therefore, interviews were held at a wedding in Bérégadougou when the interviewing team learned that it happened to be taking place during the time of their field work.

During the training, interviewers were instructed to interview 16 men and 8 women at each of the selected sites. To minimize selection bias, people were selected for the interview using a method that systematically allocated interviews throughout the site rather than choosing a convenience sample. Interviews were conducted during the busiest times at the site, either in the evening hours and during the weekend at sites such as bars and clubs, or during the day for other sites, such as markets. If there were fewer than 24 people at a site, the interviewers interviewed everyone at the site.

Consent information was given at the beginning of an interview. To ensure confidentiality, interviews were conducted at a safe distance from others at the site. In a few cases, one bottled drink (soda or beer) was provided to the respondent as a token of appreciation.

B. Results of individual interviews, Banfora Health District

A total of 11 days were devoted to individual interviews over the course of the five weeks of fieldwork in the Banfora Health District. A total of 843 individuals were interviewed at 41 sites, 69% of whom were male. Participation rates

Table 5.1. Characteristics of individual interviews, Banfora Health District, 2001

Characteristic	
Number of Sites Visited for Individual Interviews	41
Number of Individual Interviews	843
Mean/median number of men observed at site	16/8
Mean/median number of women observed at site	8/3
Interview participation rate among men	94%
Interview participation rate among women	86%
Percent male among interviewed	69%

Table 5.2. Socio-demographic characteristics of men and women interviewed, Banfora Health District, 2001

Characteristic	Men	Women
Lives in the study village	76%	86%
Mean age	28 years	23 years
Currently a student	9%	17%
Employed (Either full or part-time)	77%	43%
Has any education	69%	66%
Has 10 years or more of education	28%	13%
Has attended an AIDS information session	44%	35%

were higher among men than women (94 and 86%, respectively) (see Table 5.1 and Appendix Tables D1 and D2).

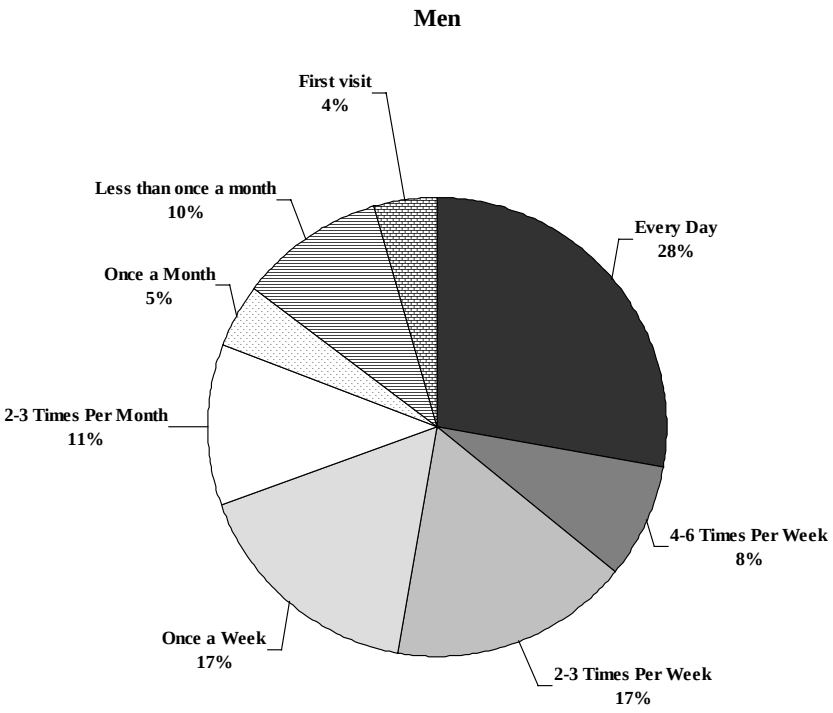
The mean number of men observed at the sites at the time of the interview was twice the mean number of women (16 and 8, respectively) (see Appendix Table D3). Though the majority of interviewers observed less than 10 men and less than 10 women at the sites (61 and 84%, respectively), a few sites that attract high volumes of people, including certain bar/dancing establishments, markets and a film cinema, inflate the mean number of people observed at sites.

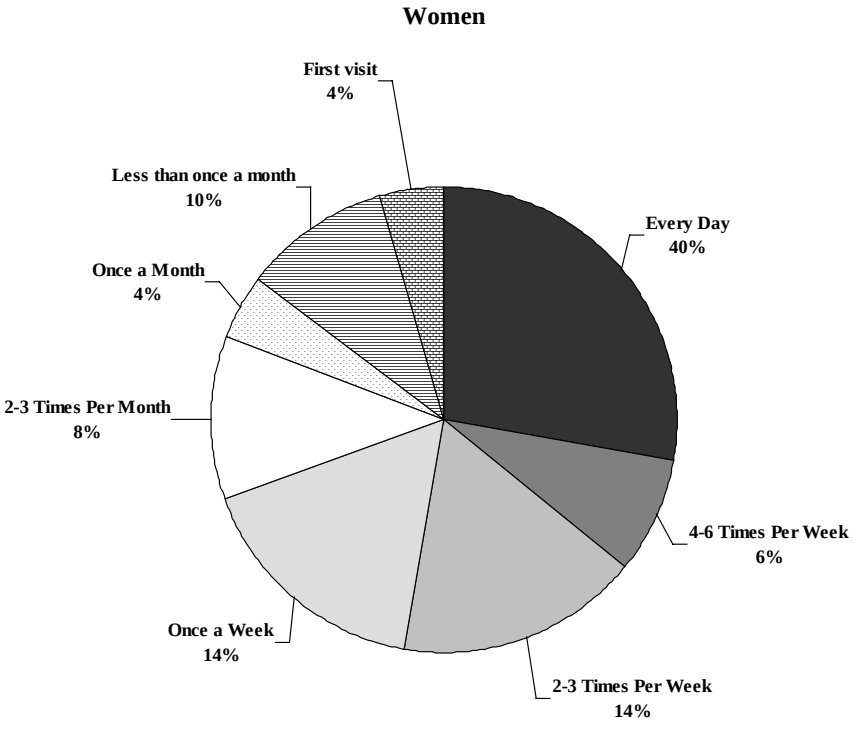
Table 5.2 and Appendix Tables D4 and D5 present socio-demographic characteristics of individuals interviewed at the sites. The majority of men and women resided in the study village (76 and 86%, respectively). While nearly half of all respondents had lived in their current residence for more than ten years, over 40% of women in the border town of Niangoloko reported they had lived in their stated residence for less than a year. Women were younger than men (mean ages 23 and 28 years, respectively) and were more likely to report currently being a student (17 and 9%, respectively). Men were more likely than women to be employed (77 and 43%, respectively). The majority of both men and women reported having had some education (69 and 66%, respectively), with smaller proportions of men and women reporting 10 years or more of education (28 and 13%, respectively).

Individuals reported the frequency with which they attended the sites, presented in Figure 5.1 and Appendix Table D6. About 70% of all respondents reported having gone to the site at least once a week. Women were more likely than men to report going to the site daily (40 and 28%, respectively), with nearly 60% of women in Niangoloko reporting such frequency. Men and women living in the health district reported they either had been or would go to a similar site that day (41 and 28%, respectively), with those in the town of Banfora more likely to report multiple site attendance in one day. Women in Niangoloko were the least likely to report attending a site different from that where the interview was held (14%). Respondents who reported attending the site frequently or visiting multiple sites were interviewed at a variety of sites including large bar/dancing establishments, small bars and informal meeting places such as markets, streets and the border crossing at Niangoloko.

Affirming key informant reports, the majority of men and women interviewed reported that individuals meet new partners at the site

Figure 5.1. Frequency of attendance at site, by gender, Banfora Health District, 2001





(95% or greater) (see Figure 5.2 and Appendix Table D7). When asked if they, themselves, had met partners at the site, women were more likely than men to report having ever met a partner and recently having met a partner at the site. Women from Niangoloko were more likely than those from the town of Banfora and the rural villages to report ever having met a partner at the site (64, 40 and 28%, respectively) and meeting a partner at the site in the past three months (43, 23 and 15%). Though less common than reports by women, men also reported having ever met a partner at the site (about 30%) and meeting a partner at the site in the past 3 months (about 15%).

Individuals interviewed in the Banfora Health District reported high numbers of sex partners (see Appendix Tables D8 and D9). At least 95% of men and women reported at least one partner in the 12 months preceding the survey. Reports of two or more sex partners in the past year were given by the majority of men in women in the town of Banfora (74 and 68%, respectively) and Niangoloko (66 and 77%, respectively) and large proportions in the rural areas (54 and 43%, respectively). About a quarter reported having had two or more sex partners within the past month.

Figures 5.3 and 5.4 present the distribution of numbers of new sex partners of study respondents in the 4 weeks and 12 months preceding the survey, respectively, by gender and study village (see Appendix Tables D8 and D9). Reports of new partners were particularly high among women in the towns of Banfora and Niangoloko, with some women reporting hundreds and thousands of new partners in the year preceding the survey. Nearly half of all women in the towns of Banfora and Niangoloko reported having had at least one new sex partner in the past month. Similar reports were observed in smaller proportions among men in the town of Banfora (33%), men in Niangoloko (22%) and men and women in the rural areas (23 and 21%,

Figure 5.2. Percent of men and women who have ever met a partner on site and who have met a partner on site in the past three months, Banfora Health District 2001

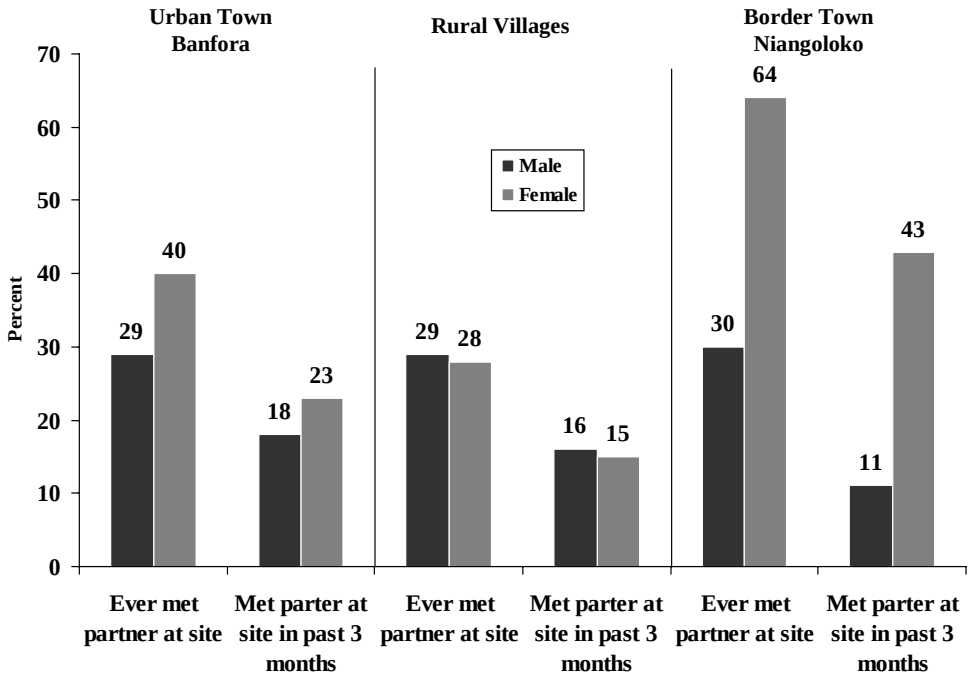


Figure 5.3. Distribution of number of new sex partners in the 4 weeks preceding the survey, Banfora Health District, 2001

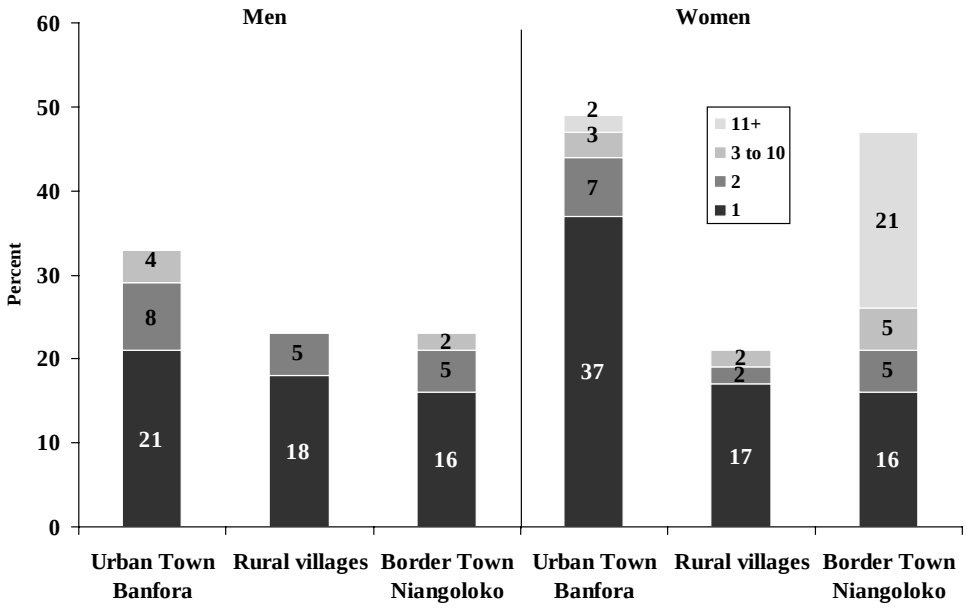


Figure 5.4. Distribution of number of new sex partners in the 12 months preceding the survey, Banfora Health District, 2001

respectively). At least 10% of men and women in the town of Banfora and women in Niangoloko reported between 2 to 10 new partners in the month preceding the survey, and over 20% of women in Niangoloko reported having more than 11 new partners in the month preceding the survey.

Reports of at least one new partner in the year preceding the survey were highest among women in Niangoloko and women and men in the town of Banfora (75, 70 and 69%, respectively), while a significant proportion of each group reported three or more partners (36, 30 and 20%, respectively). Though comparatively smaller, significant proportions of rural men and women reported at least one new partner in the past year (54 and 45%, respectively), while smaller proportions reported 3 or more new partners (11 and 4%, respectively).

Men and women who reported having a new partner within 12 months prior to the survey were asked where they had met new partners (see Appendix Table D11). The majority of men and women who had had a recent new partner reported that they had met the partner in the study village (84 and 74%, respectively) (see Figure 5.5). Both men and women in each study area reported that they had found a new partner at the site itself, with women in Niangoloko particularly likely to meet an on-site partner (about 60%).

An individual who reported at least one new partner in the year preceding the study also reported the new partner's origin. More than half of individuals reported that the partner came from the study village. Among the respondents who stated that partners were not from the study village, the majority reported that partners came from elsewhere in the Banfora Health District. To assess the potential for sex work at the sites, men were asked whether they had ever given money, goods or services for sex, and women were asked whether they had ever received money, goods or services for sex (Figure 5.6 and Appendix Table D12). Sex work was reported at nearly every site, with the largest percentages reporting sex work at brothels, bar/dancing establishments, film cinemas, markets and streets (data not shown). In Niangoloko, women were more likely than men to report involvement in sex work (43 and 32%, respectively), and at certain sites, such as brothels, 75-100% reported sex work. Men were more likely than women to report involvement in sex work in the town of Banfora (37 and 30%, respectively) and the rural villages (24 and 12%, respectively). While a proportion of men at every nearly every site had given money, goods and services for sex, women's reports of sex work were concentrated at a few key sites, where large proportions would report involvement. For example, sex work was reported by 80% of women at one of the large bar/dancing establishments in the town of Banfora and 60% of women at a market in one of the rural areas.

Respondents were asked to report previous involvement in HIV/AIDS-prevention activities, including participation in AIDS information sessions and condom use (see Appendix Table D13). Men were more likely than women to have participated in an AIDS education session (44 and 35%, respectively), whether attending a session led by a community worker or listening to a TV or radio program about HIV/AIDS. Reported condom use was high. The majority of all men and women reported having ever used a condom, with men and women in the town of Banfora (85% or more) and Niangoloko (about 80%) slightly more likely to report condom use than men and women in rural areas (71 and 60%, respectively). Furthermore, among those reporting having a new sex partner in the past 4 weeks, about 79% of men and 72% of women reported having used a condom.

Despite a high proportion of reported ever-condom use, small percentages of men and women possessed a condom at the site at the time of the interview, where presumably they could have met new sexual partners. Figure 5.7 and Appendix Table D14 indicate that rates of condom possession were highest among men and women in Niangoloko (10 and 18%, respectively), followed by the town of Banfora (8 and 7%, respectively) and the rural villages (7 and 0%, respectively). It is encouraging to note that in all areas, people who reported

Figure 5.5. Percent who met their most recent sex partner in the study village and at the site, Banfora Health District, 2001

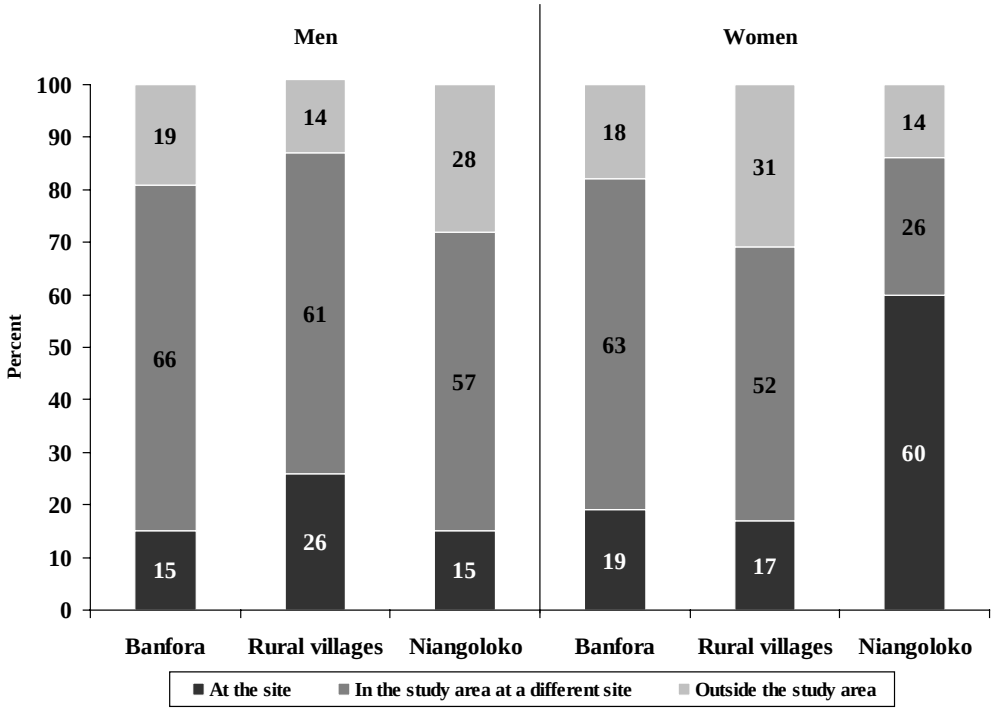
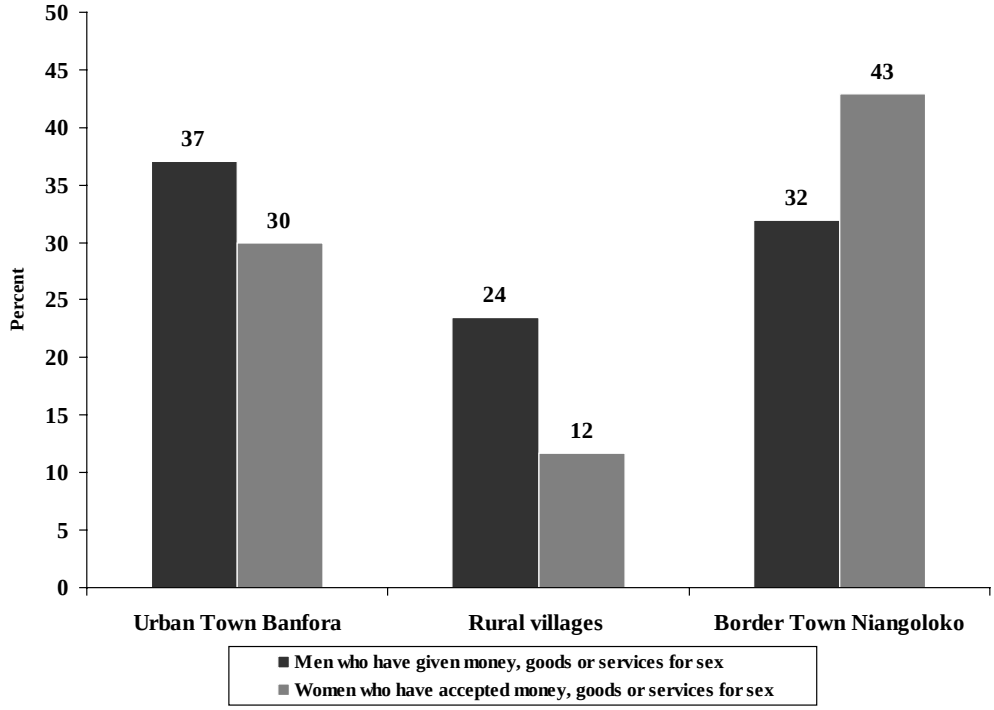


Figure 5.6. Percent of men who gave money, goods and services and women who received money, goods and services for sex, Banfora Health District, 2001



involvement with sex work were more likely to be carrying a condom on site (26, 11 and 11%, respectively). Encouragingly, a majority of individuals from Niangoloko who had met a new partner in the week preceding the survey were likely to have had a condom (59%) (see Appendix Table D14). In contrast, among those from the town of Banfora and from the rural villages who reported meeting a partner in the week preceding the survey, no person had a condom with them at the interview.

Respondents were asked to report whether they had experienced STD symptoms, another indicator of risk behavior, though self-reports always must be interpreted with caution (Appendix Table D15). Women were more likely than men to report unusual discharge (12 and 3%, respectively) and genital sores (8 and 5%, respectively). Women in Niangoloko were more likely to report lower abdominal pain, unusual discharge and genital sores (30, 16, and 11%, respectively) than women in rural areas (19, 12 and 8%, respectively) and the town of Banfora (22, 7 and 3%, respectively). Reports of STD symptoms in men differed little by study village.

C. Results of individual interviews, Tenkodogo Health District

Over the course of three weeks of fieldwork in the Tenkodogo Health District, seven days were devoted to interviewing individuals at sites. A total of 551 individuals at 24 sites were interviewed (Table 5.3), 68% of whom were male. Participation rates were excellent among both men and women (99%) (see Table 5.3 and Appendix Tables D16 and D17).

The observed number at sites varied by study area. In the town of Tenkodogo, relatively small numbers were observed at the sites (15 and 7, respectively), similar to the mean number of people observed at sites in the Banfora Health District (see Appendix Table D18).

The mean number of men at sites in the border area Bittou (79) was far greater than the mean number of women (20), due to the large numbers of men present at large, public meeting places including the customs area and the bus/truck stop situated near the Togo border. The mean number of women at sites in the rural areas was greater (58) than that for men (32), as women comprise a large proportion of those who work at and attend the markets that were included in the sample of sites. Table 5.4 and Appendix Tables D19 and D20 present socio-demographic characteristics of individuals interviewed at the sites. The majority of men and women lived in the study village (about 85%), with individuals in Bittou slightly more likely to report being from outside the study village. The amount of time individuals had lived in their stated residence varied by study village. The greatest

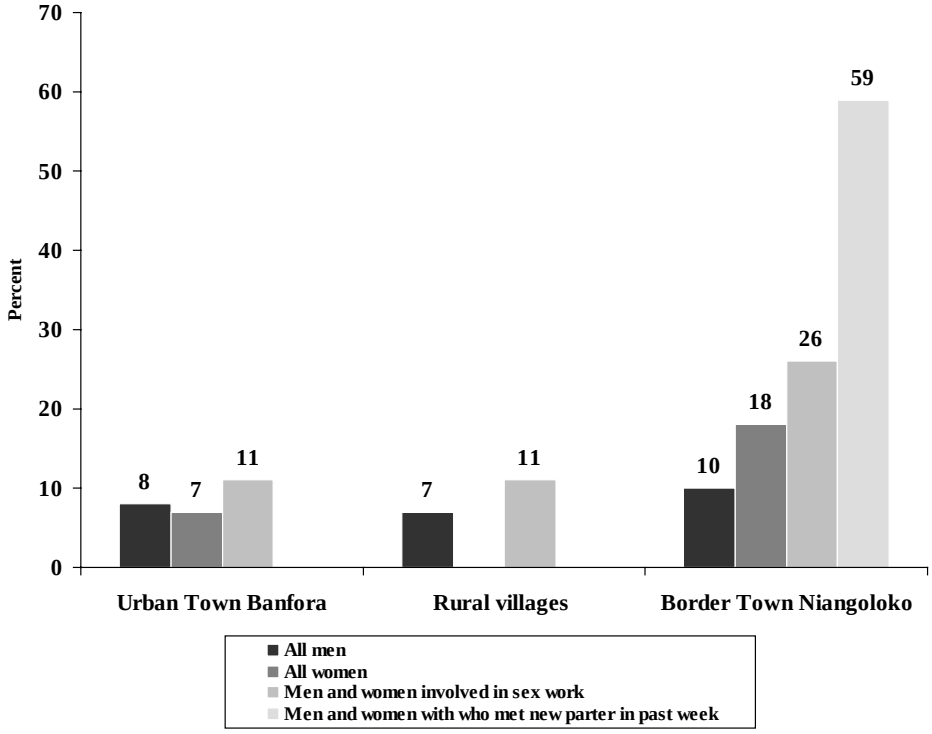
Table 5.3. Characteristics of individual interviews, Tenkodogo Health District, 2001

Characteristic	%
Number of Sites Visited for Individual Interviews	24
Number of Individual Interviews	551
Mean/median number of men observed at site	42/15
Mean/median number of women observed at site	29/7
Interview participation rate among men	99%
Interview participation rate among women	99%
Percent male among interviewed	68%

Table 5.4. Socio-demographic characteristics of men and women interviewed at the site, Tenkodogo Health District, 2001

Characteristic	Men	Women
Lives in the study village	86%	85%
Mean age	29 years	23 years
Currently a student	5%	1%
Employed (Either full or part-time)	88%	71%
Has any education	62%	57%
Has 10 years or more of education	9%	0%
Literate	10%	7%
Has attended an AIDS information session	39%	31%

Figure 5.7. Percent of men and women carrying a condom when socializing on site, Banfora Health District, 2001



proportion of men and women who had lived in the study village for more than a decade were interviewed in the rural area Beguedo/Niaogho (77 and 63%, respectively). In the towns of Tenkodogo and Bittou, all respondents, particularly women, were less likely to have reported living in their current residence for 10 years. In fact, 60% of women in the town of Tenkodogo and over 22% of women in Bittou reported living in their respective villages for less than one year.

Women were younger than men (mean ages 23 and 29 years, respectively). Less than 5% of people reported currently being a student, and large proportions of men and women reported being employed (88 and 71%, respectively). About 62% of men and 57% of women reported having had some education, though reports in the rural areas and Bittou were less than in urban areas. In addition, very low percentages of men and women reported having higher levels of education (10 years or more) (9 and 0%, respectively) or being literate (10 and 7%, respectively).

Respondents reported how often and for how long they had attended sites (see Figure 5.8 and Appendix Table D21). Daily site attendance was common among men (45%) and women (61%), and between 75 and 80% of men and women attended sites at least once a week. Differences between men and women regarding site attendance can be observed between study villages. In the town of Tenkodogo, where interviews took place at bars and brothels and women were known to be involved in sex work, a much larger proportion of women than men reported visiting the site daily (78 and 22%, respectively). Interviews were held largely at markets in the rural areas, where both men and women were likely to report attending daily (60 and 56%, respectively). In the border town, Bittou, interviews were held at a variety of site types, and about half of the men and a slightly smaller proportion of women reported coming to sites daily.

Individuals reported whether, that day, they would visit other sites similar to the site at which the interview was being held. Men were more likely than women to visit other sites on the day of the interview, with higher reports of multiple site attendance among men and women in the town of Tenkodogo (58 and 28%, respectively) and Bittou (35 and 26%, respectively) than in rural areas (30 and 14%, respectively). Men in the town of Tenkodogo were particularly likely to visit multiple sites, with over 30% reporting that they would visit two or more additional sites by the end of the day. Those who reported multiple site attendance were interviewed at a variety of site types, including large bar/dancing establishments, small bars or large public areas such as markets, streets and the customs area at Bittou.

Nearly 100% of respondents affirmed that people meet sex partners at the sites, and about 40% had met sex partners themselves at the sites (see Figure 5.9 and Appendix Table D22). In the town of Tenkodogo, the majority of women reported having met a partner at the site (77%) and having met a partner at the site in the past three months (72%). Reports of ever having met a partner at the site were also common among men in the town of Tenkodogo (43%), men and women in the rural areas (48 and 25%, respectively) and men and women in Bittou (34 and 29%, respectively).

Each study village of the Tenkodogo Health District reported high rates of sexual partnership (see Appendix Table D23 and D24). More than 95% of individuals interviewed reported having at least one partner in the 12 months preceding the survey. More than three-quarters of men reported two or more sex partners in the past year, regardless of study village, and about 60% of all men reported three or more partners in the past year. Two or more partners in the past year were reported by the vast majority of women in the town of Tenkodogo (87%) and significant proportions in Bittou (64%) and the rural areas (37%). Likewise, reports of three or more partners were greatest among women in the town of Tenkodogo (73%) followed by those in Bittou (59%) and the rural areas (22%).

