

Media Release

JOHANNESBURG – The HIV infection rate in persons aged two years and older is estimated to be 10.8%, with a higher rate in females (13.3%) than in males (8.2%). HIV prevalence among young adults in the 15–49 age group increased slightly from 15.6% in 2002 to 16.2% in 2005, which may be an indication that the epidemic in the general population of South Africa has entered a phase of levelling off.

Of great concern is the finding that young women in the 15–24 age-group are up to four times more likely to be HIV positive than young men in the same group.

These are some of the results from the 2005 South African national household survey on *HIV Prevalence, Incidence, Behaviour and Communication*, commissioned by the Nelson Mandela Foundation (NMF) and conducted by the Human Sciences Research Council (HSRC) of South Africa, in partnership with the Medical Research Council (MRC), and the Centre for AIDS Development Research and Evaluation (CADRE).

The 2005 survey is a repeat of the 2002 survey, and allows for generating estimates of HIV and associated factors in a representative sample of the total South African population. It excludes children under two years of age and adults who live in university dormitories, boarding schools, army barracks and hospital patients.

Dr Olive Shisana, principal investigator and CEO of the HSRC, emphasised that the sample size in the 2005 survey was larger than that in 2002 and the estimates are therefore more robust. In 2005, 23 275 people took part in the survey and 15 851 respondents agreed to be tested for HIV, compared to 2002, when 9 963 people took part in the survey and 8 428 agreed to be tested.

John Samuel, Chief Executive of the Foundation, said today that the organisation commissioned the repeat survey as part of its continuing effort to promote understanding, dialogue and action on the central challenges South Africa is tackling.

“While the Foundation is not primarily a research body, we occasionally commission research to broaden scientific and social knowledge of HIV/AIDS. This is the first time a repeat study of HIV prevalence has been done in South Africa, and the first time incidence has been investigated. We believe the findings can make a meaningful contribution to policy. It is also important that the vital information produced by the study be used to focus practice in the field of HIV/AIDS,” said Samuel.

The Foundation’s support for a repeat study was also informed by positive responses to the usefulness of the first which was ground-breaking and, for the first time, demonstrated levels of infection in South Africa, by age, gender, location and race.

Since then, the Foundation has participated with the HSRC in providing technical assistance in Botswana, Swaziland, Mozambique and Lesotho in conducting similar household studies. The first study also received international acclaim and influenced government policy on treatment. A second study to assess risk exposure of HIV in the age group 2 to 9 and provided an evidence base for AIDS Service Organisations.

“The second study has allowed us to assess trends in infection and knowledge of HIV between 2002 and 2005. It enables us to probe behaviour, communication and perceptions around treatment, mental health, and vaccine development. It also provides critical insights into contextual, structural and political factors for HIV,” said Samuel.

“It is the intention of the Foundation to discuss these figures with government to help to inform the national Comprehensive Plan for Prevention, Treatment, Care and Management of HIV/AIDS.”

Professor Thomas Rehle, a co-principal investigator of the report, explained that technological developments have allowed new biological tests to be conducted on samples gathered in the survey. One of the hallmarks of the 2005 survey is the availability of nationally representative estimates of annual new infections, or incidence rates.

“The addition of HIV incidence testing into the survey protocol allows a simultaneous analysis of HIV prevalence and incidence that will significantly improve our understanding of the current dynamics of HIV transmission in South Africa. Such information is vital to informing interventions and systems of support”, Rehle said. The analysis will also contribute to improvements in models for projecting existing and future trends in relation to HIV and AIDS.

Comparing the 2002 household survey with the 2005 survey, the study found increased HIV prevalence among young people aged 15–24 (10.3% vs. 9.3%) and a similar prevalence in adults 25 years and older (15.6% vs. 15.5%). In the broader age group of people 15–49, the study found a HIV prevalence of 16.2% in 2005 and 15.6% in 2002. Among children aged 2–14, however, a substantially lower HIV prevalence was recorded – 3.3% in 2005, compared to 5.6% in 2002. A further breakdown for ages 2–4 (5.1%) and 5–9 (4.4%) indicates that the HIV problem is significant among children.

