IMPLICATIONS OF DIFFERING HIV/AIDS COMMUNICATION STRATEGIES FOR HIV/AIDS PREVENTION

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Abstract

Prevention efforts in South Africa, despite increasing investment, have not positively impacted on prevalence rates. This research report sets out to determine the implications, if any, of differing communication strategies on prevention. The funding environment in which programmes strategies are developed and implemented are explored to determine if funding issues impact on programme strategies. Interviews were conducted with experts from the NGO sector, government as well as international donor organizations. In the absence of a clear national communications strategy there has been minimal impact on prevention. Key issues emerging from this research point to the lack of a national strategy and cohesion of programming, and the need to address the complexities of HIV communication. Going forward the importance of an inclusive strategy which is sound in its epidemiological understanding will be critical in providing a framework in which all communication programmes can contribute to reducing prevalence in South Africa.

Declaration

I declare that this report is my own unaided work. It is submitted in partial fulfillment of the requirements of the degree of Master of Management (in the field of Public and Development Management) in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.

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Abbreviations and Acronyms

ABC messaging	"A" = Abstinence; "B" = Being Faithful, "C" = Correct and Consistent use of Condoms
CADRE	Center for AIDS Development and Research
EQUINET	Regional Network fro Equity in Health in Southern Africa
JHHESA	Johns Hopkins Health Education and South Africa
GCIS	Government Communication and Information System
JHUCCP	Johns Hopkins University Centre for Communication Programs
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IEC	Information, Education and Communication
IDASA	Institute for a Democratic Alternative in South Africa
MDG's	Millennium Development Goals
NDoH	National Department of Health
NGO	Non Government Organisation
OECD	Organization for Economic Cooperation for Development
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Fund for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
WHO	World Health Organisation
UN	United Nations
UNAIDS	United Nations Aids Programme
USAID	United States Agency for International Development
UNRGE	UNAIDS Reference Group on Economics
SANAC	South African National AIDS Council
STI	Sexually Transmitted Infection

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1 CHAPTER 1: BACKGROUND AND CONTEXT

The world has known about HIV and AIDS for over twenty years. In the time subsequent to its discovery, its origins, still a subject being debated and researched, the causal agent, the Human Immunodeficiency Virus (HIV), has been isolated, named and its modus operandi understood. Approximately 10 million people worldwide were infected by the end of 1980's, with this figure quadrupling to an estimated 40 million additional infections in the 1990's (UNAIDS, 2001). Although clinical prevention by way of post-exposure prophylaxis (PEP) and prevention of mother-to-child transmission (PMTCT), and treatment of the disease has advanced, a cure is yet to be discovered. The advancement of the disease has sparked global concern and mobilised an international response to prevent, treat and care for those infected and affected by the disease.

The pandemic currently receives more global attention, effort and funding than any other public health issue (PANOS, 2002). International spending on HIV/AIDS in developing countries has increased from US$ 300 million to US$47 billion in 2003 (UNIADS, 2005). The recognition that HIV/AIDS is much more than a health issue has propelled thinking about the disease in the context of "eradication of poverty and hunger, access to education and the promotion of gender equality" (Garmaise, D. 2005). This has placed funding for HIV/AIDS outside the realm of traditional health funding, and has gone so far as to include the prevention and management of HIV/AIDS in the UN's Millennium Development Goals (MDG). In 2004, it was estimated that spending on HIV/AIDS interventions (including funding from domestic governments, foreign donors and personal spending) was in the region of US $6.1 billion. Going forward, in the period between 2004 and 2007, the UNAIDS Reference Group on Economics (UNRGE) projected that funding would have to double to at least US$14 billion (Garmaise, D. 2005).

As far as Africa is concerned, the growing global awareness about the devastating impact of AIDS on Africa primarily, but secondarily on developing nations, has meant that opportunities for advocacy to mobilise foreign funding has increased. Given the weak economic position of the vast majority of African countries, most of the required funding will have to come from outside sources (United Nations Economic Commission for Africa (UNECA), 2001). UNECA estimated in 2000 that a funding gap existed between required funding of $3-4 billion and expenditures of $0.3-0.4 billion. In this scenario, domestic spending would have to increase to 0.25%-0.5% of GDP and foreign funding make up the balance. What is required then, in the estimation of the UNECA, is a "simultaneous and sustained response from all role players to ensure a tenfold increase in resources required" (UNECA, 2001). Further, capacity of African governments and institutions to manage expanded funding should be built as part of the funded interventions.