Figure 5.8. Frequency of attendance at site, Tenkodogo Health District, 2001

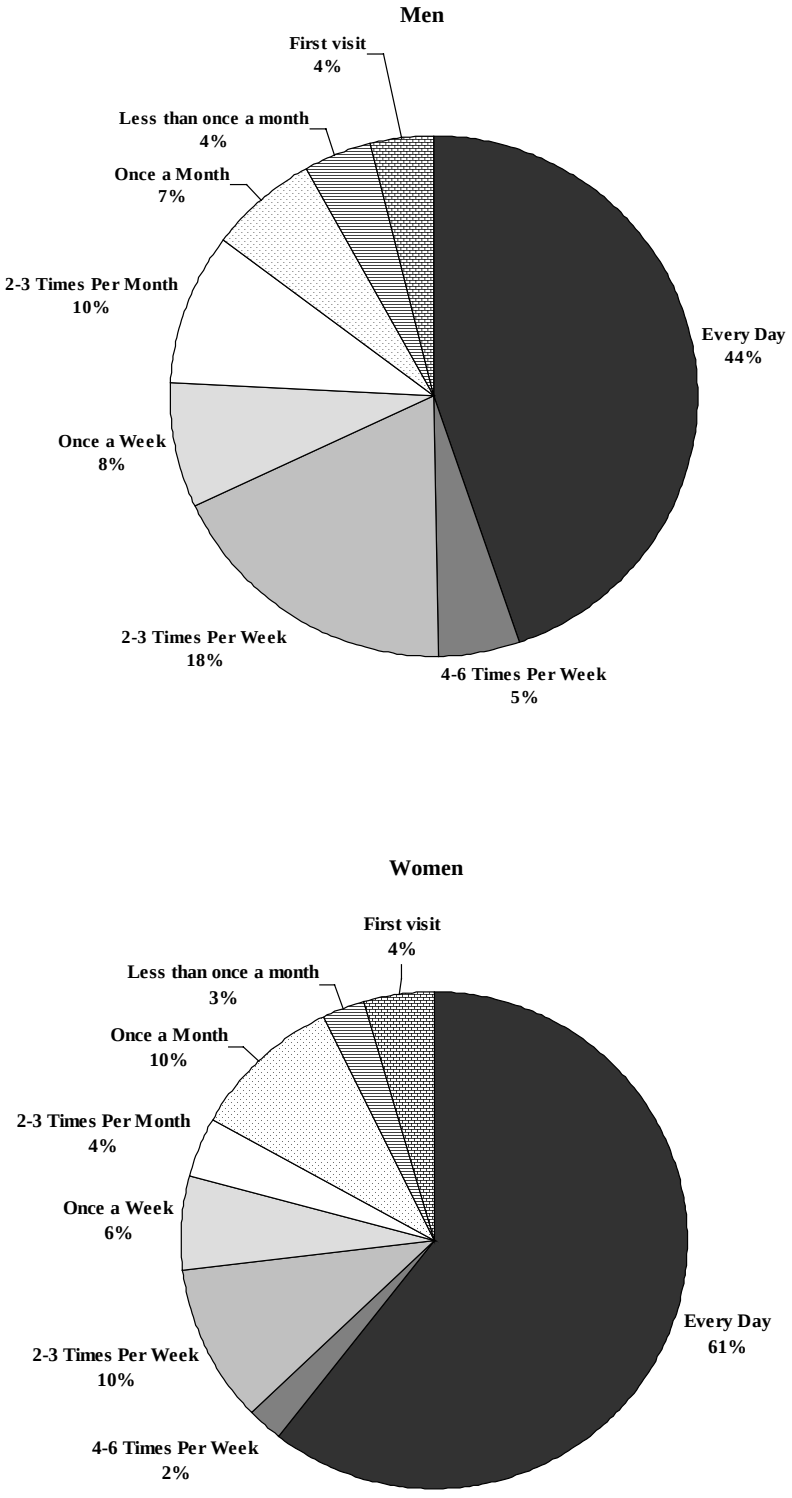
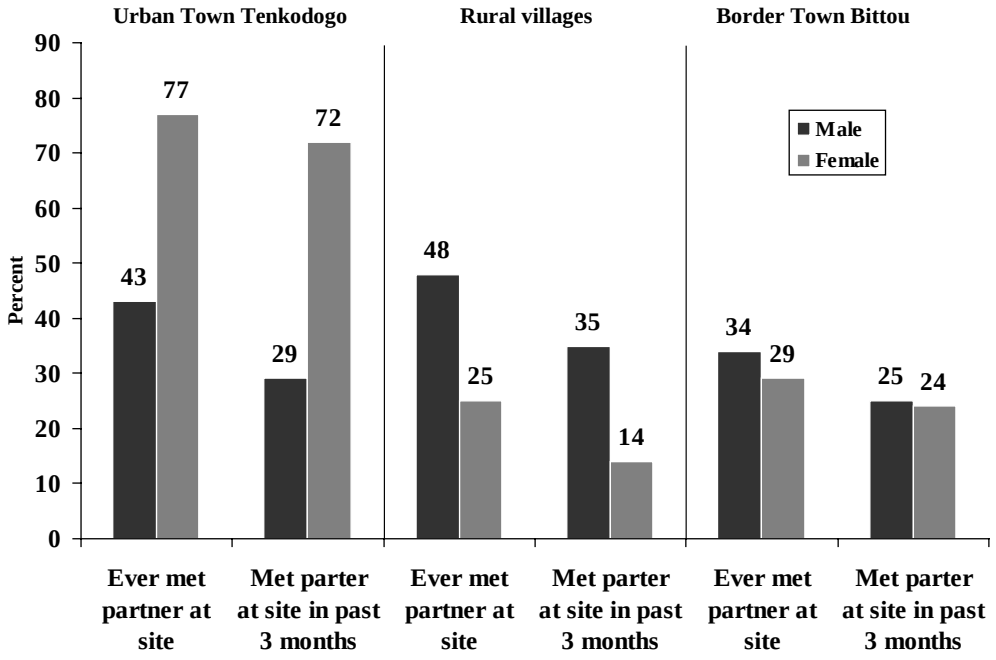


Figure 5.9. Percent of men and women who have ever met a partner on site and who have met a partner on site in the past three months, Tenkodogo Health District 2001



Figures 5.10 and 5.11 demonstrate the distribution of new sex partners in the 4 weeks and 12 months preceding the survey, respectively, by gender and study village. Significant proportions of men and women in each study village report new and regular partners. More than 70% of women in the town of Tenkodogo reported having had at least one new partner in the month preceding the survey. Reports of one new partner in the past month were also given by over half of men in the town of Tenkodogo, about 40% of men and women in Bittou and between 30 and 40% of men and women in the rural areas. Two or more new partners in one month were also reported, ranging from about 10% of men and women in the rural areas to 28% women in Bittou and 37% of women in the town of Tenkodogo.

Sexual partnership rates were highest in the town of Tenkodogo. Men and women in the town of Tenkodogo were most likely to report having had two or more partners in one year (52 and 67%, respectively), followed by those in Bittou (50 and 42%, respectively) and the rural areas (43 and 22%, respectively). In the past month, about 17% of women reported 3 to 10 new partners and 12% reported 11 or more new partners.

Figure 5.12 demonstrates that, among individuals who reported having a new sex partner in the month prior to the survey, over three-fourths of men and women in all areas met partners in the study village (90 and 79%, respectively) (see Appendix Table D26). Furthermore, large proportions of those with recent partners met these partners at the site, with women in the town of Tenkodogo particularly likely to meet someone at the site (82%). Men in the towns of Tenkodogo and Bittou reported meeting recent partners in other cities within the district and elsewhere in Burkina Faso.

Those with recent sex partners reported origins of these partners. Over three-fourths of individuals in the rural area reported recent partners came from the study villages, while smaller proportions from Tenkodogo and Bittou

Figure 5.10. Distribution of number of new sex partners in the 4 weeks preceding the survey, Tenkodogo Health District, 2001

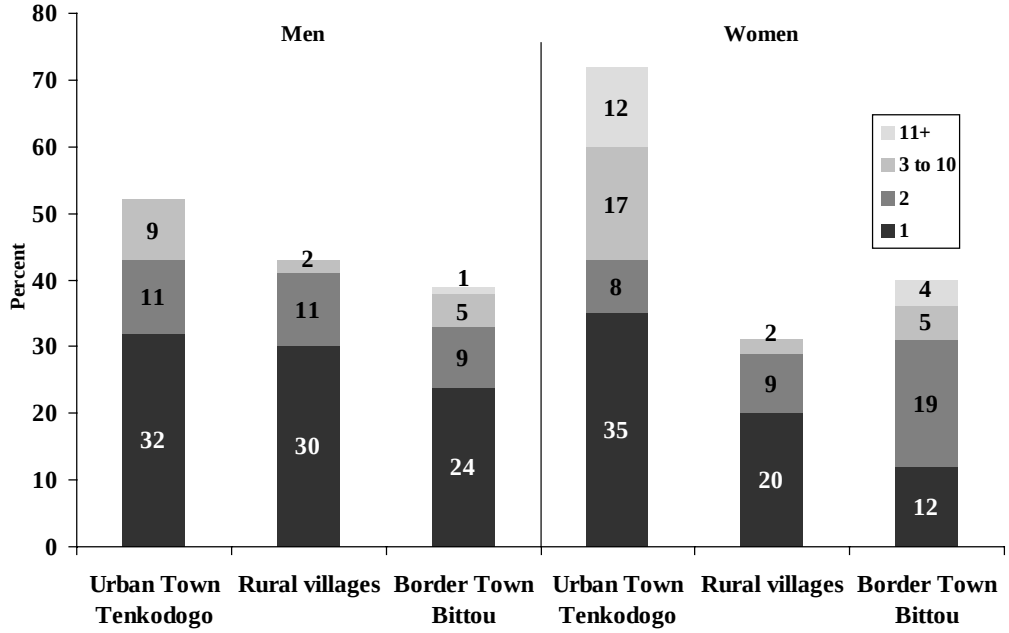
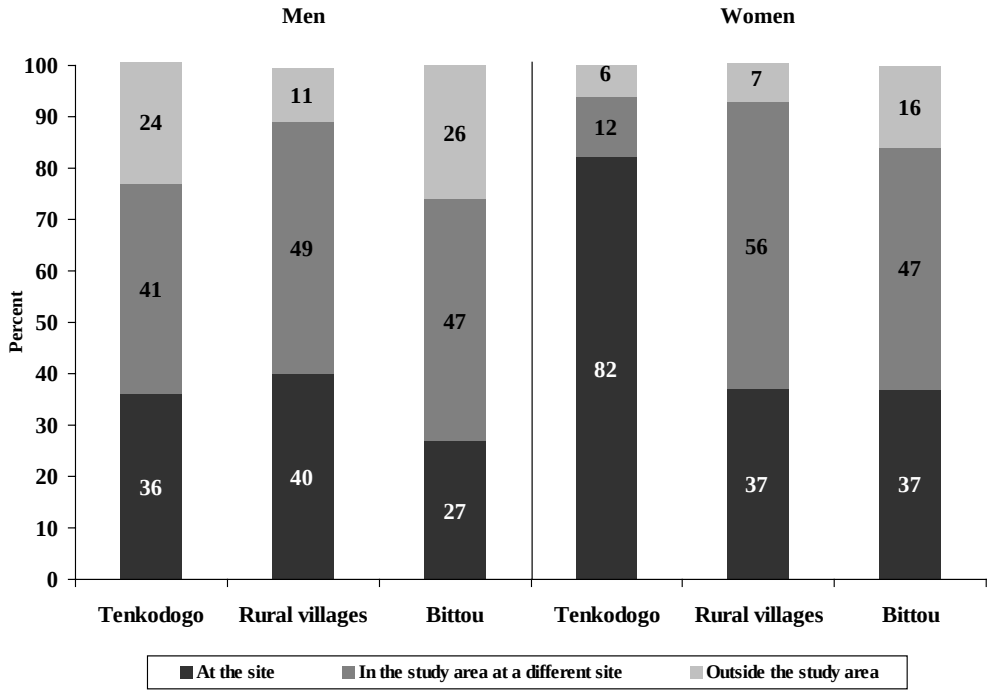


Figure 5.11. Distribution of number of new sex partners in the 12 months preceding the survey, Tenkodogo Health District, 2001

Figure 5.12. Percent who met their most recent sex partner in the study village and at the site, Tenkodogo Health District, 2001



reported that partners came from the study villages (about 60 and 40%, respectively). Individuals in all areas reported that partners came from other towns in the health district and elsewhere in Burkina Faso. About 10% of men reported that sex partners came from Togo and Ghana, common origins of women who become sex workers in the Banfora and Tenkodogo Health Districts. Individuals in rural areas were less likely to report that sex partners came from abroad.

Large proportions of men had given money, goods or services for sex and women had received money, goods or services for sex (about 50% in the health district) (Figure 5.13 and Appendix Table D27). There are differences between urban, rural and border areas, with involvement in sex work most likely to be reported by women and men in the town of Tenkodogo (82 and 62%, respectively), followed by Bittou (40 and 47%, respectively) and the rural areas (22% and 36%, respectively). Between 75 and 100% of women reported sex work at brothels, bar/dancing establishments and *maquis* in the town of Tenkodogo and at the customs area of Bittou (data not shown). Sites in rural areas where men and women were more likely to report sex work included larger bar/dancing establishments as well as markets.

Respondents were asked to report condom use and participation in AIDS education (Appendix Table D28). About one-third of respondents had participated in an AIDS education session, with slightly higher reports among men in each area. Ever-condom use was higher among men and women in the town of Tenkodogo (90 and 97%, respectively) than in Bittou (84 and 69%, respectively) and Beguedo/Niaogho (63 and 24%, respectively). Furthermore, among those who reported having a new sex partner in the past 4 weeks, about 73% of men and women reported having used a condom. Men and women in rural areas gave the lowest reports of condom use with a recent partner (66 and 21%, respectively).

Despite relatively high rates of ever-condom use, less than 10% of respondents through the district had a condom with them at the time of the interview, a time when individuals were

Figure 5.13. Percent of men who gave money, goods and services and women who received money, goods and services for sex, Tenkodogo Health District, 2001

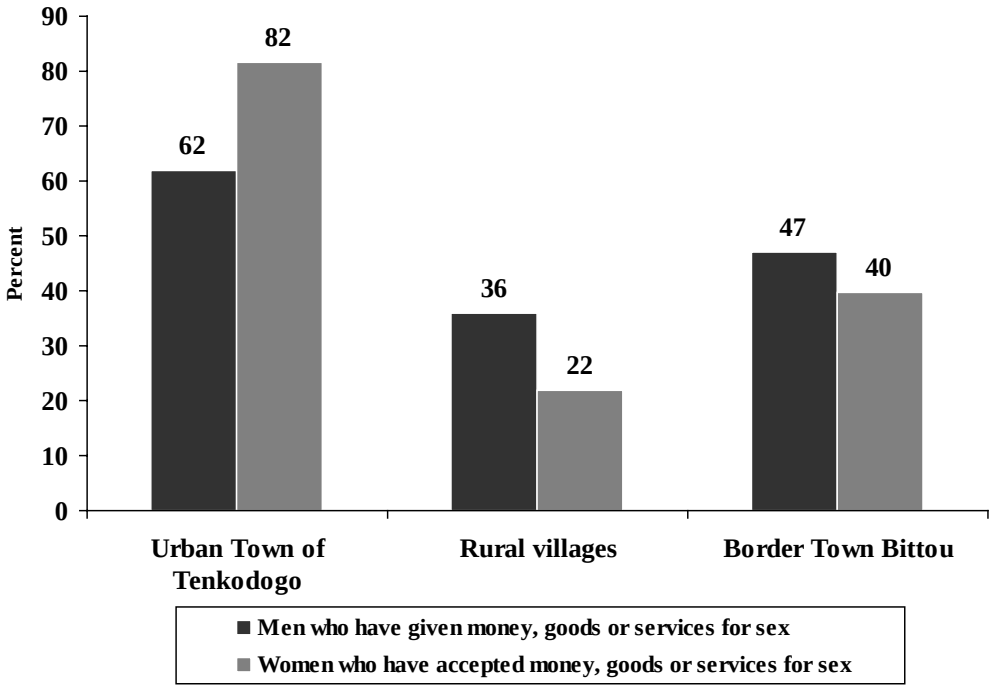
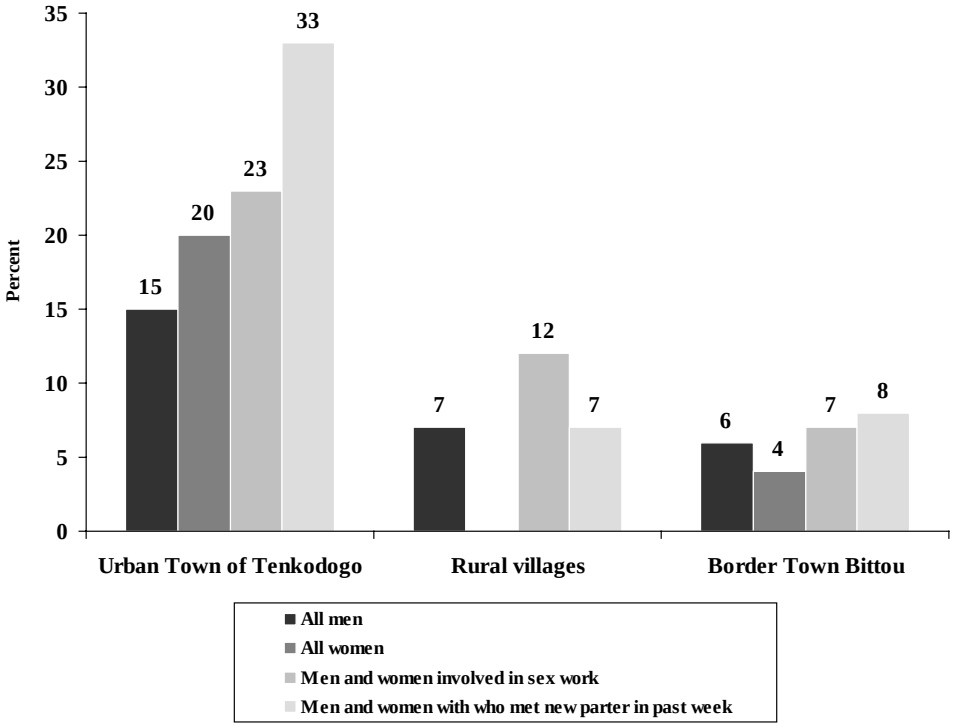


Figure 5.14. Percent of men and women carrying a condom when socializing on site, Tenkodogo Health District, 2001



likely to meet new sex partners (Figure 5.14). Men and women in the town of Tenkodogo, where high rates of sex work were reported, were much more likely to have a condom at the site (15 and 20%, respectively) than those in rural areas (7 and 0%, respectively) and Bittou (6 and 4%, respectively) (see Appendix Table D29). In the towns of Tenkodogo, Beguedo/Niaogho and Bittou, condom possession on site was higher among individuals who reported previous involvement in buying or selling sex (23, 12 and 7%, respectively) as well as among those who met a new partner in the past week (33, 7 and 8%, respectively).

Respondents were asked to report STD symptoms, another indicator of high-risk sexual behavior (Appendix Table D30). Women were more likely then men to report unusual discharge (11 and 3%, respectively) and genital sores (11 and 5%, respectively). Lower abdominal pain, unusual discharge and genital sores were reported more frequently by women in the towns of Tenkodogo (12, 18, and 17%, respectively) and Bittou (21, 7 and 12%, respectively) than women in rural areas (9, 7 and 5%, respectively). Reports of STD symptoms in men differed little by study village.

D. Summary of sexual behavior and AIDS awareness

Characteristics of individuals interviewed at sites in the two health districts were fairly similar. The vast majority reported living in the town where the interview was held. Men were older than women in both health districts, with mean ages of about 29 and 23 years, respectively. A larger proportion of men and women in the Tenkodogo Health District reported having some type of employment, though it must be considered that a larger proportion of interviews in the Tenkodogo Health District took place at markets, shops, and other places of work. Individuals in the Banfora Health District reported slightly higher rates of any formal education, significantly higher rates of higher education and higher rates of AIDS-prevention education, which was not surprising given the relative prosperity of the Banfora Health District.

Particularly high rates of partnership were observed in women of urban and border areas of the two health districts. Individuals in the Tenkodogo Health District were more likely to report at least one new sex partner in the month preceding the survey than those in the Banfora Health District, ranging from 31% of women in the rural area to 72% of women in the urban town (see Figure 5.15). Furthermore, over 10% of men and women in the Tenkodogo Health District reported having two or more new partners in the month preceding the survey, regardless of urban, rural or border setting. In the Banfora Health District, reports of at least one new sex partner in the month preceding the survey ranged from 21% of women in rural areas to about half of women in the urban and border areas.

Reports of sex work were more common at sites in the Tenkodogo Health District than in Banfora Health District. In Tenkodogo compared with Banfora, larger proportions of men reported giving money, goods or services for sex (48 and 29%, respectively) and larger proportions of women reported receiving money, goods or services for sex (48 and 23%, respectively) (see Figure 5.16). While the border area Niangoloko had the highest rates of sex work activity in the Banfora Health District, sex work in the Tenkodogo Health District was more commonly reported in the urban town of Tenkodogo than in the border area Bittou.

Not only did interviews reveal a high level of sexual activity in the Banfora and Tenkodogo Health Districts, individuals confirmed that sexual activity is focused at the sites named by key informants. Over 95% of respondents in Banfora Health District and nearly 100% of respondents in Tenkodogo Health District affirmed that people came to sites to meet new partners. Significant proportions reported that they themselves met new partners at sites, particularly women in the urban area of the Tenkodogo Health District (over 70%) and women in the border town of Banfora Health District (over 60%). High proportions of daily attendance at the site, reaching nearly 80% of sites in the urban areas of the Tenkodogo Health

Figure 5.15. Percent reporting at least one new sex partner in the 4 weeks preceding the survey, Banfora and Tenkodogo Health Districts, 2001

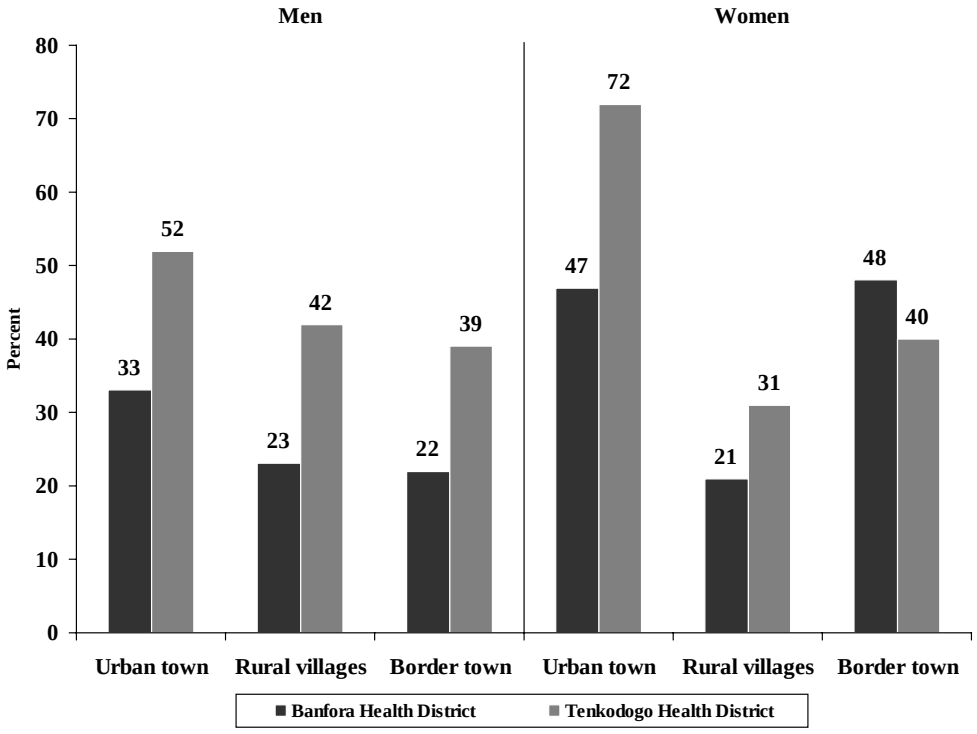
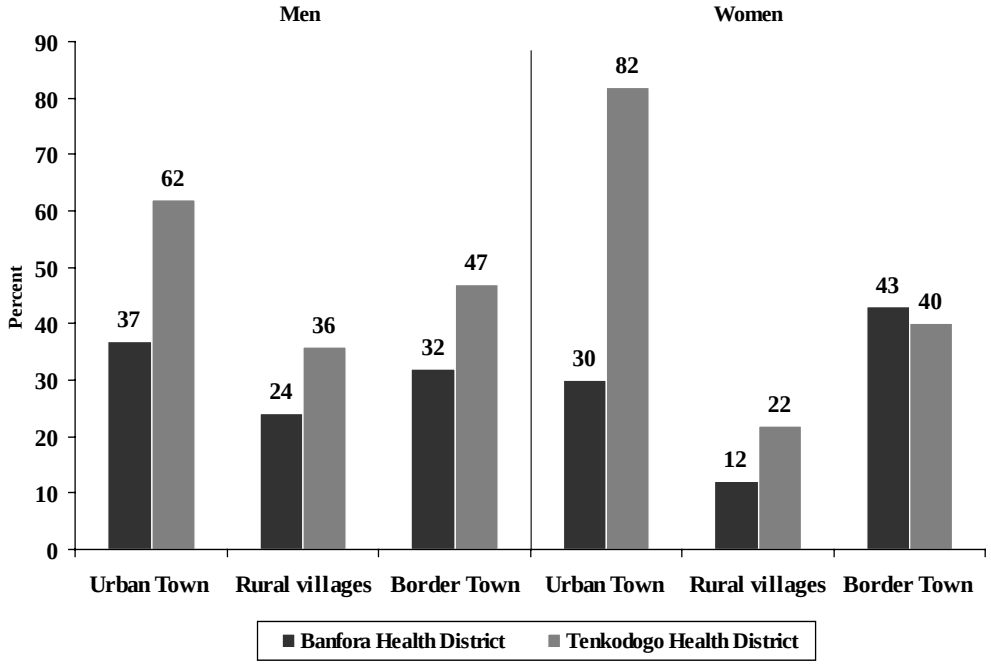


Figure 5.16. Percent of men who gave money, goods and services and women who received money, goods and services for sex, Banfora and Tenkodogo Health Districts, 2001



District, provides further evidence that sites are vital centers of sexual activity that must be considered in intervention planning.

More than 70% of all respondents reported ever using a condom and using a condom with a new recent partner. Women throughout the district had lower rates of ever-condom use, with significantly reduced rates of condom use among women in rural areas of the Tenkodogo Health District (less than one quarter). Despite generally high reports of ever-condom use in the Banfora and Tenkodogo Health Districts, only a minority of individuals had condoms with them at the time of the interview (between 5 and 10% in both districts), a time when they could have met a new sex partner. It is encouraging that men and women who reported previous involvement in sex work were more likely to have a condom with them at the time of the interview (about 15%). In fact, women in the border town Niangoloko and the urban town of Tenkodogo, where sex work was more common, were most likely to have a condom at the time of the interview (19%).

It is possible that only a proportion of individuals had condoms with them at the sites, because condoms were widely available nearby the sites. Over 85% of site representatives in the two health districts reported that condoms could be found within a ten minute walk of sites, such as with street vendors. Despite availability near a large proportion of sites, regular use of condoms has not been demonstrated. Furthermore, some local collaborators argued that exposure to sunlight could diminish quality of condoms available from mobile vendors.

Investigating differences in characteristics and sexual behavior by site type – comparing formal commercial establishments (Site category 1), informal small sites (Site category 2) and large public sites (Site category 3) – is also informative for intervention (see Table 5.5). The formal commercial establishments (Site category 1) such as bars, dance clubs, hotels and brothels, sites where risky sex perhaps is expected, indeed have the highest levels of reported sexual activity. Women at these sites average 6.9 new partners per month compared with 1.3 new partners or fewer among women at other sites. In addition, reports of selling sex for money, goods or services were highest among women at formal bars, clubs and brothels (43%) than among women at informal small sites (13%) or large public sites (25%). At formal commercial establishments, men and women were most likely to have ever used condoms (85 and 82%, respectively) or possessed a condom at the interview (10 and 12%, respectively) compared with small and large informal establishments.

The informal small sites (Site Category 2) are the most numerous sites in the health districts. Greater than one-third of men and about half of women had met a new partner at the site and had a new sex partner in the month preceding the survey. About 60% reported ever having used a condom, while 10% of men and 0% of women carried a condom with them at the site.

High rates of reported sex work together with low rates of ever-condom use define sexual behavior at large informal sites, such as markets, the customs areas at international borders and bus stations (Site Category 3). About 25% of women report selling sex for money, goods or services, while proportions of ever-condom use and possession of condoms on the site were low. Men were more likely than women to have ever used condoms (70 and 48%, respectively) and to have a condom at the interview (7 and 0%, respectively).

Regardless of site type, men outnumber women by two to one, and men are generally five years older than women (about 28 and 23 years, respectively).