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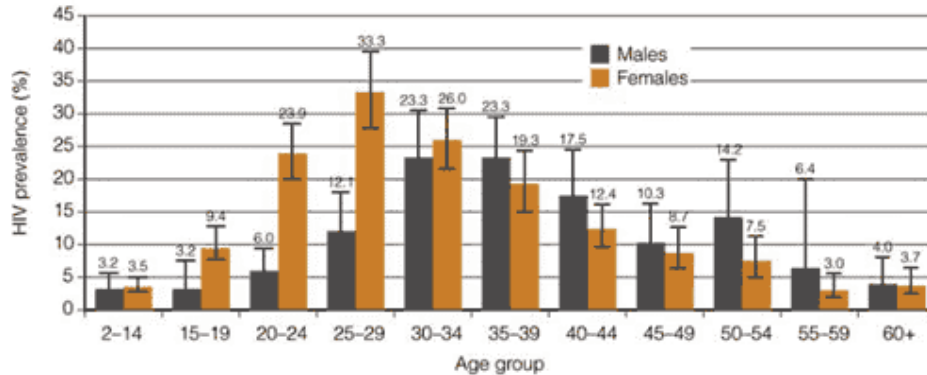
Fact Sheet 2

National HIV prevalence in South Africa – the graphics.

The national HIV prevalence in the population of people two years and older is estimated to be 10.8%, with a higher prevalence in women (13.3%) than in men (8.2%). HIV prevalence increases with age from 3.3% in children aged 2-14 years to 16.2 % in adults 15-49 years of age. In people 50 years and older, HIV prevalence is estimated to be 5.7%.

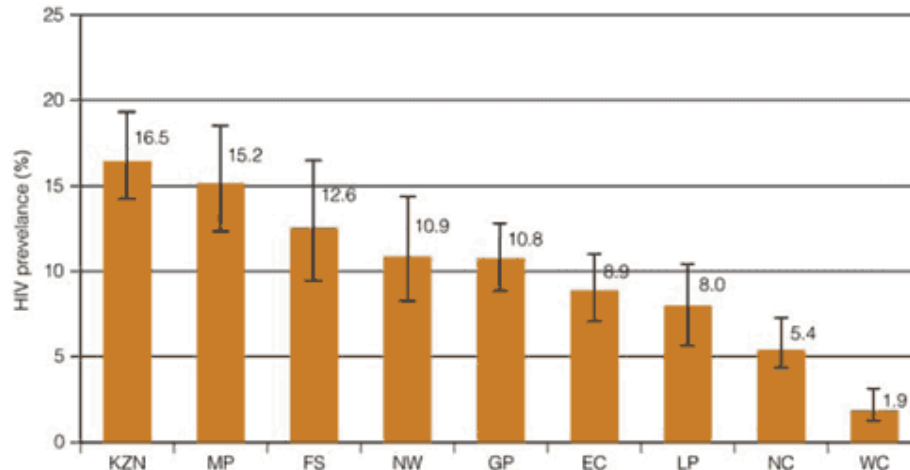
The HIV prevalence among children aged 2-4 and 4-9 is high [\[See Fact Sheet 3\]](#)

Figure 3.1 Prevalence of HIV by sex and age group, South Africa 2005



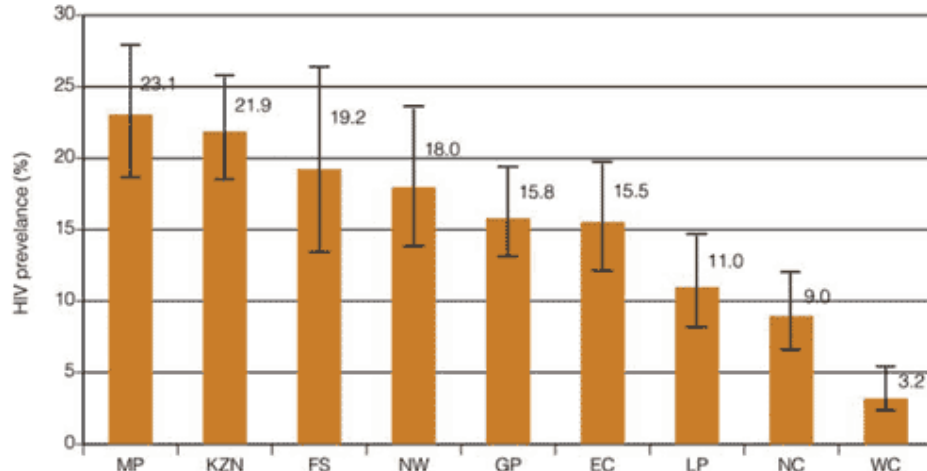
HIV prevalence by province is shown in Figure 3.2. KwaZulu-Natal, Mpumalanga and Free State have the highest HIV prevalence in South Africa. The lowest HIV prevalence levels were recorded in the Western Cape and Northern Cape.