The spread of the disease globally has been skewed toward developing countries, with Africa in general, and Sub-Saharan Africa in particular, experiencing the most rapid and devastating growth. In 2001 Sub- Saharan Africa, which "contains 10% of the world's population, accounted for two-thirds of the 40 million people living with HIV" (De Cock, M., Mbori-Ngacha, D & Marum E., 2002). HIV/AIDS currently also makes up the "biggest single component of the continents disease burden, accounting for 20% of all deaths and disability-adjusted life-years lost in Africa" (Creese, A., Floyd, K., Alban, A., & Guinness, L., 2002). Whilst the pandemic has gradually abated in industrialized countries, it has spread almost unabated on the African continent with current figures surpassing projections made in the 1980's (De Cock et al, 2002). The impact of HIV and AIDS in Africa is further compounded by the effects it has on the control of other infectious diseases such as tuberculosis, malaria and sexually transmitted infections (Corbett, E., Steketee, R.W., O ter Kuile, F., Latif, A.S., Kamali, A., & Hayes, R.J., 2002).

This rapid spread in Africa, with its compounding and aggravating factors, has commanded world attention, including Governments, non-Governmental organisations and global bodies. By all accounts, early "African denialism" has passed (De Cock et al, 2002), with several countries such as Senegal and Uganda acting decisively to halt the spread and effects of the disease. Amidst concerted efforts by many players to understand the disease holistically, it has became clear that, amongst others factors, epidemiological differences which exist between individuals, communities and consequently between countries, is a major contributing factor to the infection rates in Africa (De Cock et al, 2002). With this realization, and with the absence of a cure or vaccination against the disease, came the advancement of approaches to prevention beyond the clinical, to include behavioural approaches in line with traditional public health approaches. Against this backdrop, the potential of communication to change HIV related behaviour has been touted as being a powerful agent, demanding as much investment as other preventative measures (Family Health International, 2002).

The results of prevention information, education and communication (IEC) efforts in the form of all types of media as well as community driven interventions, however, have been at best unsatisfactory. In fact, despite the large investments in communication and education, myths and misconceptions still abound about HIV and AIDS (UNAIDS, 2003), particularly in Africa. The reality is that not all of Africa has been affected in the same ways, with the disease in different phases in different countries. Further, HIV and AIDS has affected men and women at different ages differently, the rich and the poor, the educated and uneducated as well as rural and urban populations. This diversity in the potential audience for communication and education adds to the complexity of the job at hand.

2 CHAPTER 2 - INTRODUCTION

Sub- Saharan Africa, and notably South Africa, appears, by many accounts, to have grabbed the attention of the international community, not only because of the high prevalence rates in the region, but because of the contributing contextual (socio-economic) factors which have made the fight against the disease complex, protracted and challenging. Within this context, this research is focused on addressing South Africa's communication prevention efforts aimed at curbing the spread of the disease and its impact on HIV and AIDS risk related behaviour. With the reality of a number of key players who have implemented communication prevention programmes in the absence of a national strategy, this research aims to explore what the implications of sometimes divergent strategies have been for overall prevention.

This research report has been divided into five chapters. The first chapter provides the context for this research in terms of the problem it wishes to address and the questions which have guided the development and design of this research. This chapter also gives a detailed description of the methods followed in order to gather data, present and analyse the data, with a rationale provided for the specific choice of research design.

A detailed literature review is presented in chapter two, and is arranged thematically to provide structure for the review of literature deemed relevant to this research. Chapters three and four deal with the presentation and analysis of the data. Data is presented thematically and is drawn from a mix of primary and secondary data sources. The fourth chapter provides an analysis and discussion of the data presented in the previous chapter, following the same thematic arrangement of the two proceeding chapters. The final chapter is a synthesis of the research findings and discussions. Final conclusions are presented and some recommendations are provided for HIV/AIDS prevention communication in South Africa

2.1 PROBLEM STATEMENT

South Africa has one of the highest HIV prevalence rates in the world (South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005) with a rapid rise in prevalence between 1992 and 2000. The first significant response from Government came in 2000, with the development of Governments' five year plan to address HIV and AIDS. With the reality of the rapid and seemingly unchecked spread of the disease, a plethora of communication programmes mushroomed in the country from as early as 1994. Three stakeholder groupings emerged as key players in the arena of HIV communication viz. the National Department of Health (NDoH), the non-government sector (NGO's) and the international donor community. At a national coordinating level, however, Government structures charged with planning and implementing the fight against HIV/AIDS were undergoing periodic transformations, with no central point of co-ordination.