E. Assessing bias of individual interviews

It is expected that self-reported sexual behavior will be affected by self-presentation bias. Underreporting of sexual partnerships is likely, particularly among women, while it also has been noted that men inflate reports, particularly in cultures where machismo is prominent

Table 5.5. Characteristics of individuals, by three site types in Banfora and Tenkodogo Health Districts, 2001

	Site category 1 Formal bars, hotels, brothels, dance clubs		Site category 2 Informal small sites		Site category 3 Informal large sites	
	Male N= 513	Female N=231	Male N=89	Female N=39	Male N=338	Female N=160
Are 15 to 24 years	34.3	64.1	31.4	53.8	31.1	65
Are older than 40 years	8.4	1.7	17	2.6	8	2.5
Are residents of the study area	80.7	84	71.9	94.9	84.6	86.9
Are unemployed	16.6	38.5	28.1	64.1	17.8	45.6
Visit the site every day	25.9	48.1	29.2	46.2	49.4	50.6
Have visited/will visit multiple sites that day	44.4	25.1	48.3	41	42.3	30
Have attended an AIDS educational session in past three months	46.6	36.4	34.8	38.5	37	29.4
Have met a new sex partner at the site	33.5	50.2	22.5	18	37.3	32.5
Have had a new sex partner in the past year	68.2	68.8	39.3	43.6	62.7	55
Have had a new sex partner in the past month	35.7	48.9	13.49	10.3	34	34.4
Have had more than 10 new partners in the past month	0	4.8	0	0	0.3	0.6
Have been sexually active in the past year	97.1	97.4	89.9	94.9	93.5	92.5
Have had only 1 partner in the past year and that partner was not new in the past year	19.5	25.1	43.8	51.3	21.9	35.0
Have ever used a condom	85.4	82.3	59.6	61.5	70.1	46.9
Used a condom with the most recent new partner*	29.2	39.4	10.1	5.1	23.4	19.4
Possessed a condom at the time of the interview	9.6	12.1	9.55	0	6.81	0
Women have received money, goods or services for sex		42.9		12.8		25
Total mean number of sex partners in past month	1.5	6.9	0.9	0.9	1.4	1.3
Mean number of new sex partners in past month	0.5	4.9	0.2	0.1	0.5	0.6

* Among people with at least one partner in last three months

(Catania et al. 1990). That said, the PLACE methodology includes a stage of interviewing individuals while socializing at sites, because asking individuals about their sexual behavior is the most efficient way to estimate partnership rates. Certain precautions were taken in the study methodology to attempt to minimize bias. Although conducting face-to-face interviews may contribute to under-reporting of sexual behavior, interviewers did not ask names of respondents, and they reassured them that interviews were entirely confidential. Interviews were conducted in the anonymity of a public setting where the atmosphere perhaps condones sexual meeting, therefore creating a safer space for speaking openly about partnerships than perhaps is afforded by a household interview. Interviewers took care to make the respondent feel comfortable, and not judged, when reporting partnership. Interviews also were trained to elicit responses in a sensitive manner.

Participation rates for individual interviews were lower for men and women in the Banfora Health District (94 and 86%, respectively) than in the Tenkodogo Health District (99%), though participation rates probably were high enough to avoid severe non-participation bias. Lower participation in the Banfora Health District could be due to the fact that this health district has been the host of many previous health-related studies; interviewers believed that the population of the Banfora Health District was disillusioned by health investigations. Particularly low participation among women may have been due to the fact that all interviewers working in the Banfora Health District were male. The inclusion of women in the interviewing team probably played an important role in the improved participation among women in the Tenkodogo Health District than women in the Banfora Health District.

Participation in both the Banfora and Tenkodogo Health Districts was improved by local administrative authorities, who forewarned villagers of fieldwork activities and emphasized the importance of the study for improving health services in their communities. In addition, participation most likely was improved by the distribution of small incentives, a departure from standard PLACE methodology. The issue of whether using incentives and involving local authorities is coercive or yields a biased assessment was discussed extensively during the fieldwork. On the one hand, some argued that increasing the participation rates of individuals identified in random sampling, such as by giving incentives or by other means, will decrease non-participation bias. In addition, some believed that the distribution of incentives was important not only for increasing participation, but also to serve as a gesture of appreciation for individuals' participation. However, others believed that participation should be completely voluntary. They argued that a population could be coerced into participation if interviewers gave incentives or if local authorities made statements appealing to the community to participate. They also remarked that individuals who want to help their communities would participate, and a sample of individuals who demanded incentives would yield a biased measurement.

An experience in the Banfora Health District illuminated the predicament of involving local authorities in increasing study participation. A bar largely visited by the Fulani, an ethnic minority, was included in the sample of sites where individual interviews were conducted. Interviewers were having difficulties recruiting participants, and a non-Fulani police officer happened to overhear the interviewers' failure to recruit participants. He announced the presence of the interviewer team and encouraged everyone to participate in the interview, stating that their participation would benefit the health of the community. Interviewers did not ask him to make such an announcement, and he did not demand that people in the bar participate. However, the officer's statement may have been coercive, because he was appealing to individuals belonging to a minority population who would do anything to prevent upsetting the police.

Section 6. Summary of Main Findings and Recommendations for AIDS-Prevention Programs

6.1 Summary of main findings

Key informants identified 295 unique sites in five study areas of the Banfora Health District and 159 sites in three study areas of the Tenkodogo Health District. Over 30 different types of sites were identified, with differences observed among types and characteristics of sites in urban, rural and border areas. In the urban towns of both districts, the most frequently named sites were formal bars, dance clubs and brothels. The semi-urban border towns in both districts were known to have a prominent sex industry based around migration traffic. Frequently named sites in these areas included certain brothels and bars, as well as informal public meeting areas, such as markets, customs areas, truck stops and bus stops. Where rural areas did not have formal establishments such as dance clubs or brothels, the most frequently named sites included informal bars serving home brewed beer and large public sites such as markets, streets and video clubs. Rural sites also included meeting places such as the hospital or the phone booth, places not typically considered sexual meeting sites.

The number of people present at the sites varied greatly depending on the type of site, with some small bars serving less than 10 individuals during peak hours, while over 1,000 individuals were observed visiting certain markets. In general, men outnumbered women by two to one, and men were five years older than women (about 28 and 23 years, respectively). Drinking was a common activity at sites: consumption of commercially produced alcohol was more common in urban areas, while drinking home brewed wine and beer was popular in rural areas.

Time of peak operation differed, often reflecting differences between the common sites in urban-rural settings. In urban towns, bars, brothels and dance clubs are common, and over 70% of sites reported that Friday and Saturday nights are the busiest times. Sites in rural areas and border towns were less likely to be busy on weekend nights, either in the Banfora Health District (about 33 and 50%, respectively) or the Tenkodogo Health District (50%). In these areas, commonly reported sites included schools, markets, shops and transport stations, which are most busy during the weekdays.

Community events had not emerged as important for sexual meeting in past PLACE studies, though key informants in Burkina Faso repeatedly reported events that serve as important moments for sexual meeting. While events were reported in areas throughout the health districts, events comprised a larger proportion of all key informant reports in rural areas of Banfora (14%) and Tenkodogo (35%). Events may play a more significant role in less developed rural areas because formal bars, hotels, brothels and dance clubs are less common. Commonly reported events included weddings, funerals, baptisms, harvest celebrations and traditional rituals. Such events are seasonal and are not geographically fixed, therefore, planning event-based intervention would be challenging. In 2003, the Burkina Faso PLACE study group plans to further investigate the potential for intervention at community events.

Sexual mixing in study areas is extensive and diffuse, and it clusters around sites identified with the PLACE method. About 85% of site representatives confirmed key informant reports that people meet new sex partners at their sites, while 13% of representatives reported on-site sex work. At a sample of 64 of the most frequently named sites in the health districts, 1394 men and women were interviewed and reported high rates of sexual partnership. About 40% of women and 33% of men interviewed at sites reported at least one new partner in the past month, and nearly 60% of respondents in the Banfora Health District and 70% of respondents in the Tenkodogo Health District reported one new partner in the past 12 months.

Women were more likely than men to report having had at least one new partner in the past month (40 and 33%, respectively). There were

also differences between the health districts. Men and women in the Tenkodogo Health District were more likely to report having met at least one new sex partner in the month preceding the survey (44 and 48%, respectively) than men and women in the Banfora Health District (26 and 33%, respectively) (Table 6.2).

Differences in sexual behavior were observed among urban, rural and border areas in each health district. The border town of the Banfora Health District, Niangoloko, and the urban town of Tenkodogo were reputed for sex work. Women in these areas reported a mean number of 8 new partners in the month preceding the survey, while all other men and women in the health districts reported a mean of less than 1 new partner. As perhaps expected, reports of trading sex for money, goods or services were also higher among women in Niangoloko (43%) and the town of Tenkodogo (81%) than among women in other areas of the Banfora and Tenkodogo Health Districts (17 and 31%, respectively).

Investigating differences in characteristics and sexual behavior site type – comparing formal commercial establishments (Site category 1), informal small sites (Site category 2) and large public sites (Site category 3) – is also informative. The formal commercial establishments (Site category 1) such as bars, dance clubs, hotel and brothels, sites where risky sex perhaps is expected, indeed have the highest levels of reported sexual activity. Women at these sites reported the highest level of sexual activity, with an average of 6.9 new partners per month compared with 1.3 new partners or fewer among women at other sites. In addition, reports of selling sex for money, goods or services were highest among women at formal bars, clubs and brothels (43%) than among women at informal small sites (13%) or large public sites (25%).

In comparison with those interviewed in this PLACE method assessment, sexual partnership is low among individuals sampled from Burkina Faso's general population for the 1998-1999 Demographic and Health Survey (DHS). The proportions reporting one casual partner in the DHS were very low among married men and women (4.2 and 0.5%, respectively), and about 20% among single men and women (EDSBF-II 2000). It should be noted that comparisons between rates of sexual partnership among individuals sampled in the PLACE study with those sampled in the DHS should be made with caution, as the PLACE study does not inquire into the marital status of respondents.

The number of people in a community who visit sites was estimated from site representative reports of the number of people who come to their sites during peak hours, with a correction factor based on the number of sites visited by individuals interviewed at a sample of sites. Of the 1394 individuals interviewed, more than one-third of men and nearly half of all women visit the sites daily, and 44% of men and 28% of women visit multiple sites in one day. Based on these findings, we estimated 12,112 men and 9,890 women from the study areas of the Banfora and Tenkodogo Health Districts socialize at the 422 sites identified by key informants during the site's peak hours. These numbers represent approximately 52% of the men and 33% of the women age 15 to 44 in the Health Districts. In addition, approximately 3100 men and 1700 women who visit sites are non-residents who commute to sites from outside the study areas. The high proportion of residents and non-residents who frequent sites coupled with reported mobility between sites suggests that study areas are characterized by a high degree of mixing.

Over 70% of individuals interviewed while socializing at sites reported ever having used a condom, though reports of ever-condom use are lower among women in general and very low among women in rural areas (less than one-quarter). Individuals at the sites identified during the PLACE study are not representative of the general population, so it is possible that condom use among those interviewed during the PLACE study indeed is higher than in the general population. However, social desirability bias leads to over-reporting of condom use in surveys, therefore these reports also must be interpreted with caution (Catania and Chitwood et al. 1990).

Table 6.1. Critical site-based indicators

	Banfora Health District	Tenkodogo Health District
Number of unique sites identified	263 in 5 ZIPs	159 in 3 ZIPs
Sites existence and popularity with key informants (%)		
•Site located and interview completed	89.0	91.2
•Site located but site representative refused to participate	2.7	1.3
•Site not identified or closed	8.4	7.5
•Reported by more than 25 key informants	6.5	5.0
•Reported by only one key informant	37.3	45.3
Site characteristics (%)		
•That are formal bars, clubs, hotels and brothels	34.7	30.2
•That are informal small sites (eg., *cabarets*, street vendors)	38.4	33.4
•That are large public places (eg., markets, stations)	26.9	36.7
•Where alcohol is consumed	63.3	57.2
•That have dancing	9.4	8.3
•That have musical performance	37.2	31.7
•That have been operating for two or more years	78.2	81.4
Site clientele (%)		
•With male youth	47.0	57.2
•With female youth	48.7	56.6
•With patrons from inside the study area	98.7	89.9
•With patrons from outside the study area	84.6	90.3
•With more than 100 patrons at the site's busiest time	12.9	20.1
•Where people meet new sexual partners	85.0	84.8
•With commercial sex on site	11.5	15.9
•With male youth and commercial sex	40.7	56.4
•With female youth and commercial sex	44.4	52.1
•With gay patrons	1.7	2.1
AIDS-prevention program coverage (%)		
•That ever had an HIV/AIDS program	23.1	36.6
•Willing to have prevention program	82.5	89.7
•Where condoms were available at the time of the interview	3.8	4.1
•Where condoms were never available	74.8	71.0
•Where condoms were available within a ten-minute walk	85.5	85.5
•Willing to have condoms	62.4	69.0

Though a minority of sites provided condoms and AIDS education materials (4 and 10%, respectively), 85% of site representatives affirmed that they are willing to host prevention activities and 65% are willing to sell condoms.

6.2 Recommendations for district-level AIDS-prevention programs

Under direction of the CNLS, the original PLACE protocol was adapted for use as a district-level tool to plan HIV/AIDS interventions and was piloted in the Banfora and Tenkodogo Health Districts of Burkina Faso. Given below are indicators and recommendations to aid district health officials in Banfora and Tenkodogo in planning AIDS interventions. See **Section 7** for an in-depth review of key themes underlying intervention recommendations.

Supply condoms at sites. Promote regular condom use.

Though a minority of sites provided condoms and AIDS education materials (4 and 10%, respectively), 85% of site representatives affirmed that they are willing to host prevention activities and 65% are willing to sell condoms. While condoms must reach sex worker populations, which are concentrated in urban and border towns, rural women experience risk of HIV transmission because condom use is low while risk behavior is high. It is discouraging that less than one-quarter of women in this rural area reported ever having used a condom, and no woman carried a condom with her at the time of the interview. Condom promotion must reach all urban, border and rural areas, as well as sites with and without reported sex work.

Education at sites in Niangoloko and Tenkodogo, towns that have the highest rates of sexual partnership and sexual mixing, should be prioritized. Women in these areas reported a mean number of 9 new partners in the month preceding the survey, while all other men and women in the health districts reported a mean of less than 1 new partner. As perhaps expected, reports of selling sex for money, goods or services were higher among women in Niangoloko (43%) and the town of Tenkodogo (81%) than among other women in their respective districts. As centers of migration and trade, people come from throughout Burkina Faso to sites in Niangoloko and the town of Tenkodogo. More than half of individuals interviewed at sites in Niangoloko and Tenkodogo reported that their most recent new partner did not come from within the study village, compared with 40% of men and women in all other areas. As the majority of women at sites in Niangoloko and Tenkodogo met their most recent new sex partner at the site of the interview (60 and 82%, respectively), intervention at these sites would capture those most likely to be sex workers as well as other high risk women.

Promote reduction in numbers of sexual partners.

Over 10% of men and women in the Tenkodogo Health District reported having two or more new partners in the month preceding the survey, regardless of urban, rural or border setting. In the Banfora Health District, reports of at least one new sex partner in the month preceding the survey ranged from 21% of women in rural areas to about half of women in the urban and border areas. Education messages should emphasize that a reduction in number of partners mitigates risk of HIV transmission.

Promote STI treatment.

Over 10% of women and about 5% of men reported a STI symptom. The district health service needs to expand STI treatment services, and education messages at sites need to inform individuals that STI treatment reduces HIV transmission.

Promote delayed onset of sex, particularly among women.

Male and female youth under the age of 18 come to over half of the sites where people meet sex partners. Among individuals interviewed at the sites, about 33% of men and 64% of women were between 15 to 24 years old. Age at first sex for Burkinabe women just precedes age at first union (17.4 and 17.6, respectively) and falls earlier than men's age at first sex (20.5). Safer sex education at sites should send the message that it is acceptable to wait for first sex.

Educate and empower women.

Among those socializing at the sites, men outnumbered women by 2:1. Women were five years younger than men (about 23 and 28 years, respectively) and were much more likely to be unemployed than men (44 and 18%, respectively). These differentials in age and employment make the women socializing at sites vulnerable. Women were more likely then men to report having had a new sex partner at the site, while sex work – trading sex for money, goods or services – was also common. Meanwhile, ever use of condoms and recent AIDS education is lower among women (67 and 27%, respectively) than among men (78 and 42%, respectively). Intervention should therefore consider gender-specific approaches in raising HIV/AIDS awareness and promoting female controlled methods of protection.

Train peer educators.

The infrastructure of sites where managers are willing and eager to participate in AIDS intervention is a valuable resource in Burkina Faso's resource-poor context. Individuals who come to sites to socialize or to work are already at home and familiar at sites. Peer educators, whether a trusted bartender or another patron of a brothel, should be based at sites to promote safer sex. Because individuals are familiar with sites and with the people they know at the sites, they may be more open to receiving AIDS education messages.

Target as many sites as possible. Focus on formal commercial establishments and large public areas in all areas.

About 85% of site representatives confirm key informant reports that people meet new sex partners at their sites, suggesting that the risk of HIV transmission is distributed among many and across diverse sites in the health districts. Formal commercial establishments such as bars, dance clubs, hotel and brothels, sites where risky sex perhaps is expected, indeed have the highest levels of reported sexual activity. Women at these sites reported an average of 7 new partners per month compared with 1.3 new partners or fewer among women at other sites. However, informal sites such as large markets should not be overlooked. Women gave reports of selling sex for money, goods or services at all site types, most often at formal bars, clubs and brothels (43%) and at large public sites (25%), with a smaller proportion of women reporting sex work at informal small sites (13%).

Intensify intervention during the dry season.

People must work in the fields through the rainy season, while in the dry season after the harvest, they have both free time and money to relax and socialize. Therefore, larger proportions of site respondents reported that the dry season was a busy time (over 70%) compared with those who reported the rainy season (less than 10%). Not only are sites busier during the dry season, but many important community events take place during this time period.

Include large public sites and community events to reach people and to help generalize HIV/AIDS prevention messages.

The community is an important factor in the African cultural context, and informal sites such as markets, as well as community events, can play a particularly important role in addressing AIDS. While focusing HIV/AIDS intervention only at select sites such as brothels may stigmatize prevention efforts, as well as the sites themselves, inclusion of large public sites will generalize HIV/AIDS awareness.

Health districts must share experiences with the PLACE method to make intervention planning efficient and effective.

Members of the study teams of the Banfora and Tenkodogo Health Districts, along with the CNLS, developed a generic study protocol and questionnaires for future use in other health districts. District health officials from Banfora and Tenkodogo who were involved in the implementation of PLACE have invaluable experience in the field and insight into how the method can be most effectively used for planning interventions. They should be involved in implementation of PLACE in other health districts to share this knowledge and foster relationships across health districts.

Table 6.2. Critical sexual behavior indicators

	Banfora Health District		Tenkodogo Health District	
Number of sites visited for interviews	40		24	
Percent of sites in ZIPs visited for interviews	17.5		16.6	
Mean/median number of individuals socializing at sites	23.3/11.0		71.1/21.1	
Mean male: female ratio at sites	2.7:1		2.9:1	
Range in male: female ratio at sites	0:1-16:1		0.1:1-37:1	
	Men	**Women**	**Men**	**Women**
Percent of individuals refusing interview	5.7	14.4	1.1	1.1
Number of completed interviews	582	261	374	177
Characteristics of individuals (%):				
• Are 15 to 24 years	36.2	69.0	28.4	57.1
• Are older than 40 years	7.7	3.1	11.2	0.6
• Are residents of the study area	76.1	86.2	85.8	84.8
• Are unemployed	22.3	54.8	11.8	28.3
• Visit the site every day	27.7	39.5	44.7	60.5
• Have visited/will visit multiple sites that day	40.9	27.6	47.6	28.8
• Have attended an AIDS educational session	44.0	35.3	39.0	31.1
Sexual partnership and condom use (%):				
• Have met a new sex partner at the site	29.2	38.3	42.0	44.1
• Have had a new sex partner in the past year	58.3	57.4	70.8	64.4
• Have had a new sex partner in the past month	25.5	33.0	44.1	47.4
• Have had more than 10 new partners in the past month	0.0	5.0	0.3	5.1
• Have been sexually active in the past year	93.7	94.3	97.6	94.3
• Have had only 1 partner in the past year and that partner was not new in the past year	28.5	34.5	17.1	26.0
• Have given (if men) or received (if women) money, goods, services for sex	28.5	22.6	48.0	47.9
• Have ever used a condom	77.2	69.7	78.3	63.3
• Used a condom with the most recent new partner*	78.8	71.9	73.5	72.9
• Possessed a condom at the time of the interview	7.9	5.4	9.1	7.9

* Of people with at least one partner in last three months and who have non-missing condom use data

Section 7. Reflections on Key Themes and on the Application of the PLACE Method in Burkina Faso Health Districts

7.1 Reflections on key themes

The case for focusing on PLACE rather than people.

Elevated rates of HIV in some Burkina Faso sex worker populations (52%) compared with the national prevalence estimate (7.2%) suggest the continuing need to reach female sex workers when planning AIDS interventions (UNAIDS 2000, CNLS 2001). Among a sample of sex workers in Ouagadougou and Bobo-Dioulasso (N=426), although 98% had heard of AIDS, only 80% knew that AIDS could be sexually transmitted, 27% knew of blood transmission and 1% was aware of mother-to-child transmission. Though regular condom use was reported by 81% of sex workers, a large majority (61%) believed that their work did not expose them to HIV/AIDS (Nebie et al. 2001).

Though intervention should continue to target sex workers, intervention targeted at particular groups also could be stigmatizing. In addition, focus on a "core" group may result in the exclusion of those not categorized as part of the group. The value of focusing on sites rather than on individuals is particularly important in Burkina Faso, where the definition of sex work in the Burkinabé context is ambiguous and fluid, and the spectrum of women who exchange sex for money, goods or services is broad. While some women work as professional prostitutes and wait for their clients outside their 'studios,' others are bar workers who leave with the bar's clients or schoolgirls who trade sex for school fees (Nagot et al. 2002, Nebie et al. 2000). The PLACE study identifies sites where sexual partnership occurs, without requiring prevention planners to distinguish between "professional" sex workers and other women.

The PLACE study revealed that formal bars, hotels, brothels and dance clubs have the highest rates of new partnership acquisition and sex work, and intervention planners must begin at these sites. Thailand's success story of decreasing rates of HIV can be attributed, in large part, to the site-based intervention of condom distribution at brothels (Rojanapithayakorn and Hanenberg 1996). Increased condom distribution, together with educational materials, has also increased condom use in hotels in Nicaragua (Egger et al. 2000). Sexual encounters may be expected at formal bars, hotels, brothels, and dance clubs, however informal sites, such as tea clubs, video clubs, and large markets should not be overlooked. High rates of sex work were reported at large informal sites in the Banfora and Tenkodogo Health Districts (between 40 and 50%), indicating that risky sexual behavior occurs in informal as well as formal establishments. While prevention planners will diminish stigmatizing particular groups, they must take care to minimize the stigmatization of sites where AIDS-prevention efforts will be held.

Because the network in the health districts is extensive and diffuse, targeting individuals would be a difficult task. However, site-based intervention would reach a full spectrum of at-risk individuals in the community without needing to identify particular risk groups. The infrastructure of sites where managers are willing and eager to participate in AIDS intervention should be recognized as a valuable resource in Burkina Faso's resource-poor context. Furthermore, the people that AIDS-prevention efforts wish to reach are already at home and familiar with sites where interventions could take place, and this familiarity may improve chances of people accepting AIDS education messages.

Public sites and community events generalize HIV/AIDS awareness.

Rallies, parades and public announcements about AIDS in a public place such as a market or at community event, with the involvement of local authorities, community organizations or celebrities, will help focus AIDS prevention

towards entire communities rather than individuals or small groups.

An experience during the fieldwork in one of the rural areas of the Banfora Health District, Bérégadougou, suggests that there is potential in using community space with the involvement of local authorities to engage the community about AIDS. As the importance of events had become evident over the course of the fieldwork, interviewers asked the Bérégadougou village chief if they could conduct interviews at a wedding that happened to be taking place during the time of field work in the village. The village chief made a public announcement during the wedding that the interviewers were with them to celebrate and ask questions, and he implored the community to speak with them because it would benefit their health programs. Community members at the wedding accepted the interviewers as if they were part of the celebration, most probably because their leader stated the importance of their involvement.

Political commitment is vital to the fight against AIDS. Not only are statements made by leaders at the national level important, but community leaders who publicly speak about AIDS also demonstrate the importance of the issue at the local level. It is likely that leadership exhibited by the Bérégadougou village chief legitimized AIDS-prevention messages in the eyes of community members.

Community leaders may be local political authorities, as well as religious leaders or local celebrities. About half of Burkinabé follow an animist religion, and traditional authorities are respected members of the community whose involvement in AIDS intervention may be invaluable (Englebert 1996). Potential for promoting discussion about AIDS in public forums also lies in the drumming and dancing groups that are already popular in a Burkinabé cultural context, whether at community events or formal bars, restaurants and dance clubs. For example, in Bobo-Dioulasso, Burkina Faso, a group of governmental and non-governmental community representatives, musicians and researchers have created an organization, "SIDA KATAA," in which popular Burkina Faso musicians raise community awareness of AIDS through song.

While the involvement of local politicians, religious leaders and popular entertainment groups in planning and participating in AIDS intervention may persuade the community of the importance of the issue, it is important to involve other community representatives and organizations to ensure that intervention is non-coercive as well as sensitive to the variable needs within communities. Burkina Faso, with other countries, has begun to introduce new contraceptive technologies with the "strategic approach," a method that shifts attention away from pushing a particular product to emphasizing flexibility, reproductive choice and participation by the community to better meet needs (Simmons et al. 1997). The same sensitivity must be espoused when considering the method for introducing AIDS-related messages into a community.

Although findings of the PLACE study highlighted the importance of community events in rural areas, which are less developed with formal commercial establishments such as bars, hotels, brothels, etc., community-centered AIDS intervention should be prioritized in urban as well as rural environments.

Condom availability is not enough. People must perceive risk of HIV/AIDS.

Condom availability in Burkina Faso has greatly improved owing in large part to PROMACO's success in providing subsidized condoms throughout the country since its inception in 1986. Figure 7.1 demonstrates that the number of condoms made available has increased from about 17,000 in 1986 to about 10 million in 1998. Figure 7.2 presents the increase in the average number of condoms per person aged 15-49 years available in Bobo-Dioulasso, with condom availability increasing to about 6 or 7 condoms per person by the late 1990s.

An increase in requests for condoms by store-owners may imply an increase in condom

Figure 7.1. Evolution in the number of condoms distributed in Burkina Faso, 1986-1998 (Auregan et al. 2000)

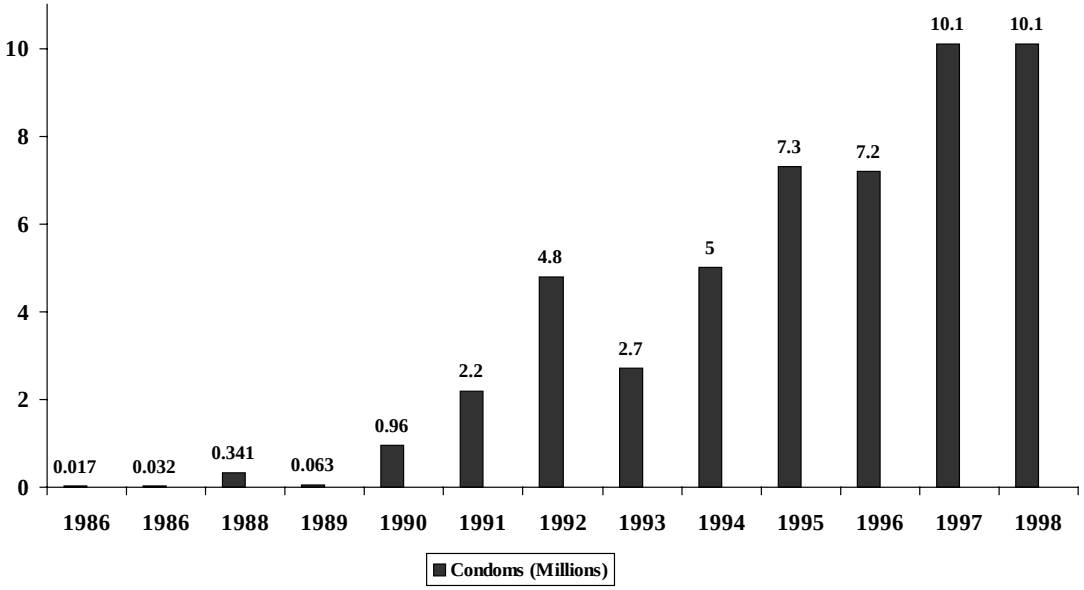
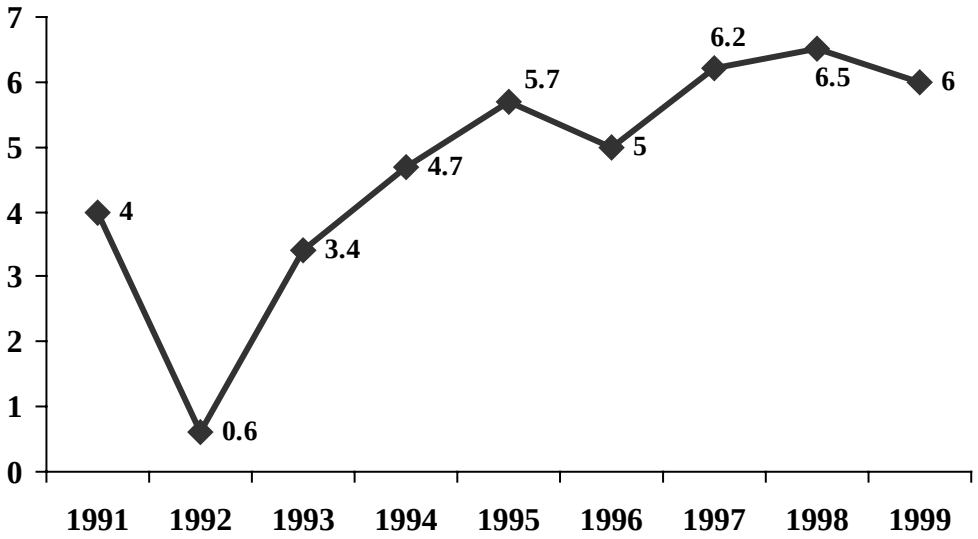


Figure 7.2. Number of available condoms per year per person (aged 15-49 years), Bobo-Dioulasso, Burkina Faso (Meda et al. 2001)



use (PROMACO, July 2001, personal communication). However, no study has been performed to demonstrate that increasing distribution in Burkina Faso has been translated into increased condom use and national rates of HIV continue to rise despite a rise in condom availability. Though PROMACO's success in improving condom availability means that more condoms are in circulation, it cannot be inferred that condoms are being used regularly. Though reported condom use in the two health districts is relatively high – over 70% of women and nearly 80% of men reported using a condom with their most recent new partner – evidence from the PLACE study and other studies suggests a gap in condom use. Rates of reported condom use were lower among women in general and very low among women in rural areas of the Tenkodogo Health District. In addition, other surveys among the general population indicate lower rates of ever-use of condoms (EDSBF-II 2000, Sengare et al. 1997).