Figure 3.2 HIV prevalence in population aged two years and above, by province, South Africa 2005



Mpumalanga has the highest prevalence in this age group, 23.0%, followed by KwaZulu-Natal at 21.9%. Western Cape has the lowest prevalence, 3.2% (Figure 3.8).

Figure 3.8: HIV prevalence among adults aged 15-49 years by province, South Africa 2005



Among persons of reproductive age, Mpumalanga has the highest HIV prevalence, followed by KZN and Free State. These three provinces have HIV prevalence rates that are not significantly different.

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Fact Sheet 4 Perceptions of being invulnerable to HIV.

An individual's belief in his or her personal susceptibility to illness or disease is an important element in health behaviour and influences whether someone adopts risk-reducing behaviour and/or preventive strategies.

In this study respondents were asked how they would rate themselves on a scale of 1-4 in terms of risk of becoming infected with HIV and their reasons for believing so. The main finding is that about two-thirds (66%) of the adult and youth participants in the study felt that they would not get infected with HIV.

Table 3.46: Self-rating of own risk of becoming infected with HIV among respondents aged 15 years and older, South Africa 2005

Ranking	Response category	n	%
1	I will not get infected	6021	32.7
2	I probably won't get infected	5179	33.2
3	I am probably going to get infected	4676	31.8
4	I am definitely going to get infected	247	2.2

When asked what the reasons were for those who believed that they would not get infected, prominent responses included being faithful to their partner or trusting their partner, abstaining from sex, always using condoms, and not being sexually active (Table 3.49).

Table 3.49: Reasons respondents aged 15 years and older believed they would not get infected (n = 11 100), South Africa 2005

Reasons	n	%
Faithful to one partner or trust my partner	5 208	46.4
Now abstaining from sex	2 630	22.6
Always use condoms	1 676	19.0
Have never had sex before	1 849	14.3
Do not have sex with prostitutes/sex workers	454	5.2
Do not share used needles or body piercing instruments	563	5.1
Know that both my partner and I have tested negative for HIV/AIDS	229	1.9
Other*	1 066	9.7

Note: * Includes 'God protects me', 'my ancestors protect me', 'HIV does not occur in my community', 'it is an urban disease', 'it is a white disease', 'it is a black disease', 'it is a rural disease', 'it is a woman's disease' and 'other' unspecified.

Age is often a mediating factor that influences a person's likelihood to take action to change his or her lifestyle. In this study, the older participants (50 years and above) felt less vulnerable to HIV than younger participants. The group that felt most vulnerable to HIV infection was those aged 25-49 years. This is consistent with prevalence in this age group.

The findings indicated that more participants who perceive themselves to be at high risk of HIV infection had been for an HIV test.

Of major concern is that more females (12.8%) than males (7.5%) who perceived themselves to be at low risk of being infected by HIV, were found to be HIV positive in this study.

The majority of Africans indicated that they were more vulnerable to HIV infection, a perception that is related to high prevalence in this group.

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Fact Sheet 3

Children with HIV and exposure to risk of infection.

The figures show that South African children have a high HIV prevalence. In the 2-4 age group, 4.9% of boys and 5.3% of girls are HIV positive, translating into an estimated 129 621 children. In the slightly older age group of 5-9, 4.2% of boys and 4.8% of girls have HIV - an estimated 214 102 children, and in the 10-14 age group, this figure drops to 1.6% among boys and 1.8% among girls.

Most children in this group are likely to have been HIV positive from birth, but the incidence data suggests other factors, which could include a breakdown in infection control in healthcare facilities, or sexual abuse.

The researchers of the study were not in the position to make any specific findings about child sexual abuse, but the *Children's Report South African National HIV Survey* by Brookes, Shisana & Richter, based on the 2002 household survey, established that children are at risk for contracting HIV through a number of sources, besides mother-to-child transmission during pregnancy and early infancy. These include within homes, schools and communities.

Risks associated within the home include sexual abuse, and the levels of care and protection afforded to children within the home. Schools and communities can also be unsafe, especially for children who may be unsupervised in going between school and home.

Risk environments. Poverty, types of housing settlements, businesses run from home and exposure to alcohol and drugs all contribute to increasing risk for children to sexual abuse because such environments diminish protection and increase exposure to negative consequences.

Of the households surveyed, at least 12% run businesses from home. The majority of these businesses are informal spaza shops. Among children aged 12-14 years, one in ten children reported exposure to someone taking drugs and slightly over a third (36%) were exposed to someone who got drunk at least once a month.

Care and protection of children at home and at school is essential to preventing sexual abuse and HIV transmission. A little under half of children aged 2-11 years are often or sometimes sent out on errands alone. Among 12-14 year olds, this proportion reaches 77.7%.

A little less than one-third of children aged 2-11 years are allowed outside the home yard without adult supervision, while the corresponding figure for children aged 12-14 years is 57.1%. A substantial number of children are left alone at home, and the percentage increases with age, from 11.7% of children aged 2-11 years to almost half of the children aged 12-14 years, with more males likely to be left alone at home.

Over a quarter of children aged 2-11 years are left in the care of a girl 15 years or younger (26.1%), while 44.8% of children aged 12-14 years are left alone in the care of a male non-family member. Over a third of girls and over a half of boys aged 12-14 years are left in the care of a male family member.

A key area of risk for children is travelling to and from school. Just over one-quarter of children aged 2-11 years travelled to school on their own or with older siblings, while 17-18% reported going to school and returning unaccompanied. In the age group 12-14, about 40% of children went to school and returned unaccompanied. The vast majority of children (68.1%) aged 2-11, travelled to and from school on foot, and this increases to 72% for children aged 12-14.

Given that children spend a considerable part of their daily lives in school, it is critical that such environments are safe for children. Table 3.96 and 3.97 shows that sexual harassment at schools is a serious problem. Three out of ten children surveyed reported that boys sexually harass girls and 8% reported that male educators propose relationships with girl pupils.

Table 3.96: Sexual harassment at school of children aged 12-14 years, South Africa 2005

Sexual harassment	n	Always/often/sometimes %	Never %	No information %
Boys sexually harass girls by touching, threatening or making rude remarks to them	1 599	31.0	48.0	21.0
Girls sexually harass boys by touching, threatening or making rude remarks to them	1 599	19.9	57.7	22.3
Male educators propose relationships with girl pupils	1 598	8.3	53.3	38.5
Female educators propose relationships with boy pupils	1 598	4.4	56.1	39.6
Teachers propose relationships with pupils of the same sex	1 598	3.8	53.8	42.5

Table 3.97: Sexual harassment at school of female children aged 12-14 years, South Africa 2005

Sexual harassment	n	Always/often/sometimes %	Never %	No information %
Boys sexually harass girls by touching, threatening, or making rude remarks				

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Fact Sheet 1

Why incidence is important.

HIV prevalence figures reflect the proportion of people in the population living with HIV at a given point in time. The observed HIV prevalence is the result of cumulative new infections over time, minus the cumulative deaths that occurred in HIV infected persons. HIV prevalence includes past and recent infections.

In the 2005 South African national household survey on *HIV Prevalence, Incidence, Behaviour and Communication*, another important measurement was added, namely incidence. In contrast to prevalence, HIV incidence quantifies the number of new infections that occur in non-infected individuals during a specified period of time, e.g. the annual incidence during a given year.

The complexities and limitations of epidemiological approaches to measure national HIV incidence in large cohort studies made a case for a laboratory-based method that can distinguish recent from established long-term HIV infections. The availability of tests for recent HIV infection promises to be a major advance in estimating incidence in selected populations. Incidence measures are generally better than prevalence measures for assessing the dynamics of HIV transmission in different population strata. The addition of HIV incidence testing into the 2005 survey protocol enables us for the first time to analyze HIV prevalence estimates, HIV incidence estimates and HIV associated risk factors concurrently.

Current HIV-transmission dynamics in South Africa are best reflected by the HIV-incidence figures observed in the different sub-populations. Especially alarming are the incidence rates among young females at prime childbearing age. Women in the 15-24 age group have an eight-times higher HIV incidence than males (6.5% compared to 0.8%) and account for 87% of the recent HIV infections in this age group.