Intervention planners must take into consideration the factors that may prevent condom use. First, lack of education about AIDS may prevent condom use. According to the Burkina Faso DHS 1998-1999, though the majority of men and women surveyed have heard of AIDS (96 and 87%, respectively), very low percentages of men and women who have heard of AIDS believe that it can be prevented (5 and 9%, respectively). While some individuals may be aware of the ways in which HIV can be prevented, low perceived risk of HIV infection may limit regular condom use. A study of condom use involving eight countries in sub-Saharan Africa indicates that a primary reason that individuals do not use condoms with marital and casual partners is because they trust partners (Agha and Kusanthan et al. 2002). A proportion of men and women interviewed during the Burkina Faso DHS 1998-1999 believe that they are not at risk of contracting HIV/AIDS (22 and 36%, respectively). While men were likely to report that they changed their sexual behavior to protect themselves from HIV/AIDS (78%), nearly half of women reported having done nothing to change their sexual behavior in light of AIDS (47%) (EDSBF-II 2000).

Naturally, intervention to heighten awareness of the need for condom use should reach women with high partnership acquisition rates and high rates of sex work. Even if this segment of the population reports higher rates of condom use than other women, intervention would affirm the need to use condoms not only often but *regularly*. Studies with sex workers in the United States and Thailand suggest that risk of HIV infection may be greater among regular partners who exchange sex for goods and services than among one-time clients, when condom use is more likely (Lamptey et al. 1997).

Gender inequality puts women at disproportionate risk of HIV, while potentially fueling the epidemic.

Disparities between men and women at sites in the Banfora and Tenkodogo Health Districts were reflected in results of the PLACE study. Men outnumbered women at sites two to one, and they were more than 5 years older than women (average ages of 29 and 23 years, respectively). Significant proportions of men reported buying sex, while significant proportions of women reported selling sex for money, goods and services.

Certain aspects of Burkinabé culture that result in unequal treatment of women could play a role in the spread of HIV/AIDS. The disparity in the opportunity for women in education, employment, politics and participation in the formal economy together with more overtly oppressive culture practices such as female circumcision (Engleber 1996) underlie both women's lack of awareness about AIDS and their inability to negotiate safe sex. Findings from the Burkina Faso DHS 1998-99 and the PLACE study in the Banfora and Tenkodogo Health Districts indicate that women were less likely than men to have participated in an AIDS awareness session, to have used a condom and to know ways that AIDS can be prevented. Even if women are aware that condoms will prevent HIV, those who sell sex for their livelihoods have little power to advocate for their needs and desires. One self-identified sex worker who was interviewed in the Banfora Health District explained that men willingly pay more for sex without a

condom than for sex with a condom, and her economic dependence results in her opting for the unsafe sex.

A number of vulnerabilities to HIV infection that women experience are linked to the common practice of early onset of sexual relations for women in Burkina Faso (17.4 years) compared with men (20.5 years) (EDSBF-II 2000). It is common for older men to seek out younger female sex partners. The power many men exercise in the sexual relationships because they are more educated or because they control the financial resources only increases if they are older. The age differential not only increases the difficulties women face in negotiating for their needs such as condom use, but the risk of HIV to women increases because older male partners have been sexually active for a longer period of time and hence have increased risk of exposure to HIV. While the age differential increases the vulnerability of women, it also impacts the size and shape of the epidemic. If infected older men limited sexual activity to women in their own age cohort, the epidemic would be more likely to move out of the population rather than be passed to a younger group whose sexual activity will sustain the presence of HIV (Garnett and Anderson 1993).

Polygyny is a widespread practice in Burkina Faso, involving 55% of women and 32% of men (EDSBF-II 2000). Whether polygyny further increases HIV transmission has not been demonstrated. However, the increased risk of HIV due to the unequal power dynamic between the sexes would impact not only one woman but multiple women in the context of polygyny. Data indicate that similar percentages of men in monogamous and polygamous partnerships in Tanzania have non-marital partners (16 and 18%, respectively) (Nnko S. et al. 2001). Therefore, these similar rates of infidelity would impact a greater number of individuals in polygynous unions, as STIs move easily through the system of multiple and concurrent partnerships (Pebley et al. 1988).

Though addressing the underlying cultural, economic and social inequality women may face is outside the scope of most AIDS intervention budgets, there is potential for mitigating the impact of HIV transmission by empowering women and appealing to men. Sites could serve as important places to decrease vulnerability of women by increasing awareness of AIDS, improving availability of condoms and introducing female controlled methods of protection. As women face difficulties in negotiating safe sex, intervention should also aim to reach men to use protection when having sex. Male involvement has been illuminated as an important consideration for developing family planning programs in West Africa, and the role of male education also should be given to HIV/AIDS prevention (Oppong C 1987). Site-based intervention at community events, with the involvement of respected key leaders, for example, could influence men to use condoms.

7.2 Reflections on application of the PLACE method in Burkina Faso

Modification of the PLACE study for use as a district-level tool.

In May 2001, the CNLS of Burkina Faso, the DRS of Banfora and the Centre Muraz approved the PLACE study protocol. The study instruments were translated into French, and representatives of UNC, the Centre Muraz and the DRS of Banfora collaborated to adapt the PLACE protocol and questionnaires to the appropriate cultural and political context in Burkina Faso.

One major change in the protocol was the omission of mapping sexual meeting places. After many discussions between the Centre Muraz and representatives of the CNLS and the DRS of Banfora, it was decided that a map indicating high transmission areas of HIV risks would stigmatize certain areas and establishments in a health district. In addition, mapping was regarded as a potential violation of confidentiality, as respondents were reassured during the interview that the information they give during an interview is confidential.

Unlike previous PLACE studies, the study team decided to give incentives to encourage people to participate in the interview, such as condoms or a beverage to drink during the interview. It was decided that the refusal rate would be high

if no incentives were given, and the gesture to the respondent that the investigation team valued his or her participation in the interview was considered important in its own right.

A few changes were also made to the questionnaires to make them more suitable to the Burkinabé context. For example, in past PLACE studies, the inclusion of community events was not emphasized. Events such as weddings and funerals are important moments when people can gather and socialize in the Burkinabé context, and the questionnaires were rewritten to better probe respondents about such events.

The results of the pilot study in the Banfora Health District informed the development of a more cost-effective version of the protocol, a "roll-out" version, that requires less technical assistance and less time. In August 2001, members of the Centre Muraz, the DRS of Banfora and the CNLS met to discuss preliminary results of the PLACE study in the Banfora Health District and reflect on ways to improve the PLACE study. Participants in the August meeting reconvened in September with members of the Tenkodogo Health District to discuss adaptations to make the PLACE study a more simple and effective tool for Burkina Faso health districts.

The most significant change to this "roll-out" protocol was the decision to decrease the number of study villages within a district in order to save time and cost in the field. Five study villages were included in the Banfora Health District, including one urban, three rural and one semi-urban border town. It was decided that the PLACE study should be implemented in at least one urban and one rural area within a health district. If there were another important town in the district with characteristics distinct from an urban or rural area, such as a village situated at an international border or an area that receives a great deal of tourism, it would also be studied. Members of the DRS of Tenkodogo decided that the PLACE study should be implemented in one urban, one rural, and one border area of their health district. All three stages were to be implemented in the chosen study villages, with only minor clarifications made to the questionnaires.

The possibility of omitting individual interviews was discussed when brainstorming ways to decrease costs of the PLACE study, as individual interviews simply validate the reports that sites are places of sexual encounter given by key informant and the site verification respondents. It was decided, however, that the three stages of interviews – the key informant interviews, the site verification interviews and interviews with individuals socializing at sites – each yielded different, useful information. Therefore, only minor clarifications were made to questionnaires and all three questionnaires remained as a part of the "roll-out" protocol.

Findings from the PLACE study in the Banfora and Tenkodogo Health Districts were disseminated to the CNLS, the DRS of Banfora and the DRS of Tenkodogo, as well as to representatives of other health districts. Based on the "roll-out" protocol and experience in the two health districts, members of the study teams of Banfora and Tenkodogo Health Districts with the CNLS developed a generic study protocol and questionnaires for future use in other Burkina Faso Health Districts. In 2002-03, the "roll-out" PLACE protocol will be disseminated to other Burkina Faso Health Districts. Funding is currently being sought to implement and assess the generic protocol in other Burkina Faso Health Districts and to further investigate the potential of community events for HIV/AIDS education.

Strengths of the method

The PLACE study identified priority sites for HIV/AIDS intervention with the integral involvement of health district officers to better ensure that goals of the assessment and the assessment process were aligned with the needs and sensitivities of the communities involved. This method is a rapid assessment tool for planning of AIDS intervention programs. It offers an alternative to a population survey design that is less expensive and able to reach a high-risk population. The method emphasizes the importance of site-based intervention, enabling intervention to reach a spectrum of high-

risk groups without stigmatizing certain core groups or individuals that have been the focus of past intervention. Not only is stigma associated with AIDS-related prevention decreased, but site-based intervention allows a wider range of the sexually active population to be reached. The PLACE study reveals sites with increased potential for HIV transmission, and by asking site representatives whether they are interested in hosting AIDS intervention activity, the method also identifies resources for implementing intervention activity. The network of sites in a community serves as an infrastructure upon which AIDS-prevention programs can be based. By basing interventions at sites, prevention messages and condoms would be available at the time and place of sexual encounter. In addition, this infrastructure of sites could prove to be more effective in delivering AIDS-prevention messages than other places in the community, such as in the health clinic setting, because the people that intervention wishes to reach are already comfortable at the sites and therefore may be open to AIDS-prevention messages. Intervention planners can be confident that sites identified by key informants are priority sites of intervention because subsequent stages of the PLACE study (interviews with representatives of the sites, and interviews with individuals at a sample of sites) validates that sexual activity occurs at sites.

District health officials from Banfora and Tenkodogo developed a generic "roll-out" PLACE protocol for use in other Burkina Faso health districts. This protocol minimizes time, technical assistance and cost by reducing the number of study areas within a health district. Implementation of the "roll-out" protocol requires about 6 weeks and US $4,000 for recruitment of the study team, identification of towns in the health district where the PLACE method will be implemented, interviewer training, field work, and dissemination of results to appropriate community and health representatives.

Weaknesses of the method

The method is not immune to a number of biases. The first goal of the study was to identify key areas with increased potential for HIV transmission in a health district, though it is possible that different areas within Burkina Faso and within the chosen health districts experience a higher risk of HIV than those chosen. The CNLS identified the Banfora and Tenkodogo Health Districts. Though at-risk areas were identified because they experience a higher risk of HIV, practical concerns also informed the choice of the Banfora Health District, including feasibility and the presence of organizations that could potentially use study results for intervention. Likewise, a lack of previous HIV/AIDS intervention in the Tenkodogo Health District was a consideration for including this health district. To identify study areas within the health district, district health officials conducted a meeting and identified important villages in an orderly process. Justification was given for the inclusion of each area as an area with an increased risk of HIV, though the choice of study villages was not based on HIV prevalence data.

The second aim was the identification and characterization of key sites in a study area, and it is possible the site list generated by key informants does not perfectly reflect the reality of the most popular and/or important sites. Selected key informants may not know the most current sites, while characterization of sites yielded during the site verification may not be accurate if the respondent was not truly knowledgeable about the site.

Finally, if the process of sampling individuals was not properly followed, an unrepresentative estimate of sexual behavior at the sites may have resulted. Interviewers followed a sampling strategy to obtain a random sample constructed for four-walled bar environments, such as bars or clubs. This sampling strategy was difficult to follow in sites such as film cinemas, markets or open areas.

Self-presentation bias is probable in studies concerning self-reported sexual behavior (Catania et al. 1990). This bias is minimized during the key informant interviews, because respondents are asked to give information about others' behavior. However, it is possible that some key informants felt embarrassed about revealing that they knew where sexual meeting

spots were located. During the site verification interview, self-presentation bias could have emerged if managers or workers at sites felt hesitant to admit that alcohol is consumed at sites of if there is potential for meeting sex partners and sex workers on the site, particularly in the more traditional rural areas. The greatest potential for self-presentation bias occurs during the individual interviews, particularly with questions that ask about the number of sex partners or involvement with sex work. With each questionnaire, the key informant interview, the site verification interview and the individual interview, self-presentation bias was minimized by reassuring the respondent that all responses were confidential, that the interviewer was not asking for unique identifiers and by creating a non-judgmental, reassuring atmosphere during the interview.

The interviewers could have introduced bias if they were inconsistent in the way they asked questions, or if they elicited responses to questions differently from one another. For example, it is difficult to discern whether higher reporting of events in the Tenkodogo Health District than in the Banfora Health District is due to a greater importance of events or because interviewers were more persistent about eliciting events in the Tenkodogo Health District because the fieldwork in the Banfora Health District revealed the importance of focusing on events. Differences in style could have resulted in differences in reports of sexual partners, as well. The interviewer training minimized differences through role-play and discussions about the method and the questionnaire, to ensure that all interviewers were interpreting questions in the same manner.

Finally, though this study reveals gaps in condom availability and potential places for intervention, the method does not give insight into reasons why condoms are not regularly used. People socializing at sites were unlikely to carry condoms, despite the fact that condoms were located within 10 minutes walk of a majority of sites (80%). The questionnaires are kept short to respect the time of the interviewee, however more in-depth information about what motivates people to use condoms is important for planning pertinent interventions.

Conclusion

The PLACE study can successfully be mobilized for planning and evaluating HIV/AIDS-prevention programs at the level of the health district. A high level of sexual activity was confirmed throughout the Banfora and Tenkodogo Health Districts, though the nature of the sites differed among urban, rural towns and border areas. The lesson is that health district officials must take care to assess needs in the diverse areas that comprise a district, in order that programs be best suited to variable situations. AIDS education and condom promotion at hubs of sexual activity, whether bars and brothels in urban areas or markets and weddings in rural areas, coupled with the success of PROMACO's condom distribution, will better ensure that condoms are not only in circulation but in use.

References

Aegis - Agence France-Press (2001). *Burkina-SIDA: Creation d'un conseil national de lutte contre le SIDA au Burkina Faso*. Cited in December 2001: www.afp.com.

AFRIC Conseil (2000). Etude relative à l'assiette fiscale et au recouvrement des ressources budgétaires de la commune de Bittou. Commission Nationale de la Décentralisation.

Agha S, Kusanthan T, Longfield K, Klein K and J Berman (2002). Reasons for Non-Use of Condoms in Eight Countries in Sub-Saharan Africa, PSI Research Division, Working Paper No 49, Washington DC: Population Services International.

Ainsworth M and Teokul W (2000). Breaking the silence: setting realistic priorities for AIDS control in less-developed countries, The Lancet; 356: 55-60.

Anderson R (1999). Transmission dynamics of sexually transmitted infections. In: Holmes KK, Sparling PF, Mardh P-A, Lemon SM, Stamm WE, Piot P, Wasserheit J (eds). Sexually Transmitted Diseases, Third Edition. New York: McGraw Hill: 25-37.

Auregan G, Gregoire L and Renterghem H (2000). Epidemi du VIH/SIDA au Burkina Faso: Diagnostics et reponses operationelles (version preliminaire) Ouagadougou, Burkina Faso.

Cartous M et al.(1998). Attitude of pregnant women towards HIV testing in Abidjan, Côte d'Ivoire and Bobo-Dioulasso. Burkina Faso, AIDS; 12: 2337-2344.

Catania J, Chitwood D, Gibson D and Coates T (1990). Methodological Problems in AIDS Behavioral Research: Influence on Measurement Error and Participation Bias in Studies of Sexual Behavior, Psychological Bulletin; 108 (3): 339-362.

CHR de Tenkodogo (2001), Laboratoire d'analyses, SIDA Retro Infos n°004, Données de sérosurveillance.

Direction Regionale de la Santé de Banfora (1999). Plan de developpement sanitaire 2000 – 2004 du district sanitaire de Banfora. La ville de Banfora (Burkina Faso), Direction Regionale de la Santé de Banfora.

Direction Régionale de la Santé de Tenkodogo (2000). Plan de developpement sanitaire 2000-2004 du district sanitaire de Tenkodogo. La ville de Tenkodogo (Burkina Faso), Direction Regionale de la Santé de Tenkodogo.

Direction Régionale de la Santé de Tenkodogo (2001). Plan d'action 2001 du district sanitaire de Tenkodogo. Direction Régionale de la Santé de Tenkodogo.

EDSBF-II: Institut National de la Statistique et de la Demographique, et Macro International Inc. (2000) Enquete Demographique et de Santé, Burkina Faso 1998-1999. Calverton, Maryland (USA): Macro International.

Englebert P (1996). Burkina Faso: Unsteady Statehood in West Africa. Bolder, Colorado: Westview Press, Harpers Collins Publishers.

Garnett G and Anderson R (1993). Factors controlling the spread of HIV in heterosexual communities in developing countries: patterns of mixing between different age and sexual activity classes. Philos Trans R Soc Lond B Biol Sci; 342 (1300):137-59

Lampty P, Kamenga M and Weir S (1997). Prevention of sexual transmission of HIV in sub-Saharan Africa: lessons learned. AIDS; 11 (suppl B): S63-S77.

Malkin J, Yamengo M et al. (1997). Tuberculosis and HIV in West Burkina Faso: Clinical presentation and clinical evolution. International Journal of Tuberculosis and Lung Disease; 1: 68-74.

Meda N, Cartoux M, Dabis F, Bazié B, Hetherington J, Dahourou H, Ouangré A, et al. (2001). Stabilization of HIV infection rates in urban Burkina Faso, 1995-1999. International Journal of STD and AIDS; 12(7): 460-2.

Meda N, Zoundi-Guigui M, Van de Perre P, Alary M, Ouangre A, Cartous M, Mandelbrot L, et al. (1999). HIV infection among pregnant women in Bobo-Dioulasso, Burkina Faso: Comparison of voluntary and blinded seroprevalence estimate. International Journal of STD and AIDS; 10: 738-40.

Meda N (1998). Suivi evaluation des programmes nationaux de lutte contre le SIDA: Examen de l'experience du Burkina Faso, 1987-1998. Monographie preparee dans le cadre de l'initiative OMS/ONUSIDA/MEASURE Evaluation (USAID) sur le Suivi-Evaluation de Programmes de lute contre le SIDA.

Nagot N, Ouangre A, Ouedraogo A, Cartoux M, Huygens P, Defer MC, Zekiba T, Meda N and Van de Perre P (2002). Spectrum of commercial sex activity in Burkina Faso: classification model and risk of exposure to HIV. Journal of Acquired Immune Deficiency Syndromes. 29(5): 517-21.

Nagot N et al. (2001). Change of STI ecology in Bobo Dioulasso, Burkina Faso: what implications for the syndromic approach and other STI/HIV control efforts. Abstract, Journée Sciences Santé Bobo Dioulasso.

Nebie Y, Meda N, Leroy V, Mandelbrot L, Yaro S, Sombie I et al. (2001). Sexual and reproductive life of women informed of their HIV positive seropositivity: A prospective cohort study in Burkina Faso, Journal of Acquired Immune Deficiency Syndromes, 28 (4): 367-72.

Nnko S, Boerma T, Urassa M and Zabia B (2001), Sexual mixing in Kisesa, Tanzania, Draft copy, to be published.

Oppong C (1987), Responsible fatherhood and birth planning. In: Oppong C (Ed.), Sex roles, population and development in West Africa. London: International Labour Organization: 165-78.

Pebley A, Mbugua W and Goldman N (1988) Polygyny and fertility in Sub-Saharan Africa. Fertility Determinants Research Notes; 21:6-10.

Pickering H, Quigley M, Hayes RJ, Todd J, Wilkins A (1993), Determinants of condom use in 24,000 prostitute/client contacts in The Gambia. AIDS; 7(8): 1093-8.

PROMACO (2001). Personal communication with director in Bobo-Dioulasso Branch.

Rojanapithayakorn W and Hanenberg R (1996). The 100% Condom Program in Thailand, AIDS; 10: 1-7.

Sangare L, Meda N, Lankoande, Van Dyke E, Cartoux M and Compaore I (1997). HIV infection among pregnant women in Burkina Faso: a nationwide serosurvey, International Journal of STD and AIDS; 8:646-51.

UNAIDS (2002). Epidemiological fact sheet on HIV/AIDS and sexually transmitted infections, Burkina Faso: 2002 Update. Cited September 2002: www.unaids.org

UNAIDS (2001). Population mobility and AIDS: UNAIDS technical update. Cited October 2002: www.unaids.org

UNDP: United Nations Development Program (2001). UNDP's partnership with Burkina Faso in the fight against HIV/AIDS. Cited in December 2001: www.undp.org

UNICEF (2002). Statistical data, Burkina Faso. Cited April 19 2002: http://www.unicef.org/statis/Country_1Page184.html

WHO/UNAIDS: Surveillance de deuxième génération du VIH: les dix prochaines années. WHO/CDS/CSR/EDC/2000.5

World Bank (2001). HIV/AIDS Disaster Response Project. World Bank Project Data. Cited in December 2001: www.worldbank.org/sproject

World Bank Group (2002). Burkina Faso at a Glance. Cited in September 2002: http://lnweb18.worldbank.org/AFR/afr.nsf/b848411bd15a6525852567cf004dde02/eb9bbeacf4c413f9852567d1004e2299?OpenDocument

Appendix A: Tables

Appendix Table A. Timeline of preparation, implementation and analysis of PLACE Method in Two Burkina Faso Health Districts

Week	Activity	Output
1	***Preliminary preparation*** ▪ Introductory meeting with officials of National AIDS Council (CNLS) ▪ Introductory meeting with key health officials from the Regional Health Office (DRS)	▪ Confirm commitment at national and district level to perform PLACE method ▪ Preliminary list of areas with potentially high STI transmission appropriate for study
1-2	***Preliminary preparation*** Research performed by DRS representatives to gather data on HIV/AIDS in the district	▪ Synthesis of transmission of HIV on the district level
2-3	**Step 1 of PLACE protocol:** **Identify high transmission areas** Hold workshop with group of health workers from the DRS to discuss and decide on study villages	▪ List of at least two PLACE study villages ▪ Identification of DRS members that continue to contribute to field work
2-3	***Field Work preparation*** ▪ Identification and training of field coordinator ▪ Completion of study budget	▪ Budget
3-4	***Field Work preparation*** ▪ Follow-up meeting with DRS ▪ Hiring and training of interviewing team ▪ Finalization of questionnaires	▪ Interviewer training materials (interviewer handbook, questionnaires) ▪ Finalized questionnaire for each district ▪ 160 Key Informant questionnaires ▪ 200 Site Verification questionnaires ▪ 200 Individual Questionnaires
5	**Step 2 of PLACE Protocol** **"Key Informant" Interviews**: Ask community members who know the area well, "key informants," to identify sites in high transmission areas where people meet new sexual partners	Data entry of key informant characteristics and site reports

Week	Activity	Output
5	**Step 3 of PLACE Protocol** **Site Verification Interviews:** Visit sites named by key informants, interview someone at the site to characterize sites in each area and map sites	Data entry of result of site verification and site characteristics
6	**Step 4 of PLACE Protocol** **Interviews with individuals Socializing at Sites:** Describe the characteristics of people socializing at sites	Data entry of characteristics of individuals socializing at the sites
7-8	Data analysis, report writing and information dissemination	Final report to be distributed to DRS for comments and reflection

Appendix B: Tables for Key Informant Interviews, Banfora Health District

Table B1. Summary of fieldwork for key informant interviews, Banfora Health District, 2001

	Banfora	Rural villages	Niangoloko	Total
Number of days of key informant interviews	1.5	3	1	5.5
Number of interviewers	9	8	8	Not applicable
Number of key informants	86	141	68	295
Response rates for key informant interviews	95.6% (86/90)	93.4% (141/151)	95.8% (68/71)	94.6% (295/312)

Table B2. Characteristics of key informants, Banfora Health District, 2001

Key informant type	% of all key informants	n
Taxi driver	2.4	7
Truck drivers (within Burkina Faso)	3.4	10
Truck divers (international)	4.1	12
Transport workers at station	4.1	12
Parker of cars, bikes	1.4	4
Private guard	3.7	11
Mobile vendor	4.7	14
Market guide/helper	1.0	3
Sex worker	3.4	10
Bar/restaurant owner	3.1	9
Bar/restaurant worker	4.7	14
Liquor store owner	2.0	6
Night club manager	0.3	1
Shop owner	2.7	8
Businessman	2.0	6
Professional worker (governmental and non-governmental workers)	5.1	15
Teacher	3.7	11
Health worker	4.7	14
Student	10.2	30
Youth out of school	8.5	25
Military/police officer*	9.8	29
Priest/imam	3.4	10
Traditional religious leader	1.7	5
Praise singer	3.4	10
Unemployed individual	4.7	14
Fisherman	1.0	3
Other	0.7	2
Total	100	295

*Includes members of police, military, customs official, prison guard

Table B3. Demographic characteristics of key informants, Banfora Health District, 2001

	% of all key informants	n
Mean age		31.2 years
Gender		
Male	79.3	234
Female	20.7	61
Total	100	295
Lives in the study village		
Yes	96.6	285
No	3.4	10
Total	100	295

Table B4. Number of sites and events named by key informants, Banfora Health District, 2001

	Banfora (N=86)	Rural villages (N=141)	Niangoloko (N=68)	Total (N=295)
Number site reports	488	627	389	1504
Mean number of site reports per key informant	5.6	4.4	5.7	5.1
Number of unique sites identified	107	115	41	263*
Number event reports	44	78	15	137
Mean number of events named by key informants	0.5	0.6	0.2	0.5
Number of unique events reported	17	22	8	27*

*Some of the same sites and events were named by key informants from each of the three areas in the district, therefore a total of unique sites and events for the district will be less than the addition of all unique reports made in each of the three areas.

Table B5. Summary of fieldwork for key informant interviews, Tenkodogo Health District, 2001

	Tenkodogo	Beguedo/Niaogho	Bittou	Total
Number of days of key informant interviews	1	2	2	5
Number of interviewers	8	8	8	8
Number of key informants	77	48	49	176
Response rates for key informant interviews	100.0% (77/79)	100.0% (48/48)	98.0% (49/50)	99.4% (176/177)

Table B6. Characteristics of key informants, Tenkodogo Health District, 2001

Key informant type	% of all key informants	n
Taxi driver	2.3	4
Truck drivers (within Burkina Faso)	4.5	8
Truck divers (international)	4.0	7
Transport workers at station	3.4	6
Parker of cars, bikes	1.7	3
Private guard	4.5	8
Mobile vendor	6.2	11
Transport station guide	2.8	5
Sex worker	2.8	5
Bar/restaurant owner	5.1	9
Bar/restaurant worker	4.5	8
Liquor store owner	2.3	4
Night club manager	0.6	1
Shop owner	2.3	4
Businessman	0.6	1
Professional worker (governmental and non-governmental workers)	4.0	7
Teacher	5.1	9
Health worker	4.0	7
Student	5.1	9
Youth out of school	6.2	11
Military/police officer*	7.9	14
Receptionist	1.1	2
Fisherman	1.1	2
Unemployed individual	7.3	13
Priest/imam	4.0	7
Traditional religious leader	2.3	4
Praise singer	1.1	2
Other	3.4	6
Total	100	177

*Includes members of police, military, customs official, prison guard

Table B7. Demographic characteristics of key informants, Tenkodogo Health District, 2001

	% of all key informants	n
Mean age		32.1
Gender		
Male	91.5	161
Female	8.5	15
Total	100	176
Lives in the study village		
Yes	90.3	159
No	9.7	17
Total	100	176

Table B8. Number of sites and events named by key informants, Tenkodogo Health District, 2001

	Tenkodogo (N=79)	Beguedo/Niaogho (N=48)	Bittou (N=49)	Total (N=176)
Number site reports	502	181	235	918
Mean number of site reports per key informant	6.4	3.8	4.8	5.2
Number of unique sites identified	89	35	35	159
Number event reports	163	99	105	367
Mean number of events named by key informants	2.1	2.1	2.1	2.1

*Some of the same sites were named by key informants from each of the three areas in the district, therefore a total of unique sites and events for the district will be less than the addition of all unique reports made in each of the three areas.

Appendix C: Tables for Site Verification Interviews

Table C1. Summary of fieldwork for site verification, Banfora Health District, 2001

	Banfora	Rural villages	Niangoloko	Total
Number of days of site verification	2	3.5	1	6.5
Number of interviewers	9	8	8	Not applicable
Number of site verification interviews	96	103	35	234
Response rates for interviews	98.0% (96/98)	96.3% (103/107)	97.2% (35/36)	97.1% (234/241)

Table C2. Results of site verification, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	%	n	%	n	%	n	%	n
Site found and site owner participated in interview	89.7	96	89.6	103	85.4	35	89.0	234
Site found but site owner not willing to participate in interview	1.9	2	3.5	4	2.4	1	2.7	7
Site not identified or closed	8.4	9	7.0	8	12.2	5	8.4	22
Total	100	107	100	115	100	41	100	263

Table C3. Demographic characteristics of site verification respondents, Banfora Health District, 2001

	Banfora (N=96)		Rural villages (N=103)		Niangoloko (N=35)		Total (N=234)	
	%	n	%	n	%	n	%	n
Mean age (years)		30.3		30.8		29.4		30.4
Gender								
Male	70.8	68	51.5	53	71.4	25	62.4	146
Female	29.2	28	48.5	50	28.6	10	37.4	88
Total	100	96	100	103	100	35	100	234

Table C4. Type of sites visited for verification, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	%	n	%	n	%	n	%	n
Caberet (Small bar where people make home brew)	10.3	11	38.3	44	19.5	8	24.0	63
Maquis (Small bar selling manufactured liquor)	19.6	21	7.0	8	19.5	8	14.1	37
Tea "club" (Gathering of men who make tea)	4.7	5	16.5	19	4.9	2	9.9	26
Bar with dancing	10.3	11	3.5	4	9.8	4	7.2	19
Chambre de passe (Brothel)	12.2	13	3.5	4	9.8	4	8.0	21
Street	9.4	10	5.2	6	4.9	2	6.8	18
Video club (Gathering to watch VCR video)	0.9	1	4.4	5	7.3	3	3.4	9
Restaurant	4.7	5	1.7	2	2.4	1	3.0	8
Station (Bus, Train, Truck)	2.8	3	1.7	2	7.3	3	3.0	8
Hotel	4.7	5	0.0	0	2.4	1	2.3	6
Liquor store	2.8	3	2.6	3	2.4	1	2.7	7
Market place	1.9	2	3.5	4	2.4	1	2.7	7
School	2.8	3	2.6	3	0.0	0	2.3	6
Street food vendor	1.9	2	2.6	3	0.0	0	1.9	5
Church, mosque	0.9	1	3.5	4	0.0	0	1.9	5
Film cinema	1.9	2	0.0	0	0.0	0	0.8	2
Near the waterfall	1.9	2	0.0	0	0.0	0	0.8	2
Night club	0.9	1	0.0	0	0.0	0	0.4	1
Sporting stadium/field	0.9	1	0.0	0	0.0	0	0.4	1
Other*	4.7	5	3.5	4	7.3	3	4.6	12
Total	100	107	100	115	100	41	100	263

*"Other" types of sites include the Red Cross Center, the hospital, the district health center, the gas station, the telephone calling center, the airport, the jewelry store and the community center.

Table C5. Operation of the site: Number working at the site and years in operation, Banfora Health District, 2001

	Banfora (N=96)		Rural villages (N=103)		Niangoloko (N=35)		Total (N=234)	
	%	n	%	n	%	n	%	n
Percent who report various number of men								
0-10 men	86.5	83	95.2	98	91.4	32	91.0	213
11-20 men	4.2	4	1.9	2	5.7	2	3.4	8
21-30 men	3.1	3	0.0	0	0.0	0	1.3	3
31-40 men	1.0	1	0.0	0	0.0	0	0.4	1
Over 40 men	2.1	2	2.9	3	2.9	1	2.6	6
Missing	3.1	3	0.0	0	0.0	0	1.3	3
Total	100.0	96	100.0	103	100.0	35	100	234
Mean number of men reported		6.2		9.0		8.5		7.8
Median number of men reported		2.0		0.0		2.0		1.0
Percent who report various number of women								
0-10 women	93.8	90	90.3	93	94.3	33	92.3	216
11-20 women	1.0	1	3.9	4	2.9	1	2.6	6
21-30 men	0.0	0	1.9	2	0.0	0	0.9	2
31-40 men	0.0	0	1.0	1	0.0	0	0.4	1
Over 40 men	2.1	2	2.9	3	2.9	1	2.6	6
Missing	3.1	3	0.0	0	0.0	0	1.3	3
Total	100.0	96	100.0	103	100.0	35	100	234
Mean number of women reported		4.4		12.2		4.8		8.0
Median number of men reported		1.0		1.0		1.0		1.0
Mean number of years site has been in operation		2.0		2.1		1.9		2.0

Table C6. Average number of patrons observed at time of site verification, Banfora Health District, 2001

	Banfora (N=99)		Rural villages (N=112)		Niangoloko (N=35)		Total (N=159)	
	Men	Women	Men	Women	Men	Women	Men	Women
Mean number so-cializing at site	11.3	9.1	12.4	11.1	6.4	3.1	11.1	9.1
Median number socializing	4.0	2.0	2.0	1.0	3.0	1.0	3.0	1.0

*including sites where respondent did not agree to interview

Table C7. Numbers of patrons at peak times, Banfora Health District, 2001

	Banfora (N=96)		Rural villages (N=103)		Niangoloko (N=35)		Total (N=234)	
	%	n	%	n	%	n	%	n
Number of men come to site (percent of site representatives)								
0-10 men	10.4	10	14.6	15	20.0	7	13.7	32
11-20 men	22.9	22	33.0	34	25.7	9	27.8	65
21-50 men	29.2	28	33.0	34	25.7	9	30.3	71
51-100 men	21.9	21	9.7	10	20.0	7	16.2	38
101-300 men	9.4	9	6.8	7	8.6	3	8.1	19
301-500 men	2.1	2	1.9	2	0.0	0	1.7	4
501-1000 men	4.2	4	1.0	1	0.0	0	2.1	5
Total	100	96	100	103	100	35	100	234
Number of women come to site (percent of site representatives)								
0-10 women	36.5	35	57.3	59	62.9	22	49.6	116
11-20 women	20.8	20	23.3	24	17.1	6	21.4	50
21-50 women	21.9	21	10.7	11	14.3	5	15.8	37
51-100 women	9.4	9	5.8	6	0.0	0	6.4	15
101-300 women	5.2	5	1.0	1	5.7	2	3.4	8
301-500 women	2.1	2	1.0	1	0.0	0	1.3	3
501-1000 women	3.1	3	1.0	1	0.0	0	1.7	4
Missing	1.0	1	0.0	0	0.0	0	0.4	1
Total	100	96	100	103	100	35	100	234

Table C8. Time periods when the site is most busy, Banfora Health District, 2001

	Banfora (N=96)		Rural villages (N=103)		Niangoloko (N=35)		Total (N=234)	
	%	n	%	n	%	n	%	n
Rainy season	7.3	7	3.9	4	5.7	2	5.6	13
Dry season	46.9	45	80.6	83	74.3	26	65.8	154
School vacation	15.6	15	6.8	7	14.3	5	11.5	27
Pay period	2.1	2	1.9	2	5.7	2	2.6	6
End of the month	52.1	50	19.4	20	42.9	15	36.3	85
End of the year	40.6	39	30.1	31	34.3	12	35.0	82
End of the harvest season	4.2	4	19.4	20	11.4	4	12.0	28
Season of funerals and weddings	4.2	4	11.7	12	8.6	3	8.1	19
Other	15.6	15	4.9	5	11.4	4	10.3	24

Table C9. Activities that take place at the site, Banfora Health District, 2001

	Banfora (N=96)		Rural villages (N=103)		Niangoloko (N=35)		Total (N=234)	
	%	n	%	n	%	n	%	n
Drinking beer, liquor or home brew	66.7	64	58.3	60	68.6	24	63.3	143
Musical performance	41.7	40	25.2	26	60.0	21	37.2	87
TV/VCR video showing	11.5	11	7.8	8	17.1	6	10.7	25
Dancing	12.5	12	6.8	7	8.6	3	9.4	22
Smoking marijuana	3.1	3	1.0	1	0.0	0	1.7	4
Other*	53.1	51	50.5	52	51.4	18	51.7	121

***** Over half of site verifiers reported that other activities take place at the site, such as eating and drinking non alcoholic drinks, such as tea. Other activities included studying and playing games, such as cards or soccer. At brothels and hotels, sexual activity was reported as the activity.

Table C10. Proportion of site verifiers who report sexual encounter takes place at the site, Banfora Health District, 2001

	Banfora (N=96)		Rural villages (N=103)		Niangoloko (N=35)		Total (N=234)	
	%	N	%	n	%	n	%	n
Men come to meet new female partners	83.3	80	84.5	87	88.6	31	84.6	198
Women come to meet new male partners	70.8	68	73.8	76	77.1	27	73.1	171
Men come to meet new male partners	4.2	4	0.0	0	0.0	0	1.7	4
Someone facilitates sexual partnership	18.8	18	10.7	11	8.6	3	13.7	32
Sex workers come to solicit new partners	12.5	12	6.8	7	22.9	8	11.5	27

Table C11. Percent of sites in the Banfora Health District with patrons from…

	Banfora (N=96)		Rural villages (N=103)		Niangoloko (N=35)		Total (N=234)	
	%	N	%	n	%	n	%	n
Study village	97.7	93	100.0	103	100.0	35	98.7	231
Town of Banfora	n/a	n/a	55.3	57	68.6	24	58.7	81
Bobo-Dioulasso	77.1	74	26.2	27	51.4	18	50.9	119
Koudougou	40.6	39	3.9	4	40.0	14	24.4	57
Ouagadougou	63.5	61	9.7	16	37.2	87	37.2	87
Ouaighouiya	33.3	32	5.8	6	31.4	11	20.9	49
Elsewhere in Banfora Health District	76.0	73	63.1	65	68.6	24	69.2	162
Elsewhere in Burkina Faso	67.7	65	30.1	31	45.7	16	47.9	112
Abidjan, Côte d'Ivoire	31.3	30	9.7	10	31.4	11	21.8	51
Elsewhere in Côte d'Ivoire	57.3	55	14.6	15	54.3	19	38.0	89
Bamako, Mali	19.8	19	2.9	3	22.9	8	12.8	30
Elsewhere in Mali	38.5	37	6.8	7	37.1	13	24.4	57
Accra, Ghana	16.7	16	1.9	2	17.1	6	10.3	24
Elsewhere in Ghana	31.3	30	7.8	8	22.9	8	19.7	46
Elsewhere outside Burkina Faso	54.2	52	8.7	9	22.9	8	29.5	69

Table C12. Percentage of sites in the Banfora Health District reporting at least some male patrons are. . .

	Banfora (N=96)		Rural villages (N=103)		Niangoloko (N=35)		Total (N=234)	
	%	N	%	n	%	n	%	n
Unemployed	70.8	68	85.4	88	48.6	17	73.9	173
Students	64.6	62	45.6	47	60.0	21	55.6	130
Younger than 18 years old	50.0	48	45.6	47	42.9	15	47.0	110
Live 10 minutes walk from the site	77.1	74	98.1	101	94.3	33	88.9	208
Live in the study village	93.8	90	100.0	103	100.0	35	97.4	228
Live in Banfora Health District	91.7	88	96.1	99	100.0	35	94.9	222
Live outside Burkina Faso	71.9	69	22.3	23	57.1	20	47.9	112
Come to the site at least once a week	91.7	88	99.0	102	100.0	35	96.2	225
Find new sexual partners at the site	65.6	63	73.8	76	91.4	32	73.1	171
Drink alcohol	70.8	68	64.1	66	68.6	24	67.5	158

Table C13. Percentage of sites in the Banfora Health District reporting at least some female patrons are. . .

	Banfora (N=96)		Rural villages (N=103)		Niangoloko (N=35)		Total (N=234)	
	%	N	%	n	%	n	%	n
Unemployed	68.8	66	81.6	84	65.7	23	73.9	173
Students	60.4	58	41.8	43	60.0	21	52.1	122
Younger than 18 years old	52.1	50	46.6	48	45.7	16	48.7	114
Live 10 minutes walk from the site	75.0	72	96.1	99	91.4	32	86.8	203
Live in the study village	92.7	89	98.1	101	97.1	34	95.7	224
Live in Banfora Health District	88.5	85	95.2	98	97.1	34	92.7	217
Live outside Burkina Faso	60.4	58	21.4	22	54.3	19	42.3	99
Come to the site at least once a week	87.5	84	95.2	98	97.1	34	92.3	216
Find new sexual partners at the site	61.5	59	68.9	71	82.9	29	68.0	159
Drink alcohol	63.5	61	63.1	65	65.7	23	63.7	149

Table C14. AIDS-prevention activities at the sites, Banfora Health District, 2001

	Banfora (N=96)		Rural villages (N=103)		Niangoloko (N=35)		Total (N=234)	
	%	N	%	n	%	n	%	n
Has ever had AIDS-prevention activities at the site	27.1	26	18.5	19	25.7	9	23.1	54
Has ever given or sold condoms								
Always	10.4	10	1	1	0	0	4.7	11
Sometimes	17.7	17	11.7	12	17.1	6	15	35
Never	63.5	61	85.4	88	74.3	26	74.8	175
Doesn't know	8.3	8	1.9	2	8.6	3	5.6	13
Total	100	96	100	103	100	35	100	234
Gave condoms in the month preceding interview	6.3	6	1.9	2	8.6	3	4.7	11
Sold condoms in the month preceding interview	7.3	7	4.9	5	8.6	3	6.4	15
Availability of condoms at the time of the interview								
Condoms available, but were not shown to inter-viewer	4.2	4	2.9	3	5.7	2	3.9	9
Condoms available, and were shown to inter-viewer	18.8	18	12.6	13	20.0	7	16.2	38
Condoms not available	75.0	72	83.5	86	74.3	26	78.6	184
Missing	2.1	2	1.0	1	0.0	0	1.3	3
Total	100	96	100	103	100	35	100	234
Possibility of finding a condom within a ten minute walk after 9pm at various locations								
Bar/restaurant/hotel	16.7	16	8.7	9	22.9	8	14.1	33
Pharmacy	30.2	29	28.2	29	37.1	13	30.3	71
Street vendor	86.5	83	81.6	84	94.3	33	85.5	200
Shop	37.5	36	34.0	35	48.6	17	37.6	88
Other	8.3	8	1.0	1	5.7	2	4.7	11
Willing to host AIDS-prevention activities on site	78.1	75	85.4	88	85.7	30	82.5	193
Willing to sell condoms on site	71.9	69	53.4	55	62.9	22	62.4	146
Had AIDS-prevention materials at the time of the interview								
AIDS posters visible	13.5	13	7.8	8	5.7	2	9.8	23
AIDS brochures visible	5.2	5	1.0	1	0.0	0	2.6	6
Condoms visible	6.3	6	7.8	8	5.7	2	6.8	16

Table C15. Summary of fieldwork for site verification, Tenkodogo Health District, 2001

	Tenkodogo	Beguedo/Niaogho	Bittou	Total
Number of days of site verification	2	2	1	5
Number of interviewers	8	8	8	8
Number of site verification interviews	85	30	30	145
Response rates for interviews	97.7% (85/87)	100% (30/30)	100% (30/30)	98.6% (145/147)

Table C16. Results of site verification, Tenkodogo Health District, 2001

	Tenkodogo (N=89)		Beguedo/ Niaogho (N=35)		Bittou (N=35)		Total (N=159)	
	%	n	%	n	%	n	%	n
Site found and site owner participated in interview	95.5	85	85.7	30	85.7	30	91.2	145
Site found but site owner not willing to participate in interview	2.3	2	0.0	0	0.0	0	1.3	2
Site not identified or closed	2.3	2	14.3	5	14.3	5	7.5	12
Total	100	89	100	35	100	35	100	159

Table C17. Demographic characteristics of site verifiers, Tenkodogo Health District, 2001

	Tenkodogo (N=85)		Beguedo/Niaogho (N=30)		Bittou (N=30)		Total (N=145)	
	%	n	%	n	%	n	%	n
Mean age (years)		31.1		30.9		30.9		31.0
Gender								
Male	69.4	59	73.3	22	70.0	21	70.3	102
Female	30.6	26	26.7	8	30.0	9	29.7	43
Total	100	85	100	30	100	30	100	145

Table C18. Type of sites visited for verification, Tenkodogo Health District, 2001

	Tenkodogo (N=89)		Beguedo/ Niaogho (N=35)		Bittou (N=35)		Total (N=159)	
	%	N	%	n	%	n	%	n
Caberet (Small bar where people make home brew)	22.5	20	11.4	4	11.4	4	17.6	28
Maquis (Small bar selling manufactured liquor)	22.5	20	0.0	0	14.3	5	15.7	25
Market place	5.7	5	17.1	6	8.6	3	8.8	14
Bar with dancing	5.6	5	11.4	4	0.0	0	6.9	11
Video club (Gathering to watch VCR video)	4.5	4	11.4	4	8.6	3	6.9	11
Restaurant*	1.1	1	2.9	1	17.1	6	5.0	8
Hotel	4.5	4	0.0	0	8.6	3	4.4	7
School	4.5	4	2.9	1	5.7	2	4.4	7
Street food vendor	0.0	0	8.6	3	8.6	3	3.8	6
Store selling alcohol	2.3	2	8.6	3	0.0	0	3.1	5
Tea “club” (Gathering of men who make tea)	4.5	4	0.0	0	0.0	0	2.5	4
Chambre de passe (Brothel)	5.6	5	2.9	1	0.0	0	2.5	4
Film cinema	2.3	2	0.0	0	2.9	1	1.9	3
Street	2.3	2	2.9	1	0.0	0	1.9	3
Empty lot	2.3	2	2.9	1	0.0	0	1.9	3
Station (Bus, Train, Truck)	1.1	1	0.0	0	2.9	1	1.3	2
Private home	1.1	1	0.0	0	2.9	1	1.3	2
Church, mosque	2.3	2	0.0	0	0.0	0	1.3	2
Sporting stadium/field	2.2	2	0.0	0	0.0	0	1.3	2
Night club	1.1	1	0.0	0	0.0	0	0.6	1
Parking lot	0.0	0	0.0	0	2.9	1	0.6	1
Garden	0.0	0	2.9	1	0.0	0	0.6	1
Other**	2.3	2	14.3	5	5.7	2	5.7	9
Total	100	89	100	35	100	35	100	159

*A restaurant is considered either an indoor building or an open-air kiosque with stools where food is served.

** Other sites include a toll booth, a shop, the community center, the hydroelectric dam, the hospital, the Red Cross. “Other” types of sites include the Red Cross Center, the hospital, the toll collector, a town store, the loading and unloading zone for fish commerce, on the side of the dam and the community center.

Table C19. Operation of the site: Number working at the Site and Years in Operation, Tenkodogo Health District, 2001

	Tenkodogo (N=85)		Beguedo/ Niaogho (N=30)		Bittou (N=30)		Total (N=145)	
	%	n	%	n	%	n	%	n
Percent who report various number of men								
0-10 men	82.4	70	73.3	22	90.0	27	82.1	119
11-20 men	5.9	5	10.0	3	3.3	1	6.2	9
21-30 men	1.2	1	0.0	0	0.0	0	0.7	1
31-40 men	4.7	4	3.3	1	0.0	0	3.5	5
Over 40 men	4.7	4	13.3	4	6.7	2	6.9	10
Missing	1.2	1	0.0	0	0.0	0	0.7	1
Total	100	85	100	30	100	30	100	145
Mean number of men reported		14.9		82.2		7.5		27.3
Median number of men reported		2.0		2.0		2.0		2.0
Percent who report various number of women								
0-10 women	90.6	76.7	23	77	93.3	28	88.3	128
11-20 women	2.4	10.0	3	2	0.0	0	3.5	5
21-30 women	0.0	6.7	2	0	3.3	1	2.1	3
31-40 women	1.2	0.0	0	1	0.0	0	0.7	1
Over 20 women	4.7	6.7	2	4	3.3	1	4.8	7
Missing	1.2	0.0	0	1	0.0	0	0.7	1
Total	100	100	30	85	100	30	100	145
Mean number of women reported			72.9	12.6		6.0		23.8
Median number of women reported			2.0	2.0		0.0		2.0
Mean number of years site has been in operation			1.8	2.0		1.8		1.9

Table C20. Average number of patrons observed at time of site verification, Tenkodogo Health District, 2001

	Tenkodogo (N=89)		Beguedo/Niaogho (N=35)		Bittou (N=35)		Total (N=159)	
	Men	Women	Men	Women	Men	Women	Men	Women
Mean number socializing at site	11.8	7.8	55.0	39.5	8.8	3.5	19.9	13.3
Median number socializing	4.0	2.0	5.5	2.5	5.0	2.0	4.5	2.0

*including sites where respondent did not agree to interview

Table C21. Numbers of patrons at peak times, Tenkodogo Health District, 2001

	Tenkodogo (N=85)		Beguedo/ Niaogho (N=30)		Bittou (N=30)		Total (N=145)	
	%	n	%	n	%	n	%	n
Number of men come to site (percent of site representatives)								
0-10 men	3.5	3	0.0	0	3.3	1	2.8	4
11-20 men	30.6	26	36.7	11	30.0	9	31.7	46
21-50 men	34.1	29	40.0	12	26.7	8	33.8	49
51-100 men	18.8	16	6.7	2	10.0	3	14.5	21
101-300 men	4.7	4	10.0	3	20.0	6	9.0	13
301-500 men	3.5	3	3.3	1	6.7	2	4.1	6
501-1000 men	3.5	3	3.3	1	3.3	1	3.5	5
Missing values	1.2	1	0.0	0	0.0	0	0.7	1
Total	100	85	100	30	100	30	100	145
Number of women come to site (percent of site representatives)								
0-10 women	35.3	30	53.3	16	36.7	11	39.3	57
11-20 women	24.7	21	10.0	3	30.0	9	22.8	33
21-50 women	17.7	15	10.0	3	20.0	6	16.6	24
51-100 women	9.4	8	16.7	5	0.0	0	9.0	13
101-300 women	7.1	6	3.3	1	6.7	2	6.2	9
301-500 women	1.2	1	3.3	1	0.0	0	1.4	2
501-1000 women	3.5	3	3.3	1	6.7	2	4.1	6
Missing values	1.2	1	0.0	0	0.0	0	0.7	1
Total	100	85	100	30	100	30	100	145

Table C22. Time periods when the site is most busy, Tenkodogo Health District, 2001

	Tenkodogo (N=85)		Beguedo/ Niaogho (N=30)		Bittou (N=30)		Total (N=145)	
	%	n	%	n	%	n	%	n
Rainy season	12.9	11	20.0	6	6.7	2	13.1	19
Dry season	70.6	60	83.3	25	83.3	25	75.9	110
School vacation	17.7	15	10.0	3	16.7	5	15.9	23
Public holidays	40.0	34	16.7	5	33.3	10	33.8	49
End of the month	54.1	46	16.7	5	36.7	11	42.8	62
End of the harvest season	31.8	27	63.3	19	46.7	14	41.4	60
Season of funerals and weddings	24.7	21	13.3	4	16.7	5	20.7	30
Other*	35.3	30	10.0	3	23.3	7	27.6	40

*****Over half of site verifiers reported that other activities take place at the site, the most sited activity was eating and drinking non-alcoholic drinks, such as tea. Other activities include playing games, such as cards or soccer. Teaching bible classes or holding information sessions were also reported activities. Commerce, such as the selling of fish, meat, fruits or home brew, as well as milling were activities at some sites.

Table C23. Activities that take place at the site, Tenkodogo Health District, 2001

	Tenkodogo (N=85)		Beguedo/ Niaogho (N=30)		Bittou (N=30)		Total (N=145)	
	%	n	%	n	%	n	%	n
Drinking beer, liquor or home brew	70.6	60	40.0	12	36.7	11	57.2	83
Musical performance	37.7	32	26.7	8	20.0	6	31.7	46
Commerce	16.5	14	33.3	10	26.7	8	22.1	32
TV/VCR video showing	23.5	20	23.3	7	16.7	5	22.1	32
Dancing	9.4	8	10.0	3	3.3	1	8.3	12
Smoking marijuana	5.9	5	16.7	5	6.7	2	8.3	12
Other	57.7	49	50.0	15	73.3	22	59.3	86

Table C24. Proportion of site verifiers who report sexual encounter takes place at the site, Tenkodogo Health District, 2001

	Tenkodogo (N=85)		Beguedo/ Niaogho (N=30)		Bittou (N=30)		Total (N=145)	
	%	n	%	n	%	n	%	n
Men come to meet new female partners	83.5	71	83.3	25	90.0	27	84.8	123
Women come to meet new male partners	83.5	71	83.3	25	90.0	27	84.8	123
Men come to meet new male partners	2.4	2	0.0	0	3.3	1	2.1	3
Someone facilitates sexual partnership	10.6	9	3.3	1	10.0	3	9.0	13
Sex workers come to solicit new partners	16.5	14	0.0	0	30.0	9	15.9	23

Table C25. Percent of sites in the Tenkodogo Health District with patrons from…

	Tenkodogo (N=85)		Beguedo/ Niaogho (N=30)		Bittou (N=30)		Total (N=145)	
	%	n	%	n	%	n	%	n
Study village	97.7	83	100.0	30	100.0	30	98.6	143
Town of Tenkodogo	n/a	n/a	50.0	15	73.3	22	25.5	57
Koupela	55.3	47	6.7	2	70.0	21	48.3	70
Cinkanse	41.2	35	3.3	1	80.0	24	41.4	60
Ouagadougou	54.1	46	43.3	13	63.3	19	53.8	78
Bobo-Dioulasso	29.4	25	10.0	3	50.0	15	29.7	43
Koudougou	21.2	18	6.7	2	43.3	13	22.8	33
Ouahigouya	24.7	21	3.3	1	46.7	14	24.8	36
Elsewhere in the Tenkodogo Health District	78.8	67	76.7	23	86.7	26	80.0	116
Elsewhere in Burkina Faso	52.9	45	23.3	7	66.7	20	49.7	72
Niamey	10.6	9	0.0	0	60.0	18	18.6	27
Elsewhere in Niger	7.1	6	0.0	0	60.0	18	16.6	24
Lome	22.4	19	0.0	0	70.0	21	27.6	40
Elsewhere in Togo	23.5	20	3.3	1	66.7	20	28.3	41
Accra	15.3	13	0.0	0	70.0	21	23.5	34
Elsewhere in Ghana	20.0	17	3.3	1	70.0	21	26.9	39
Nigeria	5.9	5	0.0	0	50.0	15	73.1	20
Elsewhere outside of Burkina Faso	23.5	20	6.7	2	53.3	16	26.2	38

There is high degree of variability regarding the degree of mobility that site verifiers in each area report. Significant proportions of site verifiers in the border town…

Table C26. Percentage of sites in the Tenkodogo Health District reporting at least some male patrons are. . .

	Tenkodogo (N=85)		Beguedo/ Niaogho (N=30)		Bittou (N=30)		Total (N=145)	
	%	n	%	n	%	n	%	n
Unemployed	85.9	73	93.3	28	90.0	27	88.3	128
Student	67.1	57	56.7	17	53.3	16	62.1	90
Younger than 18 years old	54.1	46	86.7	26	63.3	19	62.8	91
Live 10 minutes walk from the site	95.3	81	100.0	30	100.0	30	97.2	141
Live in the study village	98.8	84	100.0	30	100.0	30	99.3	144
Live in Tenkodogo Health District	97.7	83	100.0	30	100.0	30	98.6	143
Live outside Burkina Faso	43.5	37	6.7	2	80.0	24	43.5	63
Come to the site at least once a week	96.5	82	96.7	29	100.0	30	97.2	141
Find new sexual partners at the site	75.3	64	83.3	25	86.7	26	79.3	115
Drink alcohol	75.3	64	46.7	14	46.7	14	63.5	92

Table C27. Percentage of sites in the Tenkodogo Health District reporting at least some female patrons are. . .

	Tenkodogo (N=85)		Beguedo/ Niaogho (N=30)		Bittou (N=30)		Total (N=145)	
	%	n	%	n	%	n	%	n
Unemployed	83.5	71	90.0	27	80.0	24	84.1	122
Student	64.7	55	56.7	17	50.0	15	60.0	87
Younger than 18 years old	56.5	48	83.3	25	60.0	18	62.8	91
Live 10 minutes walk from the site	87.1	74	90.0	27	90.0	27	88.3	128
Live in the study village	97.7	83	96.7	29	90.0	27	95.9	139
Live in Tenkodogo Health District	96.5	82	96.7	29	90.0	27	95.2	138
Live outside Burkina Faso	35.3	30	6.7	2	70.0	21	36.6	53
Come to the site at least once a week	92.9	79	93.3	28	90.0	27	92.4	134
Find new sexual partners at the site	74.1	63	83.3	25	83.3	25	77.9	113
Drink alcohol	74.1	63	40.0	12	40.0	12	60.0	87

Table C28. AIDS-prevention activities at the sites, Tenkodogo Health District, 2001

	Tenkodogo (N=85)		Beguedo/ Niaogho (N=30)		Bittou (N=30)		Total (N=145)	
	%	n	%	n	%	n	%	N
Has ever had AIDS-prevention activities	30.6	26	36.7	11	53.3	16	36.6	53
Has ever given or sold condoms								
Always	15.3	13	13.3	4	16.7	5	15.2	22
Sometimes	11.8	10	13.3	4	6.7	2	11.0	16
Never	68.2	58	73.3	22	76.7	23	71.0	103
Does not know	4.7	4	0.0	0	0.0	0	2.8	4
Total	100	85	100	30	100	30	100	145
Gave condoms in the month preceding inter-view	4.7	4	0.0	0	6.7	2	4.1	6
Sold condoms in the month preceding inter-view	10.6	9	13.3	4	13.3	4	13.3	17
Availability of condoms at the time of the interview								
Condoms available, but were not shown to inter-viewer	4.7	4	0.0	0	6.7	2	4.1	6
Condoms available, and were shown to inter-viewer	15.3	13	16.7	5	13.3	4	15.2	22
Condoms not available	78.8	67	83.3	25	80.0	24	80.0	116
Missing	1.2	1	0.0	0	0.0	0	0.7	1
Total	100	85	100	30	100	30	100	145
Possibility of finding a condom within a ten minute walk after 9pm at various locations								
Bar/restaurant/hotel	32.9	28	0.0	0	30.0	9	25.5	37
Pharmacy	27.1	23	6.7	2	30.0	9	23.5	34
Street vendor	85.9	73	76.7	23	93.3	28	85.5	124
Shop	29.4	25	16.7	5	36.7	11	28.3	41
Other	4.7	4	13.3	4	0.0	0	5.5	8
Willing to host AIDS-prevention activities on site	88.2	75	86.7	26	96.7	29	89.7	130
Willing to sell condoms on site	68.2	58	70.0	21	70.0	21	69.0	100
Had AIDS-prevention materials at the time of the interview								
AIDS posters visible	7.9	7	14.3	5	11.4	4	10.1	16
AIDS brochures visible	4.5	4	0.0	0	5.7	2	3.8	6
Condoms visible	11.2	10	2.9	1	5.7	2	6.9	13

Appendix D: Tables for Individual Interviews

Table D1. Summary of fieldwork for interview of individuals when socializing at the site, Banfora Health District, 2001

	Banfora	Rural villages	Niangoloko	Total
Number of days of individual interviews	3	6	2	11
Number of interviewers	9	8	8	Not applicable
Number of sites visited	9	23*	9	41
Number of individual interviews	203	468	172	843
Percent male among interviewed	70.4% (143/203)	69.0% (323/468)	67.4% (116/172)	69.0% (582/843)

*The site total for the rural villages includes interviews that were administered at a wedding in place of a geographically located site in Bérégadougou.