Our incidence analysis also confirmed recent findings from Uganda by Gray et al. (2005) that suggest an increased risk of HIV acquisition during pregnancy. Among African women aged 15-49 years who were pregnant in the last 24 months an HIV incidence of 7.9% was found, the highest incidence rate of all analysed sub-populations in our survey. This is powerful information in developing prevention interventions specifically targeted at pregnant women visiting antenatal clinics.

Almost 16 000 specimens tested for HIV provided an unparalleled large sample to estimate HIV incidence on a national scale for South Africa. Table 3.18 presents HIV incidence estimates for the main reporting domains of the 2005 survey:

Table 3.18: HIV incidence among respondents 2 years and older by background characteristics, South Africa 2005

	Total sample	Number with infections 180 days	HIV+ recent (past)	Annual incidence % / year	95% CI
Total	15 851	181		2.7	1.3–4.1
Sex					
Male	6 342	40		1.5	0.0–3.3
Female	9 509	141		3.6	2.1–5.1
Race					
African	9 950	167		3.4	1.3–5.5
White	1 173	4		0.3	0.0–0.9
Coloured	3 382	8		0.3	0.0–0.6
Indian	1 319	2		0.5	0.1–0.9
Age group					
Children					
2–14	3 815	11		0.9	0.0–2.8
2–4	729	1		0.8	0.0–2.9
5–9	1 341	6		1.5	0.0–3.4
10–14	1 745	4		0.4	0.0–1.3
Youth					

Fact Sheet 5

Low overall levels of stigmatising attitudes.

Stigma and discrimination against people living with HIV/AIDS have often been identified as primary barriers to effective HIV prevention, as well as to the provision of treatment, care and support.

Table 3.64 shows that the overwhelming majority of respondents indicated that they would be willing to care for a family member with AIDS. However, varying proportions of respondents showed some degree of negative attitude and perception in relation to people living with HIV/AIDS (PLWHA).

Most respondents were willing to provide care for a family member with AIDS, and the vast majority were opposed to acts of discrimination against children and others living with HIV. Additionally, 61.9% were prepared to be open about the HIV status of a family member, and nearly half would consider marrying a person living with HIV/AIDS.

Table 3.64: Attitudes of respondents aged 15 years and older, South Africa 2005

Attitudinal item (n = 6 081)	Agree %	Unsure %	Disagree %
I would be willing to care for a family member with AIDS	90.7	2.9	6.3
HIV-positive children should not be kept separate from other children to prevent infection	79.8	5.7	14.5
It is not a waste of money to train or give a promotion to someone with HIV/AIDS	74.7	10.4	14.9
If I knew that a food seller had HIV, I would still buy food from them	71.1	5.4	23.4
I would not want to keep secret the HIV-positive status of a family member	61.9	7.6	30.5
It is not foolish to marry a person who is living with HIV/AIDS	46.5	17.6	36.0
I would not have a problem having protected sex with a partner who has HIV/AIDS	35.3	18.0	46.8

Table 3.66 shows the percentage of the population that agreed to attitude statements according to where they live. Attitudes in urban areas were more positive towards people with HIV/AIDS, but there were no differences between urban formal and urban informal populations. However, the attitude of people in formal rural areas were less positive than that of people in informal rural areas, with the exceptions in openness about a family member being HIV positive (3.4% lower) and perceptions of marriage to a person living with HIV/AIDS (6.2% lower).

Table 3.66: Attitudes of respondents aged 15 years and older by locality type, South Africa 2005

Attitudinal item (n = 6 081)	Urban formal %	Urban informal %	Rural informal %	Rural formal %
I would be willing to care for a family member with AIDS	90.7	91.4	91.2	88.1
HIV-positive children should not be kept separate from other children to prevent infection	77.8	82.1	83.5	72.8
It is not a waste of money to train or give a promotion to someone with HIV/AIDS	79.7	78.3	68.8	66.3
If I knew that a food seller had HIV, I would still buy food from them	74.9	72.0	68.4	58.8
I would not want to keep secret the HIV-positive status of a family member	61.8	64.3	61.0	64.4
It is not foolish to marry a person who is living with HIV/AIDS	52.4	49.4	38.2	44.4
I would not have a problem having protected sex with a partner who has HIV/AIDS	36.6	34.6	34.6	30.6

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Fact Sheet 6

Uptake of voluntary counselling and testing (VCT).