Table D2. Response rates: Percent of men and women who participated in the interview, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	%	n	%	n	%	n	%	n
Men	92.9	143/154	94.4	323/342	95.9	116/121	94.3	582/617
Women	81.1	60/74	87.4	145/166	86.2	56/65	85.6	261/305
Total	89.0	203/228	92.1	468/508	92.5	172/186	91.4	843/922

Table D3. Number of patrons observed at the sites, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	%	n	%	n	%	n	%	n
Distribution of numbers of men observed by interviewer								
0-10 men	42.1	96	59.9	305	88.7	165	61.3	566
11-20 men	24.1	55	19.7	100	8.6	16	18.5	171
21-30 men	6.6	15	9.2	47	2.1	4	7.2	66
31-40 men	10.1	23	3.0	15	0.5	1	4.2	39
Over 40 men	16.7	38	7.9	40	0.0	0	8.5	78
Total	100	227	100	507	100	186	100	920
Mean number of men		26.0		14.7		6.0		15.8
Median number of men		13.0		8.0		5.0		8.0
Distribution of number of women observed by interviewer								
0-10 women	72.4	165	84.9	432	95.2	177	83.9	774
11-20 women	14.0	32	9.0	46	4.3	8	9.3	86
21-30 women	4.0	9	2.4	12	0.5	1	2.4	22
31-40 women	1.8	4	1.2	6	0.0	0	1.1	10
Over 40 women	7.5	17	2.2	11	0.0	0	3.0	28
Total	100	227	100	507	100	186	100	920
Mean number of women		11.8		7.1		3.6		7.5
Median number of women		5.0		3.0		3.0		3.0

Table D4. Age of patrons, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	Men (N=143)	**Women (N=60)**	**Men (N=323)**	**Women (N=145)**	**Men (N=116)**	**Women (N=56)**	**Men (N=582)**	**Women (N=261)**
Percent of men and women in each age group								
15-19 years	2.8	31.7	11.8	45.5	5.2	32.1	8.3	39.5
20-24 years	29.4	38.3	30.3	29.0	19.0	21.4	27.9	29.5
25-29 years	28.0	11.7	25.7	13.8	39.7	30.4	29.0	16.9
30-34 years	23.8	6.7	15.2	3.5	19.8	7.1	18.2	5.0
35-39 years	6.3	1.7	9.3	4.1	8.6	5.4	8.4	3.8
Over 40 years	7.7	3.3	7.7	2.8	7.8	3.6	7.7	3.1
Missing	2.1	6.7	0.0	1.4	0.0	0.0	0.5	2.3
Total	100	100	100	100	100	100	100	100
Mean age (years)	28.6	22.6	27.5	21.9	28.8	24.2	28.0	22.6

Table D5. Socio-demographic characteristics of individuals socializing at the sites, percent by gender, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	Men (N=143)	Women (N=60)	Men (N=323)	Women (N=145)	Men (N=116)	Women (N=56)	Men (N=582)	Women (N=261)
Employment status								
Unemployed	13.3	48.3	28.2	62.8	17.2	41.1	22.3	54.8
Employed part-time	39.2	28.3	41.5	26.9	31.0	46.4	38.8	31.4
Employed full-time	47.6	21.7	29.4	7.6	51.7	12.5	38.3	11.9
Missing values	0.0	1.7	0.9	2.8	0.0	0.0	0.5	1.9
Total	100	100	100	100	100	100	100	100
Current student status								
Yes	8.4	21.7	9.0	15.2	8.6	14.3	8.8	16.5
No	90.2	75.0	89.8	82.1	91.4	85.7	90.2	81.2
Missing values	1.4	3.3	1.2	2.8	0.0	0.0	1.0	2.3
Total	100	100	100	100	100	100	100	100
Years of education								
None	19.6	26.7	38.1	37.9	23.3	33.9	30.6	34.5
1-5 (Primary)	11.9	21.7	14.9	19.3	9.5	19.6	13.1	19.9
6-9 years (Secondary)	28.7	33.3	26.3	26.2	33.6	39.3	28.4	30.7
10 years or more	39.9	16.7	19.8	14.5	33.6	7.1	27.5	13.4
Missing value	0.0	1.7	0.9	2.1	0.0	0.0	0.5	1.5
Total	100	100	100	100	100	100	100	100
Residence								
Study village	87.4	85.0	74.6	90.3	79.3	80.4	76.1	86.2
Town of Banfora	N/a	N/a	6.2	2.8	3.5	1.8	6.7	2.7
Bobo-Dioulasso	3.5	3.3	4.3	2.1	6.9	3.6	4.6	2.7
Koudougou	0.0	0.0	0.0	0.7	0.0	1.8	0.0	0.8
Ouagadougou	0.7	0.0	1.2	0.0	5.2	1.8	1.9	0.4
Ouaighouiya	0.0	0.0	0.3	0.0	0.0	0.0	0.2	0.0
Elsewhere in Banfora Health District	4.2	1.7	9.3	2.1	1.7	0.0	6.5	1.5
Elsewhere in Burkina Faso	2.1	0.0	0.9	0.7	0.0	1.8	1.0	0.8
Côte d'Ivoire	1.4	5.0	0.6	0.0	3.4	3.6	1.4	2.0
Mali	0.0	0.0	0.6	0.0	0.0	1.8	0.3	0.4
Ghana	0.0	1.7	0.0	0.0	0.0	0.0	0.0	0.4
Elsewhere outside Burkina Faso	0.7	0.0	0.0	0.7	0.0	3.6	0.2	1.2
Missing value	0.0	3.3	1.9	0.7	0.0	0.0	1.0	1.2
Total	100	100	100	100	100	100	100	100
Years respondent has lived in stated residence								
Less than 1 year	11.9	11.7	10.8	11.7	20.7	41.1	13.1	18.0
1-5 years	29.4	33.3	22.0	25.5	21.6	28.6	23.7	28.0
6-10 years	11.9	6.7	14.6	9.0	15.5	3.6	14.1	7.3
More than 10 years	46.9	46.7	52.6	53.8	42.2	26.8	49.1	46.4
Missing values	0.0	1.7	0.0	0.0	0.0	0.0	0.0	0.4
Total	100	100	100	100	100	100	100	100

Table D6. Site attendance by individuals interviewed at sites, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	Men (N=143)	Women (N=60)	Men (N=323)	Women (N=145)	Men (N=116)	Women (N=56)	Men (N=582)	Women (N=261)
Frequency of attendance								
Every Day	23.1	33.3	26.3	34.5	37.1	58.9	27.7	39.5
4-6 Times Per Week	14.7	10.0	6.8	5.5	3.5	1.8	8.1	5.8
2-3 Times Per Week	11.9	15.0	17.3	15.9	20.7	7.1	16.7	13.8
Once a Week	9.8	11.7	22.9	18.6	7.8	3.6	16.7	13.8
2-3 Times Per Month	10.5	11.7	11.2	9.7	12.9	1.8	11.3	8.4
Once a Month	8.4	6.7	3.1	1.4	4.3	7.1	4.6	3.8
Less than once a month	15.4	5.0	8.1	11.0	10.3	14.3	10.3	10.3
First visit	4.9	6.7	4.3	2.8	3.5	5.4	4.3	4.2
Missing values	1.4	0.0	0.0	0.7	0.0	0.0	0.3	0.4
Total	100	100	100	100	100	100	100	100
Time when respondent first visited site								
Night of interview	4.9	6.7	4.3	2.8	3.5	7.1	4.3	4.6
In the month preceding interview	6.3	6.7	3.1	4.8	3.5	12.5	4.0	6.9
In 2-6 months preceding interview	11.2	13.3	9.3	17.9	15.5	32.1	11.0	19.9
In 7-12 months preceding interview	9.1	16.7	10.5	17.2	17.2	14.3	11.5	16.5
More than 1 year preceding interview	46.9	33.3	42.7	29.7	37.1	28.6	42.6	30.3
More than 5 years preceding interview	18.9	15.0	26.9	22.8	22.4	5.4	24.1	17.2
Missing values	2.8	8.3	3.1	4.8	0.9	0.0	2.6	4.6
Total	100	100	100	100	100	100	100	100
Attended sites before the interview								
0	60.8	75.0	76.8	77.9	75.0	91.1	72.5	80.1
1	27.3	20.0	18.0	19.3	22.4	5.4	21.1	16.5
2	4.2	3.3	3.4	2.1	2.6	1.8	3.4	2.3
3+	7.7	1.7	1.9	0.7	0.0	1.8	2.9	1.2
Total	100	100	100	100	100	100	100	100
Will attend sites after the interview								
0	75.5	85.0	75.2	84.1	84.5	89.3	77.2	85.4
1	22.4	15.0	21.7	13.8	14.7	10.7	20.4	13.4
2	0.7	0.0	2.2	1.4	0.9	0.0	1.5	0.8
3+	1.4	0.0	0.9	0.7	0.0	0.0	0.9	0.4
Total	100	100	100	100	100	100	100	100
Number of sites will visit that day, either before or after the interview								
1	46.2	66.7	63.2	69.7	63.8	85.7	59.1	72.4
2	34.3	23.3	23.8	19.3	29.3	8.9	27.5	18.0
3+	19.5	10.0	13.0	11.0	6.9	5.4	13.4	9.6
Total	100	100	100	100	100	100	100	100
Would attend multiple sites that day, either before or after the interview								
	53.8	33.3	36.8	30.3	36.2	14.3	40.9	27.6

Table D7. Partner selection reported by individuals interviewed at sites, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	Men (N=143)	Women (N=60)	Men (N=323)	Women (N=145)	Men (N=116)	Women (N=56)	Men (N=582)	Women (N=261)
Believe other people come to site to meet a new partner								
Yes	97.2	95.0	94.7	92.4	100.0	100.0	96.4	94.6
No	2.1	5.0	5.0	7.6	0.0	0.0	3.3	5.4
Missing values	0.7	0.0	0.3	0.0	0.0	0.0	0.3	0.0
Total	100	100	100	100	100	100	100	100
Interviewee attracted sexual partner at site								
Yes	28.7	40.0	29.1	27.6	30.2	64.3	29.2	38.3
No	70.6	60.0	70.6	71.7	69.8	35.7	70.5	61.3
Missing values	0.7	0.0	0.3	0.7	0.0	0.0	0.3	0.4
Total	100	100	100	100	100	100	100	100
Period of time since interviewee last attracted new sexual partner at site								
Within Past 7 Davs	3.5	5.0	1.9	2.8	1.7	26.8	2.2	8.4
Within Past 2-4 Weeks	7.0	6.7	7.1	6.2	6.0	10.7	6.9	7.3
Within the Past 2-3 months	7.0	11.7	6.8	6.2	3.5	5.4	6.2	7.3
Within Past 4-6	0.7	11.7	3.4	2.1	6.9	7.1	3.4	5.4
Within 7-12 Months	2.8	1.7	3.4	2.1	1.7	3.6	2.9	2.3
Over a Year Ago	7.0	6.7	6.8	8.3	10.3	10.7	7.6	8.4
Never Met a New Partner at Site	70.6	56.7	70.3	71.7	69.8	35.7	70.3	60.5
Missing values	1.4	0.0	0.3	0.7	0.0	0.0	0.5	0.4
Total	100	100	100	100	100	100	100	100

Table D8. Partner acquisition over 4 weeks of individuals interviewed at sites, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	Men (N=143)	Women (N=60)	Men (N=323)	Women N=145)	Men N=116)	Women (N=56)	Men (N=582)	Women (N=261)
Number of new partners in past 4 weeks*								
0	67.1	50.0	75.9	77.9	77.6	51.8	74.1	65.9
1	21.0	36.7	18.0	16.6	15.5	16.1	18.2	21.1
2	7.7	6.7	5.3	2.1	5.2	5.4	5.8	3.8
3-10	4.2	3.3	0.0	2.1	1.7	5.4	1.4	3.1
11-50	0.0	1.7	0.0	0.0	0.0	10.7	0.0	2.7
51-100	0.0	0.0	0.0	0.0	0.0	10.7	0.0	2.3
Missing values	0.0	1.7	0.9	1.4	0.0	0.0	0.5	1.2
Total	100	100	100	100	100	100	100	100
Mean number of new partners in past 4 weeks	0.5	0.8	0.3	0.3	0.3	9.7	0.4	2.5
Median number of new partners in past 4 weeks	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total number of different partners in past 4 weeks*								
0	25.2	18.3	30.0	29.0	26.7	7.1	28.2	21.8
1	46.2	43.3	50.2	56.6	48.3	55.4	48.8	53.3
2	16.8	21.7	12.7	9.0	19.0	7.1	15.0	11.5
3-10	11.9	13.3	6.2	4.1	6.0	8.9	7.6	7.3
11-50	0.0	1.7	0.0	0.0	0.0	10.7	0.0	2.7
51-100	0.0	0.0	0.0	0.0	0.0	10.7	0.0	2.3
Missing values	0.0	1.7	0.9	1.4	0.0	0.0	0.5	1.2
Total	100	100	100	100	100	100	100	100
Mean number of total partners in past 4 weeks	1.2	1.5	1.0	0.9	1.1	11.9	1.1	3.4
Median number of total partners in past 4 weeks	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0

*Among those who reported having a sexual partner in the past 12 months

Table D9. Partner acquisition over 12 months of individuals interviewed at sites, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	Men (N=143)	Women (N=60)	Men (N=323)	Women (N=145)	Men (N=116)	Women (N=56)	Men (N=582)	Women (N=261)
Number of new partners in past twelve months								
0	30.8	28.3	44.9	53.1	44.0	25.0	41.2	41.4
1	25.2	28.3	29.4	29.0	22.4	32.1	27.0	29.5
2	23.8	11.7	13.6	12.4	11.2	7.1	15.6	11.1
3-10	18.2	26.7	10.8	4.1	19.8	10.7	14.4	10.7
11-50	2.1	3.3	0.3	0.0	2.6	1.8	1.2	1.2
51-100	0.0	0.0	0.0	0.0	0.0	7.1	0.0	1.5
101-200	0.0	0.0	0.0	0.0	0.0	5.4	0.0	1.2
201+	0.0	0.0	0.0	0.0	0.0	10.7	0.0	2.3
Missing	0.0	1.7	0.9	1.4	0.0	0.0	0.5	1.2
Total	100	100	100	100	100	100	100	100
Mean number of new partners in past 12 months	1.8	2.0	1.1	0.7	1.7	115.2	1.4	26.0
Median number of new partners in past 12 months	1.0	1.0	1.0	0.0	1.0	1.0	1.0	1.0
Number of total partners in past twelve months								
0	4.2	0.0	7.4	6.9	3.5	3.6	5.8	4.6
1	21.7	30.0	38.1	49.0	30.2	19.6	32.5	38.3
2	22.4	16.7	20.7	22.1	25.9	30.4	22.2	22.6
3-10	46.9	48.3	31.6	20.0	37.9	21.4	36.6	26.8
11-50	4.9	3.3	1.2	0.7	2.6	1.8	2.4	1.5
51-100	0.0	0.0	0.0	0.0	0.0	5.4	0.0	1.2
101-200	0.0	0.0	0.0	0.0	0.0	3.6	0.0	0.8
Over 201	0.0	0.0	0.0	0.0	0.0	14.3	0.0	3.1
Missing	0.0	1.7	0.9	1.4	0.0	0.0	0.5	1.2
Total	100	100	100	100	100	100	100	100
Mean number of total partners in past 12 months	4.0	3.5	2.3	1.8	3.2	152.7	2.9	35.0
Median number of total partners in past 12 months	3.0	3.0	2.0	1.0	2.0	2.0	2.0	2.0

Table D10. Number of regular partners in the past 12 months*, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	Men (N=143)	Women (N=60)	Men (N=323)	Women N=145)	Men N=116)	Women (N=56)	Men (N=582)	Women (N=261)
Number of regular* partners in past twelve months								
0	12.6	11.7	15.8	13.8	11.2	10.7	14.1	12.6
1	60.8	65.0	68.4	75.2	63.8	64.3	65.6	70.5
2	19.6	18.3	10.5	7.6	18.1	14.3	14.3	11.5
3-10	4.9	3.3	4.3	2.1	6.9	7.1	5.0	3.5
11-50	0.7	0.0	0.0	0.0	0.0	0.0	0.2	0.0
51-100	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
101-200	0.0	0.0	0.0	0.0	0.0	1.8	0.0	0.4
201+	0.0	0.0	0.0	0.0	0.0	1.8	0.0	0.4
Missing	1.4	1.7	0.9	1.4	0.0	0.0	0.9	1.2
Total	100	100	100	100	100	100	100	100
Mean number of regular partners in past 12 months	1.3	1.2	1.0	1.0	1.2	8.3	1.2	2.6
Median number of regular new partners in past 12 months	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0

*Among those who reported having a sexual partner in the past 12 months

Table D11. Locations where respondents met recent sexual partner and origins of recent sexual partners, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	Men (N=99)	Women (N=43)	Men (N=178)	Women (N=68)	Men (N=65)	Women (N=42)	Men (N=342)	Women (N=153)
Location where respondents met most recent sexual partners*								
At the site of the interview	15.2	25.6	15.2	19.1	16.9	59.5	15.5	32.0
In the study village, but not at the site of inter-view	65.6	60.5	56.7	63.2	52.3	26.2	58.5	52.3
Town of Banfora	--	--	6.2	7.4	9.2	0.0	5.0	3.3
Bobo-Dioulasso	7.1	4.7	6.2	0.0	7.7	7.1	6.7	3.3
Ouagadougou	0.0	0.0	1.1	0.0	7.7	0.0	2.1	0.0
Ouaighouiya	1.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0
Elsewhere in Banfora Health District	3.0	4.7	5.6	5.9	1.5	0.0	4.1	3.9
Elsewhere in Burkina Faso	3.0	0.0	3.4	1.5	1.5	0.0	2.9	0.7
Côte d'Ivoire	2.0	2.3	2.8	0.0	3.1	7.1	2.6	2.6
Mali	1.0	0.0	1.1	0.0	0.0	0.0	0.9	0.0
Ghana	1.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0
Elsewhere outside Burkina	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Missing values	1.0	2.3	1.7	2.9	0.0	0.0	1.2	2.0
Total	100	100	100	100	100	100	100	100
Origin of respondents' most recent sexual partners*								
Study village	67.7	62.8	52.8	54.4	47.7	52.4	56.1	56.2
Town of Banfora	--	--	7.9	19.1	9.2	0.0	5.9	8.5
Bobo-Dioulasso	12.1	9.3	12.4	8.8	15.4	9.5	12.9	9.2
Koudougou	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Ouagadougou	1.0	2.3	0.6	1.5	7.7	4.8	2.1	2.6
Ouaighouiya	1.0	0.0	0.0	1.5	0.0	0.0	0.3	0.7
Elsewhere in Banfora Health District	3.0	9.3	9.6	10.3	4.6	9.5	6.7	9.8
Elsewhere in Burkina Faso	7.1	4.7	8.4	1.5	3.1	2.4	7.0	2.6
Côte d'Ivoire	4.0	7.0	5.1	0.0	6.2	7.1	4.9	3.9
Mali	1.0	2.3	1.1	0.0	0.0	0.0	0.9	0.7
Ghana	1.0	0.0	0.6	0.0	0.0	0.0	0.6	0.0
Elsewhere outside Burkina	2.0	0.0	0.0	0.0	4.6	0.0	1.5	0.0
Don't know origin	0.0	0.0	0.0	0.0	1.5	14.3	0.3	3.9
Missing value	0.0	2.3	1.7	2.9	0.0	0.0	0.9	2.0
Total	100	100	100	100	100	100	100	100

*Among those who reported having a new sexual partner in the past 12 months

Table D12. Percent of men and women involved in either buying or selling sex for money, goods or services, Banfora Health District, 2001

	Banfora	Rural villages	Niangoloko	Total
Percent of women who have received money, goods or services for sex				
	N=60	N=145	N=56	N=261
Yes	30.0	11.7	42.9	22.6
No	66.7	84.8	51.8	74.0
Missing values	3.3	3.5	5.4	3.5
Total	100	100	100	100
Percent of men who gave money, goods or services for sex				
	N=143	N=323	N=116	N=582
Yes	37.1	23.5	31.9	28.5
No	60.8	72.8	68.1	68.9
Missing values	2.1	3.7	0.0	2.5
Total	100	100	100	100

Table D13. Condom use and participation in AIDS education reported by individuals interviewed at site, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	Men (N=143)	Women (N=60)	Men (N=323)	Women (N=145)	Men (N=116)	Women (N=56)	Men (N=582)	Women (N=261)
Ever used a condom								
Yes	87.4	85.0	71.2	60.0	81.0	78.6	77.2	69.7
No	11.9	11.7	26.9	36.6	19.0	21.4	21.7	27.6
Missing values	0.7	3.3	1.9	3.5	0.0	0.0	1.2	2.7
Total	100	100	100	100	100	100	100	100
Used a condom with recent sexual partner*								
Yes	74.5	66.7	76.9	68.8	92.3	81.5	78.8	71.9
No	25.5	30.0	19.2	25.0	7.7	18.5	19.2	24.7
Missing values	0.0	3.3	3.9	6.3	0.0	0.0	2.0	3.4
Total	100	100	100	100	100	100	100	100
Possessed a condom at the time of the interview								
Yes, but condom was not shown to inter-viewer	2.1	3.3	1.2	0.0	0.9	0.0	1.4	0.8
Yes, and condom was shown to interviewer	6.3	3.3	5.9	0.0	8.6	17.9	6.5	4.6
No	90.9	91.7	92.0	96.6	90.5	82.1	91.4	92.3
Missing values	0.7	1.7	0.9	3.5	0.0	0.0	0.7	2.3
Total	100	100	100	100	100	100	100	100
Participated in AIDS information session								
Yes	41.3	36.6	40.9	31.9	53.4	44.6	44	35.3
No	54.6	61.7	57.9	66.9	46.6	55.4	54.8	63.2
Missing values	2.1	1.7	1.2	2.1	0.0	0.0	1.2	1.5
Total	100	100	100	100	100	100	100	100

*Among those who reported having a new sexual partner in the past 4 weeks

Table D14. Condom use amongst individuals with potential high risk sexual behavior, Banfora Health District, 2001

	Banfora	Rural villages	Niangoloko	Total
Percent who have ever used condoms by involvement with sex work (buying or selling sex)				
Men and women involved in buying/selling sex	93.0% (66/71)	77.4 (72/93)	98.4 (60/61)	88.0% (198/225)
Men and women not involved in buying/selling sex	84.3% (107/127)	65.7 (236/359)	69.4 (75/108)	70.4% (418/594)
Percent who possess condom at the interview by involvement with sexwork (buying or selling sex)				
Men and women involved in buying/selling sex	11.3% (8/71)	10.8% (10/93)	26.2% (16/61)	15.1% (34/225)
Men and women not involved in buying/selling sex	6.3% (8/127)	3.6% (13/359)	4.6% (5/108)	4.4% (26/594)
Percent who possess condom at the interview amongst those who have recently met a new sex partner at the site				
Met a partner at site in past week	0.0% (0/8)	0.0% (0/10)	58.8% (10/17)	28.6% (10/35)
Met a partner at site in past month	0.0% (0/22)	7.1% (3/39)	40.0% (12/30)	16.0% (15/94)

Table D15. STD symptoms and treatment reported by individuals interviewed at sites, Banfora Health District, 2001

	Banfora		Rural villages		Niangoloko		Total	
	Men (N=143)	Women (N=60)	Men (N=323)	Women (N=145)	Men (N=116)	Women (N=56)	Men (N=582)	Women (N=261)
Pain during urination								
Yes	4.9	--	5.0	--	6.9	--	5.3	--
No	93.7	--	93.8	--	93.1	--	93.6	--
Missing	1.4	--	1.2	--	0.0	--	1.0	--
Total	100	--	100	--	100	--	100	--
Lower abdominal pain								
Yes	--	21.7	--	19.3	--	30.4	--	22.2
No	--	63.3	--	78.6	--	69.6	--	73.2
Missing	--	15.0	--	2.1	--	0.0	--	4.6
Total	--	100	--	100	--	100	--	100
Unusual discharge								
Yes	4.9	6.7	1.9	12.4	4.3	16.1	3.1	11.9
No	94.4	78.3	96.9	85.5	95.7	83.9	96.1	83.5
Missing	0.7	15.0	1.2	2.1	0.0	0.0	0.9	4.6
Total	100	100	100	100	100	100	100	100
Genital sores								
Yes	9.1	3.3	3.7	8.3	2.6	10.7	4.8	7.7
No	89.5	81.7	95.1	89.0	97.4	89.3	94.2	87.4
Missing	1.4	15.0	1.2	2.8	0.0	0.0	1.0	5.0
Total	100	100	100	100	100	100	100	100
Treatment-seeking behavior if any STD symptoms were experienced								
	N=24	**N=24**	**N=32**	**N=45**	**N=14**	**N=25**	**N=70**	**N=94**
At a clinic	20.8	29.2	34.4	33.3	35.7	48.0	30	36.2
At a pharmacy	20.8	12.5	6.3	24.4	21.4	24.0	14.3	21.3
At a traditional healer	20.8	20.8	21.9	11.1	21.4	4.0	22.9	11.7
Did not seek any treatment	41.7	41.7	43.8	46.7	28.6	44.0	40	44.7
Missing	0.0	4.2	0.0	0.0	0.0	0.0	0.0	0.0

Table D16. Summary of fieldwork for interview of individuals when socializing at the site, Tenkodogo Health District, 2001

	Tenkodogo	Beguedo/Niaogho	Bittou	Total
Number of days of individual interviews	2	3	2	7
Number of interviewers	8	8	8	8
Number of sites visited	8	8	8	24
Number of individual interviews	178	187	186	551
Percent male among interviewed	66.3% (118/178)	68.4% (128/187)	68.8% (128/186)	67.9% (374/551)

Table D17. Response rates: Percent of men and women who participated in the interview Tenkodogo Health District, 2001

	Tenkodogo		Beguedo/Niaogho		Bittou		Total	
	%	n	%	n	%	n	%	n
Men	96.7	118/122	100.0	128/128	100.0	128/128	98.9	374/378
Women	100.0	60/60	96.7	59/61	100.0	58/58	98.9	177/179
Total	97.8	178/182	98.9	187/189	100.0	186/186	98.9	551/557

Table D18. Number of patrons observed at the sites, Tenkodogo Health District, 2001

	Tenkodogo (N=182)		Beguedo/Niaogho (N=187)		Bittou (N=186)		Total (N=557)	
	%	n	%	n	%	n	%	n
Distribution of numbers of men observed by interviewer								
0-10 men	40.7	74	38.1	72	29.6	55	36.1	201
11-20 men	40.1	73	23.8	45	27.4	51	30.3	169
21-30 men	13.7	25	14.3	27	11.3	21	13.1	73
31-40 men	2.8	5	7.9	15	5.4	10	5.4	30
Over 40 men	2.8	5	15.9	30	26.3	49	15.1	84
Total	100	182	100	189	100	186	100	557
Mean number of men		15.3		32.4		78.8		42.3
Median number of men		12.5		15.0		19.5		15.0
Distribution of number of women observed by interviewer								
0-10 women	81.3	148	59.7	111	68.3	129	69.7	388
11-20 women	16.5	30	18.8	35	16.9	32	17.4	97
21-30 women	1.1	2	4.3	8	5.3	10	3.6	20
31-40 women	0.0	0	1.1	2	1.1	2	0.7	4
Over 40 women	1.1	2	16.1	30	8.5	16	8.6	48
Total	100	182	100	186	100	189	100	557
Mean number of women		8.0		58.0		19.9		28.8
Median number of women		7.0		8.0		5.0		7.0

Table D19. Age of patrons, Tenkodogo Health District, 2001

	Tenkodogo		Beguedo/Niaogho		Bittou		Total	
	Men (N=118)	Women (N=60)	Men (N=128)	Women (N=59)	Men (N=128)	Women (N=58)	Men (N=374)	Women (N=177)
Percent of men and women in each age group								
15-19 years	4.2	20.0	9.4	49.2	3.9	22.4	5.9	30.5
20-24 years	21.2	38.3	23.4	15.3	22.7	25.9	22.5	26.6
25-29 years	25.4	30.0	27.3	11.9	31.3	34.5	28.1	25.4
30-34 years	21.2	10.0	15.6	18.6	20.3	13.8	19.0	14.1
35-39 years	16.1	1.7	10.9	5.1	13.3	1.7	13.4	2.8
Over 40 years	11.9	0.0	13.3	0.0	8.6	1.7	11.2	0.6
Total	100	100	100	100	100	100	100	100
Mean age (years)	29.8	23.5	29.1	22.4	29.5	24.4	29.4	23.4

Table D20. Socio-demographic characteristics of individuals socializing at the sites, percent by gender, Tenkodogo Health District, 2001

	Tenkodogo		Beguedo/Niaogho		Bittou		Total	
	Men (N=118)	Women (N=60)	Men (N=128)	Women (N=59)	Men (N=128)	Women (N=58)	Men (N=374)	Women (N=177)
Employment status								
Unemployed	7.6	10.0	16.4	52.5	10.9	22.4	11.8	28.3
Employed part-time	24.6	56.7	26.6	22.0	37.5	44.8	29.7	41.2
Employed full-time	67.8	33.3	55.5	23.7	51.6	32.8	58.0	29.9
Missing value	0.0	0.0	1.6	1.7	0.0	0.0	0.5	0.6
Total	100	100	100	100	100	100	100	100
Current student status								
Yes	10.2	3.3	2.3	0.0	3.9	0.0	5.4	1.1
No	83.9	90.0	93.0	98.3	92.2	100.0	89.8	96.1
Missing value	5.9	6.7	4.7	1.7	3.9	0.0	4.8	2.8
Total	100	100	100	100	100	100	100	100
Received education								
Yes	84.8	73.3	46.1	40.7	57.8	58.6	62.3	57.6
No	14.4	26.7	53.1	57.6	42.2	41.4	37.2	41.8
Missing value	0.9	0.0	0.8	1.7	0.0	0.0	0.5	0.6
Total	100	100	100	100	100	100	100	100
Level of education received among those reporting education								
1-5 (Primary)	26.0	70.5	54.2	70.8	36.5	52.9	36.5	64.7
6-9 years (Secondary)	59.0	29.6	40.7	29.2	58.1	44.1	54.1	34.3
10 years or more	15.0	0.0	5.1	0.0	4.1	0.0	9.0	0.0
Missing value	0.0	0.0	0.0	0.0	1.4	2.9	0.4	1.0
Total	100	100	100	100	100	100	100	100
Literate								
Yes	16.1	3.3	7.0	88.1	7.8	93.1	10.2	6.8
No	83.9	96.7	92.2	10.2	92.2	6.9	89.6	92.7
Missing value	0.0	0.0	0.8	1.7	0.0	0.0	0.3	0.6
Total	100	100	100	100	100	100	100	100
Residence								
In the study area	83.1	83.3	95.3	93.2	78.9	77.6	85.8	84.8
Town of Tenkodogo	0.0	0.0	1.6	0.0	1.6	3.5	1.1	1.1
Koupela	3.4	3.3	0.0	1.7	0.8	0.0	1.3	1.7
Cinkanse	0.9	0.0	0.0	0.0	2.3	5.2	1.1	1.7
Ouagadougou	7.6	1.7	0.8	0.0	7.8	1.7	5.4	1.1
Elsewhere in the district of Tenkodogo	2.5	1.7	1.6	3.4	2.3	0.0	2.1	1.7
Elsewhere in Burkina Faso	1.7	1.7	0.8	1.7	2.3	1.7	1.6	1.7
Niamey	0.0	0.0	0.0	0.0	2.3	1.7	0.8	0.6
Lome	0.0	0.0	0.0	0.0	1.6	1.7	0.5	0.6
Elsewhere in Togo	0.9	5.0	0.0	0.0	0.0	1.7	0.3	2.3
Accra	0.0	1.7	0.0	0.0	0.0	1.7	0.0	1.1
Elsewhere in Ghana	0.0	1.7	0.0	0.0	0.0	0.0	0.0	0.6
Outside of Burkina Faso	0.0	0.0	0.0	0.0	0.0	3.5	0.0	1.1
Total	100	100	100	100	100	100	100	100
Years respondent has lived in stated residence								
Less than 1 year	15.3	60.0	5.5	8.5	7.8	22.4	9.4	30.5
1-5 years	27.1	23.3	14.1	22.0	24.2	20.7	21.7	22.0
6-10 years	4.2	3.3	3.9	6.8	12.5	15.5	7.0	8.5
More than 10 years	53.4	13.3	76.6	62.7	55.5	41.4	62.0	39.0
Total	100	100	100	100	100	100	100	100

Table D21. Site by individuals interviewed at sites, Tenkodogo Health District, 2001

	Tenkodogo		Beguedo/Niaogho		Bittou		Total	
	Men (N=118)	Women (N=60)	Men (N=128)	Women (N=59)	Men (N=128)	Women (N=58)	Men (N=374)	Women (N=177)
Frequency of attendance								
Every Day	22.0	78.3	60.2	55.9	50.0	46.6	44.7	60.5
4-6 Times Per Week	5.9	1.7	3.9	0.0	5.5	5.2	5.1	2.3
2-3 Times Per Week	17.0	5.0	18.0	15.3	19.5	10.3	18.2	10.2
Once a Week	6.8	3.3	10.2	8.5	6.3	6.9	7.8	6.2
2-3 Times Per Month	15.3	0.0	3.1	3.4	10.9	8.6	9.6	4.0
Once a Month	17.8	1.7	0.0	13.6	3.1	13.8	6.7	9.6
Less than once a month	8.5	5.0	3.1	1.7	0.8	1.7	4.0	2.8
First visit	6.8	5.0	1.6	1.7	3.9	6.9	4.0	4.5
Total	100	100	100	100	100	100	100	100
Time when respondent first visited site								
Night of interview	6.8	5.0	1.6	1.7	3.9	8.6	4.0	5.1
In the month preceding interview	12.7	36.7	0.0	6.8	6.3	8.6	6.2	17.5
In 2-6 months preceding interview	11.0	33.3	3.9	8.5	7.0	15.5	7.2	19.2
In 7-12 months preceding interview	15.3	8.3	6.3	11.9	14.8	17.2	12.0	12.4
More than 1 year preceding interview	32.2	13.3	24.2	25.4	27.3	19.0	27.8	19.2
More than 5 years preceding interview	22.0	3.3	63.3	44.1	39.8	29.3	42.3	25.4
Missing values	0.0	0.0	0.8	1.7	0.8	1.7	0.5	1.1
Total	100	100	100	100	100	100	100	100
Number of other sites attended before the interview								
0	50.0	76.7	71.1	86.4	64.8	74.1	62.3	79.1
1	22.0	15.0	23.4	11.9	18.0	19.0	21.1	15.3
2	16.1	8.3	3.9	0.0	8.6	6.9	9.4	5.1
3+	11.9	0.0	1.6	1.7	8.6	0.0	7.2	0.6
Total	100	100	100	100	100	100	100	100
Number of sites that will be attended after the interview								
0	74.6	83.3	71.1	86.2	70.3	83.1	71.9	84.2
1	22.0	11.7	21.1	8.6	24.2	17.0	22.5	12.4
2	2.5	5.0	7.0	3.5	5.5	0.0	5.1	2.8
3+	0.9	0.0	0.8	1.7	0.0	0.0	0.5	0.6
Total	100	100	100	100	100	100	100	100
Number of sites will visit that day, either before or after the interview								
1	75.5	85.0	75.2	84.1	84.5	89.3	77.2	85.4
2	22.4	15.0	21.7	13.8	14.7	10.7	20.4	13.4
3+	2.1	0	3.1	2.1	0.9	0	2.4	1.2
Total	100	100	100	100	100	100	100	100

Table D22. Partner selection reported by individuals interviewed at sites, Tenkodogo Health District, 2001

	Tenkodogo		Beguedo/Niaogho		Bittou		Total	
	Men (N=118)	Women (N=60)	Men (N=128)	Women (N=59)	Men (N=128)	Women (N=58)	Men (N=374)	Women (N=177)
Believe other people come to site to meet a new partner								
Yes	99.2	100.0	100.0	100.0	100.0	100.0	99.7	100.0
No	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Missing value	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100	100	100	100	100	100	100	100
Interviewee attracted sexual partner at site								
Yes	43.2	76.7	48.4	25.4	34.4	29.3	42.0	44.1
No	56.8	23.3	51.6	74.6	65.6	70.7	58.0	55.9
Total	100	100	100	100	100	100	100	100
Period of time since interviewee last attracted new sexual partner at site								
Within Past 7 Days	12.7	41.7	9.4	5.1	7.9	5.2	9.9	17.5
Within Past 2-4 Weeks	11.9	25.0	12.5	6.8	12.5	15.5	12.3	15.8
Within the Past 2-3 months	4.2	5.0	13.3	1.7	4.7	3.5	7.5	3.4
Within Past 4-6 Months	5.1	1.7	3.1	0.0	2.3	0.0	3.5	0.6
Within 7-12 Months	4.2	3.3	4.7	10.2	4.7	3.5	4.6	5.7
Over a Year Ago	5.1	0.0	4.7	1.7	2.3	1.7	4.0	1.1
Never Met a New Partner at Site	55.9	23.3	52.3	74.6	65.6	70.7	58.0	55.9
Missing values	0.9	0.0	0.0	0.0	0.0	0.0	0.3	0.0
Total	100	100	100	100	100	100	100	100

Table D23. Partner acquisition over 4 weeks of individuals interviewed at sites, Tenkodogo Health District, 2001

	Tenkodogo		Beguedo/Niaogho		Bittou		Total	
	Men (N=118)	Women (N=60)	Men (N=128)	Women (N=59)	Men (N=128)	Women (N=58)	Men (N=374)	Women (N=177)
Number of new partners in past 4 weeks*								
0	48.3	28.3	57.0	67.8	60.9	60.3	55.6	52.0
1	32.3	35.0	29.7	20.3	24.2	12.1	28.6	22.6
2	11.0	8.3	10.9	8.5	9.4	19.0	10.4	11.9
3-10	8.5	16.7	1.6	1.7	4.7	5.2	4.8	7.9
11-50	0.0	5.0	0.0	0.0	0.8	3.5	0.3	2.8
51-100	0.0	6.7	0.0	0.0	0.0	0.0	0.0	2.3
Missing values	0.0	0.0	0.0	0.0	0.8	1.7	0.3	0.6
Total	100	100	100	100	100	100	100	100
Mean number of new partners in past 4 weeks	1.0	8.2	0.7	0.4	0.7	0.4	0.8	3.4
Median number of new partners in past 4 weeks	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0
Total number of different partners in past 4 weeks*								
0	13.6	8.3	12.5	22.0	11.7	17.2	12.6	15.8
1	43.2	26.7	28.9	50.9	42.2	44.8	38.0	40.7
2	16.1	21.7	32.8	15.3	27.3	12.1	25.7	16.4
3-10	26.3	21.7	25.0	10.2	18.0	20.7	23.0	17.5
11-50	0.9	13.3	0.0	0.0	0.8	5.2	0.5	6.2
51-100	0.0	8.3	0.0	0.0	0.0	0.0	0.0	2.8
Missing values	0.0	0.0	0.8	1.7	0.0	0.0	0.3	0.6
Total	100	100	100	100	100	100	100	100
Mean number of total partners in past 4 weeks	2.1	12.2	1.9	1.2	1.8	2.5	1.0	5.4
Median number of total partners in past 4 weeks	1.0	2.0	2.0	1.0	1.0	1.0	1.0	1.0

*Among those who reported having a sexual partner in the past 12 months

Table D24. Partner acquisition over 12 months of individuals interviewed at sites, Tenkodogo Health District, 2001

	Tenkodogo		Beguedo/Niaogho		Bittou		Total	
	Men (N=118)	Women (N=60)	Men (N=128)	Women (N=59)	Men (N=128)	Women (N=58)	Men (N=374)	Women (N=177)
Number of new partners in past twelve months								
0	21.2	16.7	33.6	54.2	31.3	34.5	28.9	35.0
1	27.1	16.7	21.9	22.0	18.8	24.1	22.5	20.9
2	11.9	16.7	17.2	15.3	21.1	20.7	16.8	17.5
3-10	27.1	18.3	24.2	6.8	27.3	15.5	26.2	13.6
11-50	11.0	11.7	2.3	0.0	1.6	3.5	4.8	5.1
51-100	1.7	5.0	0.0	0.0	0.0	0.0	0.5	1.7
101-200	0.0	3.3	0.0	0.0	0.0	0.0	0.0	1.1
201+	0.0	11.7	0.0	0.0	0.0	1.7	0.0	4.5
Missing values	0.0	0.0	0.8	1.7	0.0	0.0	0.3	0.6
Total	100	100	100	100	100	100	100	100
Mean number of new partners in past 12 months	5.4	65.4	2.0	0.8	2.2	13.5	3.2	27.0
Median number of new partners in past 12 months	2.0	2.5	1.0	0.0	1.5	1.0	1.0	1.0
Number of total partners in past twelve months								
0	0.9	1.7	3.1	10.2	2.3	3.5	2.1	5.1
1	22.9	11.7	19.5	49.2	18.0	29.3	20.1	29.9
2	11.0	13.3	22.7	17.0	20.3	22.4	18.2	17.5
3-10	41.5	40.0	50.0	22.0	56.3	37.9	49.5	33.3
11-50	22.0	5.0	3.9	0.0	2.3	5.2	9.1	3.4
51-100	0.9	5.0	0.0	0.0	0.8	0.0	0.5	1.7
101-200	0.9	8.3	0.0	0.0	0.0	0.0	0.3	2.8
Over 200	0.0	15.0	0.0	0.0	0.0	1.7	0.0	5.7
Missing values	0.0	0.0	0.8	1.7	0.0	0.0	0.3	0.6
Total	100	100	100	100	100	100	100	100
Mean number of total partners in past 12 months	8.7	88.6	4.1	1.8	4.4	15.4	5.7	35.9
Median number of total partners in past 12 months	4.0	5.0	3.0	1.0	3.0	2.0	3.0	2.0

*Among those who reported having a sexual partner in the past 12 months

Table D25. Number of regular partners in the past 12 months*, Tenkodogo Health District, 2001

	Tenkodogo		Beguedo/Niaogho		Bittou		Total	
	Men (N=118)	Women (N=60)	Men (N=128)	Women (N=59)	Men (N=128)	Women (N=58)	Men (N=374)	Women (N=177)
Number of regular* partners in past twelve months								
0	28.0	43.3	24.2	45.8	33.6	43.1	28.6	44.1
1	58.5	31.7	57.0	52.5	60.2	55.2	58.6	46.3
2	5.9	8.3	14.1	0.0	5.5	1.7	8.6	3.4
3-10	6.8	13.3	3.9	0.0	0.8	0.0	3.7	4.5
11-50	0.9	3.3	0.0	0.0	0.0	0.0	0.3	1.1
Missing values	0.0	0.0	0.8	1.7	0.0	0.0	0.3	0.6
Total	100	100	100	100	100	100	100	100
Mean number of regular partners in past 12 months	1.1	2.4	1.0	0.5	0.7	0.6	0.9	1.2
Median number of regular partners in past 12 months	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0

*Among those who reported having a sexual partner in the past 12 months

Table D26. Locations where respondents met recent sexual partners, Tenkodogo Health District, 2001

	Tenkodogo		Beguedo/Niaogho		Bittou		Total	
	Men (N=93)	Women (N=50)	Men (N=85)	Women (N=27)	Men (N=88)	Women (N=38)	Men (N=266)	Women (N=115)
Location where respondents met most recent sexual partners*								
At the site of the interview	35.5	82.0	40.0	37.0	27.3	36.8	34.2	56.5
In the study village, but not at the site of interview	40.9	12.0	49.4	55.6	46.6	47.4	45.1	33.9
Town of Tenkodogo	--	--	3.5	0.0	1.1	2.6	1.9	0.9
Koupela	6.5	0.0	0.0	0.0	2.3	0.0	3.0	0.0
Cinkanse	0.0	0.0	0.0	0.0	4.6	5.3	1.5	1.7
Ouagadougou	9.7	2.0	2.4	0.0	4.6	0.0	5.6	0.9
Bobo-Dioulasso	2.2	0.0	0.0	0.0	0.0	0.0	0.8	0.0
Koudougou	2.2	0.0	0.0	0.0	0.0	0.0	0.8	0.0
Ouahigouya	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Elsewhere in the Tenko-dogo Health District	2.2	0.0	2.4	0.0	1.1	0.0	1.9	0.0
Elsewhere in Burkina Faso	1.1	0.0	1.2	0.0	2.3	0.0	1.5	0.0
Niamey	0.0	0.0	0.0	0.0	0.0	2.6	0.0	0.9
Elsewhere in Niger	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Lome	0.0	0.0	0.0	0.0	5.7	0.0	1.9	0.0
Elsewhere in Togo	0.0	2.0	0.0	0.0	2.3	0.0	0.8	0.9
Accra	0.0	0.0	0.0	0.0	0.0	2.6	0.0	0.9
Elsewhere in Ghana	0.0	2.0	0.0	0.0	2.3	0.0	0.8	0.9
Nigeria	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Elsewhere outside of Burkina Faso	0.0	0.0	0.0	3.7	0.0	2.6	0.0	1.7
Missing values	0.0	0.0	1.2	3.7	0.0	0.0	0.4	0.8
Total	100	100	100	100	100	100	100	100
Origin of respondents' most recent sexual partners*								
The study village	40.9	62.0	75.3	74.1	44.3	60.5	52.6	62.6
Ville Tenkodogo	--	--	10.6	3.7	3.4	5.3	4.9	4.4
Koupela	2.2	2.0	0.0	0.0	5.7	0.0	2.6	0.9
Cinkanse	0.0	0.0	1.2	3.7	9.1	5.3	3.4	2.6
Ouagadougou	15.1	10.0	3.5	3.7	4.6	5.3	7.9	7.0
Bobo-Dioulasso	5.4	10.0	1.2	0.0	1.1	0.0	2.6	4.4
Koudougou	3.2	0.0	0.0	0.0	0.0	0.0	1.1	0.0
Ouahigouya	1.1	2.0	0.0	0.0	1.1	0.0	0.8	0.9
Elsewhere in the Tenko-dogo Health District	3.2	2.0	5.9	3.7	0.0	2.6	3.0	2.6
Elsewhere in Burkina Faso	3.2	2.0	1.2	3.7	3.4	2.6	2.6	2.6
Niamey	0.0	0.0	0.0	0.0	1.1	7.9	0.4	2.6
Elsewhere in Niger	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Lome	2.2	2.0	0.0	0.0	8.0	2.6	3.4	1.7
Elsewhere in Togo	10.8	4.0	0.0	0.0	5.7	2.6	5.6	2.6
Accra	2.2	0.0	0.0	0.0	8.0	2.6	3.4	0.9
Elsewhere in Ghana	6.5	2.0	0.0	0.0	3.4	0.0	3.4	0.9
Nigeria	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Elsewhere outside of Burkina Faso	3.2	2.0	0.0	3.7	1.1	2.6	1.5	2.6
Missing	1.1	0.0	1.2	3.7	0.0	0.0	0.8	0.9
Total	100	100	100	100	100	100	100	100

*Among those who reported having a new sexual partner in the past 12 months

Table D27. Percent of men and women involved in either buying or selling sex for money, goods or services, Tenkodogo Health District, 2001

	Tenkodogo	Beguedo/Niaogho	Bittou	Total
Percent of women who have received money, goods or services for sex				
	N=60	**N=58**	**N=59**	**N=177**
Yes	81.7	22.0	39.7	48.0
No	18.3	76.3	58.6	50.9
Missing values	0.0	1.7	0.0	1.1
Total	100	100	100	100
Percent of men who gave money, goods or services for sex				
	N=118	**N=128**	**N=128**	**N=374**
Yes	61.9	35.9	46.9	47.9
No	38.1	63.3	52.3	51.6
Missing values	0.0	0.8	0.8	0.5
Total	100	100	100	100

Table D28. Condom use and participation in AIDS education reported by individuals interviewed at site, Tenkodogo Health District, 2001

	Tenkodogo		Beguedo/Niaogho		Bittou		Total	
	Men (N=128)	**Women (N=60)**	**Men (N=118)**	**Women (N=58)**	**Men (N=118)**	**Women (N=59)**	**Men (N=266)**	**Women (N=115)**
Ever used a condom								
Yes	89.8	96.7	62.5	23.7	83.6	69.0	78.3	63.3
No	8.5	3.3	36.7	74.6	16.4	31.0	20.9	36.2
Missing values	1.7	0.0	0.8	1.7	0.0	0.0	0.8	0.6
Total	100	100	100	100	100	100	100	100
Used a condom with recent sexual partner*								
	N=61	N=43	N=55	N=19	N=50	N=23	N=166	N=85
Yes	78.7	88.4	65.5	21.1	76.0	87.0	73.5	72.9
No	21.3	9.3	32.7	73.7	24.0	13.0	25.9	24.7
Missing values	0.0	2.3	1.8	5.3	0.0	0.0	0.6	2.4
Total	100	100	100	100	100	100	100	100
Possessed a condom at the time of the interview								
Yes, but condom was not shown to inter-viewer	0.9	0.0	0.0	0.0	0.0	0.0	0.3	0.0
Yes, and condom was shown to interviewer	14.4	20.0	7.0	0.0	5.5	3.5	8.8	7.9
No	83.9	80.0	92.2	98.3	94.5	96.6	90.4	91.5
Missing values	0.9	0.0	0.8	1.7	0.0	0.0	0.5	0.6
Total	100	100	100	100	100	100	100	100
Participated in AIDS information session								
Yes	38.2	35.0	21.8	10.2	57.0	48.3	39.0	31.1
No	55.9	63.3	76.6	86.4	43	51.7	58.6	67.2
Missing values	5.9	1.7	1.6	3.4	0	0	2.4	1.7
Total	100	100	100	100	100	100	100	100

*Among those who reported having a new sexual partner in the past 4 weeks

Table D29. Condom use amongst individuals with potential high risk sexual behavior, Tenkodogo Health District, 2001

	Tenkodogo	Bittou	Beguedo/Niaogho	Total
Percent who have ever used condoms by involvement with sex work (buying or selling sex)				
Men and women involved in buying/selling sex	95.1% (116/122)	89.2% (74/83)	67.8% (40/59)	87.1% (230/264)
Men and women not involved in buying/selling sex	85.7% (48/56)	71.3% (72/101)	42.9% (54/126)	61.5% (174/283)
Percent who possess condom at the interview by involvement with sex work (buying or selling sex)				
Men and women involved in buying/selling sex	22.9% (28/122)	7.2% (6/83)	11.9% (7/59)	15.5 (41/264)
Men and women not involved in buying/selling sex	3.6% (2/56)	3.0% (3/101)	1.6% (2/126)	2.5% (7/283)
Percent who possess condom at the interview amongst those who reported meeting a new sex partner at the site in the past week or month				
Met a partner at site in past week	32.5% (13/40)	7.7% (1/13)	6.7% (1/15)	22.1% (15/68)
Met a partner at site in past month	17.2% (5/29)	12.0% (3/25)	15.0% (3/20)	14.9% (11/74)

Table D30. STD symptoms and treatment reported by individuals interviewed at sites, Tenkodogo Health District, 2001

	Tenkodogo		Bittou		Beguedo/Niaogho		Total	
	Men (N=118)	Women (N=60)	Men (N=128)	Women (N=58)	Men (N=118)	Women (N=60)	Men (N=128)	Women (N=58)
Pain during urination								
Yes	13.6	--	6.3	--	8.6	--	9.4	--
No	86.4	--	93.8	--	89.8	--	90.1	--
Missing value	0.0	--	0.0	--	1.6	--	0.5	--
Total	100	--	100	--	100	--	100	--
Lower abdominal pain								
Yes	--	11.7	--	20.7	--	8.5	--	13.6
No	--	88.3	--	77.6	--	89.8	--	85.3
Missing value	--	0.0	--	1.7	--	1.7	--	1.1
Total	--	100	--	100	--	100	--	100
Unusual discharge								
Yes	3.4	18.3	4.7	6.9	0.8	6.8	2.9	10.7
No	96.6	81.7	95.3	93.1	97.7	91.5	96.5	88.7
Missing value	0.0	0.0	0.0	0.0	1.6	1.7	0.5	0.6
Total	100	100	100	100	100	100	100	100
Genital sores								
Yes	7.6	16.7	4.7	12.1	3.9	5.1	5.4	11.3
No	91.5	83.3	95.3	87.9	95.3	93.2	94.1	88.1
Missing value	0.9	0.0	0.0	0.0	0.8	1.7	0.5	0.6
Total	100	100	100	100	100	100	100	100
Treatment-seeking behavior if any STD symptoms were experienced								
	N=22	**N=18**	**N=18**	**N=19**	**N=16**	**N=10**	**N=56**	**N=47**
At a clinic	22.7	33.3	22.2	36.8	31.3	40.0	25.0	36.2
At a pharmacy	9.1	16.7	16.7	10.5	0.0	0.0	8.9	10.6
At a traditional healer	18.2	22.2	11.1	21.1	6.3	30.0	12.5	23.4
Did not seek any treatment	63.6	44.4	55.6	36.8	56.3	40.0	58.9	40.4
Missing values	0.0	0.0	0.0	0.0	6.3	0.0	1.8	0.0

Appendix E: Questionnaires

CARACTERISTIQUES DES INFORMATEURS CLES

No.	Questions	Categories de codes
K1	Nom de la <ZIP>	Ville de Banfora 1 Beregadougou 2 Sideradougou 3 Niangoloko 4 Mangodara 5
K2	Numero de l'enquêteur/Numero d'informateur clé	___ ___ / ___ ___ ___
K3	Date (jour/mois/annee)	___ ___/___ ___/___ ___
K4	Sexe de l'informateur clé	MASCULIN 1 FEMININ 2

No.	Questions	Categories de codes
K5	Type d' Informateur clé:	**ENTRER CODE: ___ ___**

DOMAIN TRANSPORT

CHAUFFEUR DE TAXI 01
CHAUFFEUR DE CAMION PUBLIQUE NATIONAL OU SON «APPRENTI» 02
CHAUFFEUR DE CAMION DE TRANSPORT INTERNATIONAL OU SON «APPRENTI» 03
REPRESENTANT DES GARE/ SYNDICAT DE TRANSPORTEURS 04
TRANSITAIRE 05

PERSONNES QUI TRAVAILLE DANS LA RUE

PARQUEUR 06
GARDIEN OU VEILLEUR DE NUIT 07
VENDEUR (AMBULANT, ETALAGISTE, TABLIERS) 08
COXAIRE AU NIVEAU DE MARCHÉ 09
TRAVAILLEUR DE SEXE 10

PERSONNES DANS LES AFFAIRES COMMERCIALES

PROPRIETAIRE OU EMPLOYER DE BAR 11
PROPRIETAIRE OU EMPLOYER DE BOUTIQUE/KIOSQUE DES LIQUEURS OU DE LA BIERE 12
SERVEUR(EUSE) DE BAR OU CUISINIER 13
ANIMATEUR DE BOITE DE NUIT 14
VENDEUR (FIXE) 15
COMMERCANT/HOMME D'AFFAIRE 16

PERSONNES PROFESSIONELS

PERSONNEL DES ASSOCIATIONS, GROUPEMENTS, COMITES ET ONG 17
ENSEIGNANT 18
PRESTATAIRE DE SERVICES DE SANTE 19

LES JEUNES

ELEVE 20
JEUNE EN DEHORS DE L'ECOLE 21

LES OFFICIERS

MILITAIRE 22
GENDARME 23
POLICIER 24
AGENT DE EAUX/FORETS 25

AUTRES

INDIVIDU SOCIALISANT DANS LE SITE 26
PECHEUR OU PIROGUIER 27
CHOMEUR OU SANS EMPLOI 28
RESPONSABLE RELIGIEUX (IMAM, PASTEUR, PRETRE) 29
AUTORITE COUTUMIERE 30
GRIOT TRADITIONNEL 31
AUTRE (PRECISER)_____32

Bonjour/Bonsoir. Je travaille pour DRS à Banfora, dans le but de contribuer au développer de meilleurs programmes de santé pour notre région. Nous souhaiterions vous poser quelques questions dans le but de collecter des informations nécessaires à la planification et à l'évaluation de ces programmes. Vos réponses resterons confidentielle. Pour cela je ne demanderai pas votre nom et le porterai pas sur le questionnaire. Les questions incluent des questions concernant votre comportement d'une manière générale y compris votre comportement en matière de sexualité. Votre participation est complètement volontaire.		
K6	Acceptez-vous de répondre aux quelques questions?	OUI 1 NON 2 SI NON, ARRETER L'INTERVIEW
K7	Quel age avez-vous? *ARRETER L'INTERVIEW SI L'ENQUETÉ A MOINS DE 15 ANS	ANS ___ ___
K8	Où habitez-vous?	DANS CETTE <ZIP> 1 VILLE DE BANFORA 2 BOBO-DIOULASSO 3 KOUDOUGOU 4 OUAGADOUGOU 5 OUAIGHOUYA 6 AUTRE DANS LE DISTRICT DE BANFORA 7 AUTRE DANS BURKINA FASO 8 HORS DE BURKINA FASO 9
K9	Depuis combien de temps viviez-vous ici / là bas ?	MOINS D'UN AN 0 NOMBRE D'ANNEES ___ ___ DEPUIS TOUJOURS 97

K10	***Nous voudrions savoir specifiquement où les gens rencontrent leurs partenaires sexuels dans le but de pouvoir planifier des programmes en matière de prévention du SIDA et de mise à disposition de condoms. Specifiquement nous voudrions savoir:*** • Où les gens de <la ZIP> rencontrent de nouveaux partenaires sexuels dans <la ZIP>? • Où les gens de <la ZIP> rencontrent leurs partenaires sexuels en dehors de <la ZIP>? • Où les gens ne venant de <la ZIP> rencontrent leurs partenaires sexuels dans <la ZIP>? • Où les jeunes de <la ZIP> rencontrent de nouveaux partenaires sexuels? • Où les hommes rencontrent les jeunes filles dans <la ZIP>? **POUR CHAQUE SITE NOMME, REMPLIR LE FORMULAIRE DU RAPPORT DE SITE** **<u>Questions optionelle de sondage pour aider les informanteurs clés à nommer les sites:</u>** • *Où (*travailleurs de sexe, résidents temporaires, travailleurs migrants, homosexuels ou bisexuels hommes, étudiants, jeunes, femme célibataires, hommes célibataires,vieilles hommes et femmes) *vont pour (*rencontre des partenaires sexuels, chercher des partenaires sexuels, rencontrer des amis, boire, danser, écouter la musique*)?* • *Où vont les gens des weekends et jours feriés pour se relaxer et se distraire?* • *Y a-t-il des weekends d'évènements sportifs (foot ball, basket ball, lutte tradionnelle) dans <la ZIP>? Si oui, où vont les joueurs et les spectateurs après le match ou le jeu?* • *Y a-t-il des weekends d'evenements culturels (les funerailles, les baptemes, les marches, les mariages)*	
K11	*COMBIEN DE SITES DIFFERENTS EST-CE QUE CET INFORMATEUR CLE A ENUMERE ?	NOMBRE DE SITES:___ ___

FORMULAIRE DU RAPPORT DE SITE

Unique Numero de Site: ___ ___ ___

S1	Nom de la ZIP	Ville de Banfora 1 Beregadougou 2 Sideradougou 3 Niangoloko 4 Mangodara 5
S2	Numéro d'Enquêteur/ Numéro d'Informateur clé	___ ___ / ___ ___ ___
S3	Nom du site nommé	_____
S4	Adresse complete du site et information precises pour le retrouver. Lister toutes les indications qui peuvent aider à localiser le site (tels que les écoles, panneaux, intersections, boutiques…).	