VCT is an important strategy for HIV prevention and access to treatment, care and support services. Although overall knowledge of where to access HIV testing services was high, rural respondents and those 50 years and older make less use of, and have less access to VCT services.

Of the 11 838 respondents 15 years and older who were tested for HIV in this survey, 3 586 (30.3%, or just under a third) said they had previously been tested for HIV. About a third of respondents indicated that they had been tested in the past year.

Table 3.53 shows that respondents who have had a HIV test before the survey, had a higher HIV prevalence (16.2%) than those who have never had an HIV test (12.8%), which is a statistically significant difference in HIV prevalence. While this suggests that people who are more at risk of HIV are more likely to be tested, it is estimated that there are over two million people living in South Africa who are HIV positive, but do not know their status.

Table 3.53: HIV prevalence among respondents aged 15 years and older by 'ever had an HIV test', South Africa 2005

Previously had an HIV test	n	HIV + %
Yes	3 586	16.3
No	8 252	12.8

The study found that HIV testing was most likely to be conducted in the public sector, and that the overall perceptions of service satisfaction within the immediate testing environment were extremely high. A quarter (25.1%) of respondents were very satisfied, 70.6% were satisfied, and only 4.3% were neutral, unsatisfied or very unsatisfied.

Willingness of individuals to undergo VCT is influenced by a range of factors, including motivation to know one's status, although in a number of instances VCT is a product of factors related to health and life insurance, pregnancy or illness.

A considerable proportion of respondents in this study found out their HIV status because they wanted to know it, or were feeling ill, or were pregnant (in the case of females), HIV testing also occurs as a product of external factors such as applying for an insurance policy or loan.

Fact Sheet 7

Sexual behaviour

Attitudes are complex to measure through questionnaire-based approaches, given that many factors influence a particular attitudinal response. In 2002, an alternate set of questions was utilised, mainly focusing on knowledge-related attitudes. This produced generally positive findings in relation to attitude. The questions used in the present survey attempted to explore more deep-seated attitudes and values.

SEXUAL DEBUT

Delayed onset of sexual activity (sexual debut) reduces incidence and prevalence of HIV in younger age groups.

Overall, very few children in the 12–14 year age group (1.9% males and 1.5% females) reported ever having had in sex.

Amongst 15 year olds surveyed, 11.7% of males and 7.9% of females had previously had sex. Amongst 20 year olds surveyed, 74.8% of males and 80.0% of females had previously had sex

Of those who had not had sex before, 71% said they were not ready, and 22.9% said they were not interested in sex

An inter-age analysis revealed a trend towards earlier sexual debut among younger respondents.

SEXUAL EXPERIENCE

The results showed that slightly more young females below 25 years of age (62.3%) were likely to have had sex before than their male counterparts (53.9%).

SECONDARY ABSTINENCE

Secondary abstinence refers to those individuals who have had sex before, but who have not had sex in the past year. Secondary abstinence reduces HIV infection risk

Overall, nearly one-third of the respondents who were previously sexually experienced had not had sex during the previous 12 months.

Secondary abstinence was higher among young men aged 15–24 (23%) than among adult men aged 25–49 years (9.8%), but it was the same among women in both these age groups (20.0% and 21.3% respectively). Secondary abstinence was highest among elderly women (71.3%) and Africans (58.7%) aged 50 years and older.

SEXUAL PARTNERSHIPS

Unprotected sex with greater numbers of sexual partners increases risk of HIV acquisition and this risk is increased in the context of South Africa's epidemic where there is high HIV prevalence. Most sexually active respondents reported that they had only one partner during the year with a higher proportion of females (97.4%) reporting this than males (83.7%).

The portions of sexually active respondents who had more than one partner in the past year were as follows:

- 27% for males and 6% for females aged 15-24
- 14.4% for males and 1.8% for females aged 25-49
- 9.8% for males and 0.3% for females aged ≥50

Overall rates were higher for informal settlements – 20.0% for males and 3.5% for females
HIV prevalence for those with more than 1 partner in past year was higher

- 20.6% for >1 partner, 16.3% for 1 partner

AGE MIXING

Having a partner 5 years or older poses high HIV infection risk for youth, as it exposes them to a higher HIV prevalence age group. Young females were more likely to have an older partner – 18.5% of sexually active females aged 15-19 had had male partners 5 or more years older, compared to 2% of males in this age group.