S5	TYPE DE SITE: *ENTRER CODE: ___ ___ 01 CABARET 02 MAQUIS 03 BOITE DE NUIT 04 CHAMBRES DE PASSE/AMPOULE ROUGE 05 « COMBINATION » (BAR, DANCING, CHAMBRES DE PASSE, RESTAURANT) 06 LOGEMENTS/HOTEL/AUBERGE 07 BOUTIQUE VENDANT DU BOISSONS ALCOLISE/CAVE 08 RESTAURANT « MEUBLE » 09 RESTAURANT POPULAIRE 10 ESPACE VERT / JARDIN 11 SALLE DE CINEMA 12 CLUB VIDEO 13 CLUB DE THÉ/GRIN 14 GARE DE TAXI 15 GARE DE BUS 16 GARE FERROVIAIRE 17 GARE DE CAMION 18 PARKINGS (VELO, MOBYLETTE, VOITURE, CAMION) 19 PLACE DE MARCHE *20 ENDROIT OÙ LES GENS GARENT LA VEILLE DU MARCHE* *21 DOMICILE PRIVE* *22 MAISON ABANDONEE* *23 ESPACE VIDE* *24 RUE* *25 COURS D'ECOLE PENDANT LES HEURES DE L'ÉTUDE* *26 COURS D'ECOLE DANS LA NUIT* *27 TERRAIN DE SPORT* *28 STADE* *29 EGLISE/MOSQUEE/AUTRE LIEU DE CULTE* *30 AU BORD DU LAC/CASCADES* *31 AUTRES (PRÉCISER)*_____

FORMULAIRE DE LA VERIFICATION DE SITE

Unique Numero de Site: ___ ___ ___

No.	Questions	Categories de codes
DE V1 À V6 SERONT COMPLÉTÉS PAR LE COORDONATEUR DE L'ENQUÊTE AVANT QUE LA FICHE NE SOIT REMISE À L'ENQUÊTEUR.		
V1	Nom de la ZIP	Ville de Banfora 1 Beregadougou 2 Sideradougou 3 Niangoloko 4 Mangodara 5
V2	Lister numéro unique de ce site	___ ___ ___
V3	Nombre d' informateur clés qui ont nommé ce site	___ ___
V4	Nom du Site	_____
V5	Adresse du Site	
*LES QUESTIONS SUIVANTES DEVRONT ÊTRE COMPLÉTÉES PAR L'ENQUÊTEUR.		

V6	Résultat de la verification de site	Site non identifié 0 Site identifié avec une adresse correcte 1 Site identifié avec une adresse incorrecte 2 Site identifié mais gérant pas disposé pour l'enquête 3 Site momentanément fermé 4 N'est plus un site 5 ADRESSE CORRECTE: _____ _____

No.	Questions	Categories de codes
V7	TYPE DE SITE: *****ENTRER CODE: ___ ___ 05 CABARET 06 MAQUIS 07 BOITE DE NUIT 08 CHAMBRES DE PASSE/AMPOULE ROUGE 32 « COMBINATION » (BAR, DANCING, CHAMBRES DE PASSE, RESTAURANT) 33 LOGEMENTS/HOTEL/AUBERGE 34 BOUTIQUE VENDANT DU BOISSONS ALCOLISE/CAVE 35 RESTAURANT « MEUBLE » 36 RESTAURANT POPULAIRE 37 ESPACE VERT/ JARDIN 38 SALLE DE CINEMA 39 CLUB VIDEO 40 CLUB DE THÉ/GRIN 41 GARE DE TAXI 42 GARE DE BUS 43 GARE FERROVIAIRE 44 GARE DE CAMION 45 PARKINGS (VELO, MOBYLETTE, VOITURE, CAMION) 46 PLACE DE MARCHE 47 ENDROIT OÙ LES GENS GARENT LA VEILLE DU MARCHE 48 DOMICILE PRIVE 49 MAISON ABANDONEE 50 ESPACE VIDE 51 RUE 52 COURS D'ECOLE PENDANT LES HEURES DE L'ÉTUDE 53 COURS D'ECOLE DANS LA NUIT 54 TERRAIN DE SPORT 55 STADE 56 EGLISE/MOSQUEE/AUTRE LIEU DE CULTE 57 AU BORD DU LAC/CASCADES 31 AUTRES (PRÉCISER)_____	
V8	Numéro d'Enquêteur	___ ___
V9	Date (jour/mois/annee)	___ ___/___ ___/___ ___
V10	Jour de la semaine	Lundi 1 Mardi 2 Mercredi 3 Jeudi 4

		Vendredi 5 Samedi 6 Dimanche 7
V11	Nombre de personnes presentes au site au début de l'interview	Hommes: ___ ___ ___ Femmes:___ ___ ___
V12	Heure du jour (24 heures)	___ ___ : ___ __

***TROUVER QUELQU'UN CONNAISSANT LE SITE POUR REPONDRE AUX QUESTIONS SUIVANTES.**

No.	Questions	Categories de codes
V13	Sexe de l'enquêté	Masculin 1 Féminin 2

Bonjour/Bonsoir. Je travaille pour DRS à Banfora, dans le but de contribuer au développer de meilleurs programmes de santé pour notre région. Nous souhaiterions vous poser quelques questions dans le but de collecter des informations nécessaires à la planification et à l'évaluation de ces programs. Vos réponses resterons confidentiel. Pour cela je ne demanderai pas votre nom et le porterai pas sur le questionnaire. Notre questionnaire comportera des questions sur les activités qui se déroulent sur place (sur le site choisi), les gens qui frequentent l'endroit, et les programmes que nous pourrions eventuellement mettre en place. Nous voudrions également revenir sur place à moment de forte affluence pour discuter avec des personnes qui frequent habituellement ce site. Votre participation est complètement volontaire.

V14	Serait-il possible à quelqu'un de revenir pour questionner approximativement 24 personnes ici ?	Oui 1 Non 2
V15	Desirez-vous repondre a nos questions? *SI NON, ARRETER L'INTERVIEW	Oui 1 Non 2
V16	Quel age avez-vous? *CONCLURE L'INTERVIEW SI L'ENQUETE A MOINS DE 15 ANS	___ ___ANS
V17	Depuis combien d'années ce site existe-il ?	Moins de 2 ans 1

		2 ans ou plus 2 Pas Applicable 8
V18	Combien d'hommes et de femmes travaillent-ils ici, un jour/une soirée de forte activité?	HOMMES FEMMES ___ ___ ___ ___

No.	Questions	Categories de codes
V19	Quel types d'activités ont lieu ici sur place? LIRE LA LISTE ENCADRER UN CODE POUR CHAQUE ACTIVITÉ	OUI NON NE SAIT PAS Consummation de bière et liqueur 1 2 9 Consummation de tabac/joints 1 2 9 Séance de télévision ou de vidéo 1 2 9 Dancing 1 2 9 Animation musicales 1 2 9 AUTRES (Préciser) 1 2 9
V20	Est-ce que ce site est frenquente par les gens habitent…. *LIRE LA LIST ET DEMANDER DE CHAQUE VILLE/ENDROIT	OUI NON NSP 01 Dans <le ZIP> 1 2 9 02 Ville de Banfora 1 2 9 03 Bobo-Dioulasso 1 2 9 04 Koudougou 1 2 9 05 Ouagadougou 1 2 9 06 Ouaighouiya 1 2 9 07 Autre au District de Banfora 1 2 9 08 Autre au Burkina Faso 1 2 9 09 Abidjan 1 2 9 10 Autre dans Côte d'Ivore 1 2 9 11 Bamako 1 2 9 12 Autre dans Mali 1 2 9 13 Accra 1 2 9 14 Autre dans Ghana 1 2 9 15 Hors du Burkina Faso 1 2 9

V21	Il m'a été rapporté que les gens rencontrent des partenaires sexuels en ce lieu. Est-ce que… *LIRE LA LISTE		OUI	NON	NSP
		Les hommes rencontrent-ils des nouveaux partenaires sexuelles féminines ici?	1	2	9
		Les femmes rencontrent-elles des nouveaux partenaires sexuels masculins ici?	1	2	9
		Les hommes rencontrent-ils des nouveaux partenaires sexuels masculins ici?	1	2	9
		Est-ce qu' il y a quelqu'un ici qui faciltate des rencontres entre des nouveaux partenaires sexuels?	1	2	9
		Est-ce que les travailleurs de sexe racolent des nouveaux partenaires sexuels ici?	1	2	9

***LIRE:**
Nous voudrions de plus amples informations sur les caractéristiques des hommes et des femmes venant ici aux heures plus forte. Pour chaque caracteristique, dites moi quelle proportion d'hommes ou de femmes ont cette caracteristique — Aucun Quel-que Presque tout/tout

V22	Combien des hommes et des femmes viennent-ils ici aux heures d'affluence*:*		Aucun	Quel-que	Presque tout/Tout	NSP
	(a) Sans emploi					
		i) H	0	1	2	9
		ii) F	0	1	2	9
	(b) Sont-ils élèves/étudiants					
		i) H	0	1	2	9
		ii) F	0	1	2	9
	(c) Ont-ils moins de 18 ans					
		i) H	0	1	2	9
		ii) F	0	1	2	9
	(d) Habitent-ils a dix minutes de marche					
		i) H	0	1	2	9
		ii) F	0	1	2	9
	(e) Sont résidents de <la ZIP>					
		i) H	0	1	2	9
		ii) F	0	1	2	9
	(f) Sont résident du district					
		i) H	0	1	2	9
		ii) F	0	1	2	9
	(g) Vivent hors du Burkina Faso					
		i) H	0	1	2	9
		ii) F	0	1	2	9
	(h) Viennent au moins une fois par semaine					
	i)H		0	1	2	9
		ii) F	0	1	2	9
	(i) Trouvent une nouvelle partenaire sexuelle ici					
		i) H	0	1	2	9
		ii) F	0	1	2	9
	(j) Consomment l'alcool					
		i) H	0	1	2	9
		ii) F	0	1	2	9

<table>
<tr><td>No.</td><td>Questions</td><td colspan="6">Categories de codes</td></tr>
<tr><td rowspan="10">V23</td><td rowspan="10">Quels sont les moments de forte ici affluence pendant le semaine?

*SONDER POUR LES JOURS ET LES MOMENTS ET COCHER DANS LES TABLEAUX CI-CONTRE.</td><td></td><td>6-12</td><td>12-16</td><td>16-21</td><td>21-24</td><td>24-6</td></tr>
<tr><td>LUNDI</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>MARDI</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>MERCR.</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>JUEDI</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>VENDRE</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>SAMEDI</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>DIMANC</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">AUTRE (Préciser)_____</td></tr>
<tr><td>V24</td><td>Approximativement combien d’hommes peut-on dénombrer ici au cours d’une journée de forte affluence? Essayer d’estimer le nombre total d’hommes ici entre l’ouverture et la fermeture.

*LIRE LES OPTIONS SI NÉCESSAIRE.</td><td colspan="6">< 10 1
11-20 2
21-50 3
51-100 4
101-300 5
301-500 6
501-1000 7</td></tr>
<tr><td>V25</td><td>En moyenne combien de femmes peut-on dénombrer ici au cours d’une journée de forte affluence? Essayer d’estimer le nombre de femmes ici entre l’ouverture et la fermeture.

*LIRE LES OPTIONS SI NÉCESSAIRE.</td><td colspan="6">< 10 1
11-20 2
21-50 3
51-100 4
101-300 5
301-500 6
501-1000 7</td></tr>
<tr><td>V27</td><td>Quels sont les périodes de grande affluence?

*POSSIBILITÉ D’ENCERCLER OU D’ AJOUTER PLUS D’UNE OPTION</td><td colspan="6">SAISON DE PLUIES 1
SAISON SECHE 2
VACANCES SCOLAIRES 3
CONGÉS PAYÉS 4
FIN DE MOIS 5
FIN D’ANNEE 6
FIN DE RECULT 7
SAISON DE FUNERAILLES/MARRIAGES 8
NE SAIT PAS 9
AUTRES_____ 10
(Spécifier)</td></tr>
</table>

V28	Y-a-t'il déjà eu des activités de prévention de SIDA dans ce site? *SONDER AVEC SENSIBILISATION ET DISTRIBUTION DE CONDOMS	OUI 1 NON 2 NE SAIS PAS 9
No.	Questions	Categories de codes
V29	Durant l'année écoulée, est-ce on a deja distribuer les condoms ici, DANS le site, soit don ou achat?	TOUJOURS 1 PARFOIS 2 JAMAIS 3 NE SAIT PAS 9
V30	Y-a-t'il des condoms disponible avec vous aujourd'hui, ici DEDANS le site? Si OUI, puis-je en voir un. Si OUI, mentionner la marque et le prix.	OUI MAIS ON NE PEUT PAS EN VOIR UN 1 OUI, ET ON PEUT EN VOIR 2 NON 3 MARQUE D'UN CONDOM VU:_____ PRIX _____CFA POUR ___(NOMBRE) CONDOMS
V31	Durant les quatre dernières semaines, combien de condoms ont-ils été vendus ou donnée gracieusement ?	VENDU: ___ ___ ___ DONNÉS GRACIEUSEMENT: ___ ___ ___ NE SAIT PAS 9
V32	Est-il possible pour quelqu'un de trouver un condom dix minutes à la ronde en quittant ce lieu après 21 heures au……? *LIRE LA LIST ET DEMANDER DE CHAQUE VILLE/ENDROIT	OUI NON NSP Bar/restaurant/hotel 1 2 9 Pharmacie 1 2 9 Vendeur 1 2 9 Autre magasin/kiosque 1 2 9 Autre 1 2 9
V33	Seriez-vous disposé à: 1) Mettre en place un pro-	OUI 1 NON 2 NE SAIT PAS 9

	gramme de prévention educatif contre le SIDA? 2) Vendre des condoms ici ?	OUI 1 NON 2 NE SAIT PAS 9
V34	Remarque: L'évidence d'activités de prévention répertoriés par l'enquêteur sur le site	NOMBRE DE POSTERS CONTRE LE SIDA ___ ____ NOMBRE DE BROCHURES SUR LE SITE ___ ____ NOMBRE DE CONDOMS VISIBLES ___ ____ AUTRES (PRÉCISER)_____

QUESTIONNAIRE INDIVIDUEL

No.	Questions	Categories de codes
Q1	Nom de la <ZIP>	Ville de Banfora 1 Beregadougou 2 Sideradougou 3 Niangoloko 4 Mangodara 5
Q2	Numéro de l'enquêteur	___ ___
Q3	Numéro d'interview individuel	___ ___ ___
Q4	Nom du site et Numéro unique de ce site	_____ NOM Numéro unique du site: ___ ___ ___
Q5	Date (JJ/MM/AA)	___ ___ / ___ ___ /___ ___
Q6	Jour de la semaine	Lundi 1 Mardi 2 Mercredi 3 Jeudi 4 Vendredi 5 Samedi 6 Dimanche 7
Q7	Heure du jour (24 heures)	___ ___ : ___ ___

No.	Questions	Categories de codes
Q8	Nombre de personnes present au site au début de l'interview	Homme: ___ ___ ___ Femme:___ ___ ___
Q9	Sexe de l'enquêté	Masculin 1 Féminin 2

No.	Questions	Categories de codes
Bonjour/Bonsoir. Je travaille pour le DRS à Banfora, dans le but de contribuer au développer de meilleurs programmes de santé pour notre région. Nous souhaiterions vous poser quelques questions dans le but de collecter des informations nécessaires à la planification et à l'évaluation de ces programmes. Vos réponses resterons confidentielle. Pour cela je ne demanderai pas votre nom et le porterai pas sur le questionnaire. Les questions incluent des questions concernant votre comportement d'une manière générale y inclus votre comportement en matière de sexualité. Votre participation est complètement volontaire.		
Q10	Acceptez-vous de répondre à ces questions? *SI NON, ARRETER L'INTERVIEW.	OUI 1 NON 2
Q11	Quel age avez-vous ? *CONCLURE L'INTERVIEW SI L'ENQUÊTÉ A MOINS DE 15 ANS	ANS

Q12	Où habitez-vous?	DANS CETTE <ZIP> 1 VILLE DE BANFORA 2 BOBO-DIOULASSO 3 KOUDOUGOU 4 OUAGADOUGOU 5 OUAIGHOUYA 6 AUTRE DANS LE DISTRICT DE BANFORA 7 AUTRE DANS BURKINA FASO 8 ABJIDAN 9 AUTRE DANS COTE D'IVOIRE 10 BAMAKO 11 AUTRE DANS MALI 12 ACCRA 13 AUTRE DANS GHANA 14 AUTRES HORS DE BURKINA FASO 15
Q13	Depuis combien de temps habitez-vous ici/ la bas?	MOINS D'UNE ANNEE 0 NOMBRE D'ANNEES ___ ___ DEPUIS TOUJOURS 97

No.	Questions	Categories de codes
Q14	Venez-vous souvent ici? *SONDER ET ENCERCLEZ SEULEMENT UNE REPONSE.	CHAQUE JOUR 1 4-6 FOIS PAR SEMAINE 2 2-3 FOIS PAR SEMAINE 3 UNE FOIS PAR SEMAINE 4 2-3 FOIS PAR MOIS 5

		UNE FOIS PAR MOIS 6 MOINS D'UNE FOIS PAR MOIS 7 PREMIERE VISITE 8
Q15	Quand êtes-vous venu dans cette place pour la première fois?	PREMIERE VISIT 1 DANS LES 4 DERNIÈRES SEMAINES 2 DANS LES 2-6 DERNIERS MOIS 3 DANS LES 7-12 DERNIERS MOIS 4 DEPUIS PLUS D'UNE ANNNEE 5 DEPUIS PLUS DE CINQ ANNEES 6
Q16	Dans combien d'endroits comme celle-ci avez-vous été aujourd'hui? *SONDER POUR OBTENIR AUTRES ENDROITS OU LES GENS PEUVENT TROUVE DES NOUVEUX PARTENAIRES SEXUELS	A ÉTÉ: ___ ___
Q17	Dans combien d'autres endroits irez-vous aujourd'hui ou cette nuit? *SONDER POUR OBTENIR AUTRES ENDROITS OU LES GENS PEUVENT TROUVE DES NOUVEUX PARTENAIRES SEXUELS	IRA: ___ ___
Q18	Certaines personnes viennent dans telles endroits pour y rencontrer de nouveaux partenaires sexuels. Croyez-vous que des personnes peuvent rencontre des nouveaux partenaires sexuels ici ? Ce sont les personnes avec qui elles n'ont jamais eu de rapport sexuel auparavant.	OUI 1 NON 2
Q19	Avez-vous déjà rencontrent un nouveau partenaire sexuel ici?	OUI 1 NON 2

No.	Questions	Categories de codes
Q20	Quelle est la dernière fois que vous avez rencontre un nouveau partenaire sexuel ici?	DANS LES 7 DERNIERS JOURS 1 DANS LES 2-4 DERNIÈRES SEMAINES 2 DANS LES 2-3 DERNIERS MOIS 3 DANS LES 4-6 DERNIERS MOIS 4 DANS LES 7-12 DERNIERS MOIS 5 DEPUIS PLUS D'UNE ANNEE 6 JAMAIS RENCONTRE UN NOUVEAU PARTENAIRE ICI 8
Q21	La dernière fois que vous avez eu des rapports sexuels avec ce partenaire, avez-vous utilisé un condom?	OUI 1 NON 2 N'A JAMAIS RENCONTRE UN NOUVEAU PARTENAIRE ICI 8
Maintenant, j'ai besoin savoir le nombre des partenaires sexuels que vous avez eu dans les 4 dernières semaines. Cela inclut les personnes que vous rencontrez ici, vos partenaires habituels, et d'autres avec qui vous avez eu des rapports sexuels dans les 4 dernières semaines. Vos réponses resteront completement confidentielles.		
Q22	Avec combien de personnes différentes avez-vous déjà eu des rapports sexuels dans les 4 dernières semaines?	TOTAL DE 4 SEMAINES ___ ___
Q23	Parmi celles-ci, combien étaient de nouveaux partenaires dans les 4 dernières semaines? *SI PAS DE PARTENAIRES DANS LES 4 DERNIÈRES SEMAINES, ENCERCLEZ '0'	TOTAL NOUVEAU DE 4 SEMAINES ___ ___ PAS DE PARTNAIRES DANS LES 4 DERNIÈRES SEMAINES 0

Q24	La dernière fois que vous avez eu des rapports sexuels avec un de ces nouveaux partenaires, avez-vous utilisé un condom? *SI PAS DE NOUVEAUX PARTENAIRES LES 4 DERNIÈRES SEMAINES, ENCERCLEZ '0'	OUI 1 NON 2 PAS DE NOUVEAUX PARTNAIRES DANS LES 4 DERNIÈRES SEMAINES 0

No.	Questions	Categories de codes
Q25	Avec combien de personnes différentes avez-vous eu des rapports sexuels dans les 12 derniers mois? *SI LA PERSONNE A DES PARTENAIRES DANS LES 4 DERNIERES SEMAINES, INSERRER LE NOMBRE DE PARTENAIRES RAPPORTE DANS LA QUESTION Q22 DANS L'ESPACE CI-DESSOUS ET DEMANDER... Incluant les _____ personnes avec qui vous avez eu des rapports sexuels dans les 4 dernières semaines, avec combien de personnes différentes avez-vous eu des rapports sexuels dans les 12 derniers mois?	TOTAL DE 12 MOIS: ___ ___ ___ ___
Q26	Parmis celles-ci, combien était de nouveaux partenaires pour vous dans les 12 derniers mois? *SI PAS DE PARTENAIRES DANS LES 12 DERNIERS MOIS, ENCERCLEZ '0'	NOUVEAUX PARTENAIRES DANS LES 12 DERNIERS MOIS: ___ ___ PAS DE PARTNAIRES DANS LES 12 DERNIERS MOIS 0
Q27	Parmi toutes les personnes avec lesquelles vous avez eu des rapports sexuels dans les 12 derniers mois, avec combien avez-vous eu des rapports sexuels régulièrement, c'est à dire au moins une fois par mois au cours de l'année passée? *LA SOMME DE Q26 ET DE Q27 DEVRAIT	PARTENAIRES REGULIERS DANS LES DERNIERS 12 MOIS: ___ ___

	ETRE EGALE OU MOINS DE Q25. *SI PAS DE PARTENAIRES DANS LES 12 DERNIERS MOIS, ENCERCLEZ '0'	 PAS DE PARTNAIRES DANS LES 12 DERNIERS MOIS 0

No.	Questions	Categories de codes
Q28	*SI AU MOINS UN <u>NOUVEAU</u> PARTENAIRE DANS LES 12 DERNIERS MOIS (Q 26) POSER LA QUESTION CI-DESSOUS. **Où avez-vous rencontre votre plus récent nouveau partenaire?** *SI PAS DE PARTENAIRES DANS LES 12 DERNIERS MOIS, ENCERCLEZ '88'	DANS CE SITE 1 DANS CETTE <ZIP> MAIS PAS DANS CE SITE 2 VILLE DE BANFORA 3 BOBO-DIOULASSO 4 KOUDOUGOU 5 OUAGADOUGOU 6 OUAIGHOUYA 7 AUTRE DANS LE DISTRICT DE BANFORA 8 AUTRE DANS BURKINA FASO 9 ABJIDAN 10 AUTRE DANS COTE D' IVOIRE 11 BAMAKO 12 AUTRE DANS MALI 13 ACCRA 14 AUTRE DANS GHANA 15 AUTRES HORS DE BURKINA FASO 16 PAS DE NOUVEAU PARTENAIRES 88

No.	Questions	Categories de codes
Q29	D'où proviennent-il (ou proviennent-elle) votre plus récent partenaire ? *SI PAS DE PARTENAIRES DANS LES 12 DERNIERS MOIS, ENCERCLEZ '99'	DANS CETTE <ZIP> 1 VILLE DE BANFORA 2 BOBO-DIOULASSO 3 KOUDOUGOU 4 OUAGADOUGOU 5 OUAIGHOUYA 6 AUTRE DANS LE DISTRICT DE BANFORA 7 AUTRE DANS BURKINA FASO 8 ABJIDAN 9 AUTRE DANS COTE D'IVOIRE 10 BAMAKO 11 AUTRE DANS MALI 12 ACCRA 13 AUTRE DANS GHANA 14 AUTRES HORS DE BURKINA FASO 15 PAS DE NOUVEAU PARTENAIRES 88 NE SAIT PAS 99
Q30	Avez-vous déjà utilisé un condom?	OUI 1 NON 2
Q31	Avez-vous un condom avec vous? *SI OUI, DEMANDER: Puis-je le voir?	CONDOM AVEC SOI MAIS VOUS NE POUVEZ PAS LE VOIR 1 OUI ET CONDOM VU 2 N'A PAS DE CONDOM AVEC SOI 3

No.	Questions	Categories de codes
Q32	A combien de sceances de sensibilisation sur le SIDA avez-vous déjà assisté dans <la ZIP> dans les trois derniers mois?	NOMBRE DE SCEANCES : ___ ___
QUESTIONS A POSER SEULEMENT AUX FEMMES:		
Q33	Avez-vous reçu de l'argent, les cadeaux ou les faveurs en échange de relation sexuels dans les 4 dernières semaines?	OUI 1 NON 2 ENQUETES MASCULINS 8
Q34	Certaines femmes ont des douleurs au bas ventre, des écoulements inhabituels du vagin, ou des chancres génitaux. Dans les 4 dernières semaines, lesquels avez-vous eu…… *LIRE LA LISTE, SI L'ENQUETES EST DE SEXE MASCULIN ENCERCLER '8' POUR CHAQUE ITEM DE LA LISTE	SYMPTOMES — OUI NON P/A DOULEURS AU BAS VENTRE? 1 2 8 ECOULEMENTS INHABITUELS ? 1 2 8 CHANCRES GÉNITAUX? 1 2 8
ALLER A LA QUESTION Q38		

QUESTIONS A POSER SEULEMENT AUX HOMMES:		
Q35	Avez-vous déjà donné l'argent, les faveurs ou les cadeaux en échange pour les rapports sexuels dans les 4 dernières semaines?	OUI 1 NON 2 ENQUETE FEMININ 8
Q36	Avez-vous déjà eu des rapports sexuels avec un homme dans les 4 semaines passées?	OUI 1 NON 2 ENQUETE FEMININ 8
Q37	Certains hommes ont des expériences de douleurs durant la miction, ou des écoulements inhabituels du penis, ou des chancres génitaux. Durant les 4 semaines passées, avez-vous eu…. *LIRE LA LISTE SI ENQUETE FEMME, ENCERCLEZ '8'	SYMPTOMES — OUI NON P/A DOULEURS MICTIONELLES? 1 2 8 ECOULEMENT INHABITUEL? 1 2 8 CHANCRES GÉNITAUX? 1 2 8

	POUR CHAQUE ITEM DE LA QUESTION.	
	ALLER A LA QUESTION Q38	

No.	Questions	Categories de codes
QUESTIONS A POSER A TOUS LES ENQUETES:		
Q38	*SI HOMME OU FEMME A N'IMPORTE LEQUEL DES SYMPTOMES: Êtes-vous allé pour un traitement? *SI OUI, DEMANDER: Est-ce que vous avez allé a la clinique, a la pharmacie ou au docteur traditional ? *SI PAS DE TRAITEMENT, ENCERCLEZ '4' *SI PAS DE SYMPTOMES, ENCERCLEZ '5' ***VOUS POUVEZ AVOIR PLUS D'UNE REPONSE.**	OUI, DANS UNE CLINIQUE 1 OUI, A LA PHARMACIE 2 OUI AVEC UN DOCTEUR TRADITIONAL 3 NON 4 PAS DE SYMPTOMES 5
Q39	Avez-vous présentement un emploi?	NON 0 OUI, OCCASIONEL / TRAVAIL MI-TEMPS 1 OUI, TEMPS PLEIN 2
Q40	Etes-vous actuellement un étudiant?	OUI 1 NON 2
Q41	Combien d'années scolaires avez-vous fréquenté?	NOMBRE D'ANNEES ___ ___