HIV prevalence of 15-19 year olds with older partners was higher. 29.5% of females with partner ≥5 years older were HIV positive, compared to 7.2% of females with partner within 5 years of own age. In the case of males, 19.0% with partner ≥5 years older were HIV positive, compared to 3.0% of males with partner within 5 years of own age

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Fact Sheet 8 Condom use and access

Table 3.34 summarises proportions of respondents who had sex in the last year who used a condom during their last sexual intercourse during the last sexual intercourse. The large majority of respondents who were young Africans with multiple partners, and likely to use a condom in the past 12 months. There were lower levels of condom use among those aged over 50 years (8.6% for men and 12.6% for women).

Table 3.34: Condom use during the last sexual intercourse among respondents aged 15 years and older by background characteristics

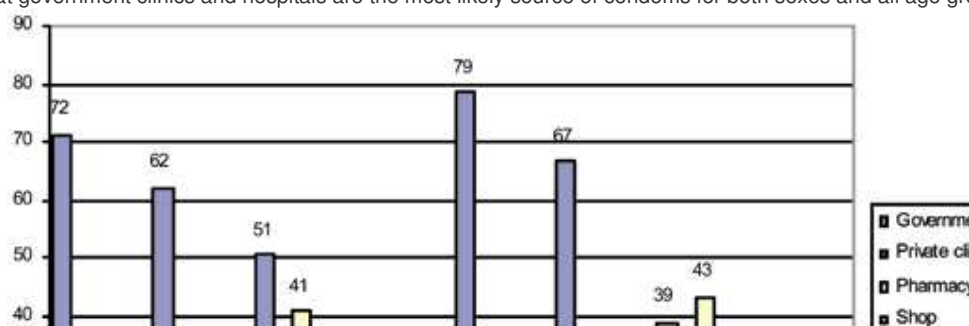
Variable	Male		
	n	%	n
Total	3 863	38.1	5393
Age group			
15-24	976	72.8	1 410
25-49	2 075	35.3	3 241
50+	812	8.6	742
Race			
African	2 239	43.6	3 281
White	482	16.7	660
Coloured	730	22.3	914
Indian	406	34.5	524
Sexual activity			
One partner	3 802	33.4	5 159
Multiple partners	538	62.3	135
Locality type			
Urban formal	2 319	38.0	3 052
Urban informal	429	42.4	642
Rural Informal area	673	44.0	1408
Rural formal	442	20.0	491

Table 3.35 shows the reasons mentioned by respondents for condom use during their last sexual encounter. The overwhelming majority used condoms to prevent HIV infection. Almost half (49.4%) responded that a condom was used as a contraceptive method.

Table 3.36 shows reported condom use for different age groups according to marital and partner status. Table 3.36 shows reported condom use for different partner status. The table shows that respondents who were single were considerably more likely to use a condom than those who were married. Young adults and those who had three or more partners in the past year were more likely to use a condom at last sex than those who either had only one partner or adults who had more than one current partner were more likely to use a condom during the last sexual encounter than respondents who were married. It also notes that condom use was also relatively high among youth and adults aged 25–49 years who had one current partner only, 25–49 year olds who are divorced or separated.

ACCESS

Main source of condoms is the Department of Health's public sector condom programme. Condom distribution has increased from 2001 to 2005. Table below illustrates condom brands most recently used, and shows that the majority of respondents used either a public sector condom or a private clinic condom. The figure below illustrates that government clinics and hospitals are the most likely source of condoms for both sexes and all age groups.



ACCESS

Main source of condoms is the Department of Health's public sector condom programme. Condom distribution has increased from 267 million in 2001 to 346 million in 2004. The table below illustrates condom brands most recently used, and shows that the majority of respondents used either a public sector condom, or a social marketing brand.

Condom brand most recently used	%
Choice condom (government brand)	25.8%
Red ribbon (previous government brand)	17.9%
Lovers Plus (social marketing brand)	17.6%
Durex (commercial brand)	8.2%
Trust (social marketing brand)	3.4%
Other or don't know	27.2%

The figure below illustrates that government clinics and hospitals are the most likely source of condoms for both sexes and all age groups.