The three key stakeholder groups developed strategies for communications based on a mixture of what was available in terms of national guidelines and their own organisational priorities. Ultimately, the goal was the same: that of providing information, increasing knowledge and changing HIV related behaviour. However, even with this common goal in mind, the combined effectiveness of the various campaigns have not had the desired impact on behaviour change, as evidenced in the continuous rise in prevalence rates in the country (Parker, 2005). Further, the 2005 South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey indicates that although the rate of increase in prevalence has started to level off, a number of issues are still of concern (HSRC, 2005). One of the recommendations made by this study is that "communication strategies need to be refocused through a systematic and coordinated approach in addressing key knowledge areas of prevention, treatment, care, support and rights" (HSRC, 2005).

This recommendation points to the fact that the differing stakeholder strategies have had some implications for the overall effectiveness of prevention campaigns.

With prevalence rates at epidemic levels, it becomes critical to understand the implications of different strategies for the delivery of effective communication prevention interventions, and more urgently what needs to be done in order to ensure that all stakeholders work towards the goal of behaviour change to reverse the spread of the disease. The key question then becomes one of determining what the effects of differing strategies have been on prevention. Understanding the current landscape in terms of programme strategies and levels of convergence or divergence between programmes may help to identify the gaps in the overall approach to prevention communication. Further, the exploration of how programme funding is structured, and ultimately shaped programmes, will begin to inform the approach needed for a more streamlined and coordinated national communication prevention strategy. Closely related to funding issues are the prospects for a nationally coordinated approach for communication prevention that will address issues of alignment of strategies with accountability to a national coordinating structure.

2.2 PURPOSE STATEMENT

The purpose of this research is to explore the differing communication strategies of Government, NGO's and the donor community and then to examine the implications these strategies have had for the effective delivery of prevention messaging in South Africa. This research will explore the effectiveness of key programme strategies as evidenced in national programme evaluations and surveys. Key areas to be explored in terms on programme strategies are the underlying theoretical models which inform programme strategies, audience targeting and general programme approach. Having established the overall effectiveness of prevention programmes, funding issues and the implications of these for prevention programmes are explored. Lastly, the

research will assess the prospects and implications of a nationally coordinated prevention communication strategy for South Africa.

2.3 RESEARCH QUESTIONS

This research will endeavor to explore and understand the implications of differing communications strategies on HIV prevalence in South Africa. The key concern of this research is thus the analysis of communication for prevention within the context of HIV/AIDS. In order to gain a broad understanding of the issues which underpin and impact on differing stakeholders' strategies, the research will address the following key questions:

- What are the implications of differing HIV communication strategies on HIV prevalence in South Africa?
- How do the current funding realities of HIV communication interventions impact on stakeholders' strategies and consequently overall prevention?
- What are the prospects for a nationally coordinated communication strategy which provides a national framework for HIV communications?

2.4 LIMITATIONS OF THIS STUDY

This research was conducted within a confined time frame. The level of research participants identified to participate in this research is all at senior levels within their respective organisations, who would provide expert opinions, making their inputs on issues invaluable. However, the availability of a few respondents did not fit into the timeframe of this research.

On a more substantive level, it is important to point out that many organisations are involved in prevention communication and HIV and AIDS communication in general. This research was limited to the larger national programmes, and excluded the smaller multitude of programmes who implement both mass media as well as community based programmes. In order to get a more comprehensive picture of prevention communication in South Africa, smaller programmes will need to be evaluated.

2.5 METHODOLOGY

The key purpose of this research is to gain an understanding of what the implications of differing strategies have had for the overall effectiveness of prevention efforts in South Africa. In order to garner a collective understanding of these implications, the opinions, perceptions and professional views of individuals who are decision makers and engage with the issues of communication prevention, are best placed to provide this information. Qualitative research allows for strategic and contextual, yet flexible method of enquiry (Mason, 1996:5), and therefore will allow the exploration of issues in a meaningful way, contributing to the overall understanding of the issues at hand. The inductive nature of qualitative research, and thus its applicability to this research, will allow for the understanding of the implications of differing strategies on the effectiveness of communication campaigns for HIV prevention (Merriam, 2002).

2.5.1 Data Collection

HIV and AIDS communication research conducted in the last ten years has been primarily quantitative, with key national surveys and evaluations commissioned by, inter alia, the NDoH. Key published reports emanating from these surveys provide demographic data, prevalence and incidence rates, as well as evaluations of communication programmes across media types. This data is used by many practitioners in the field, and is presented in this report as secondary data sources, forming the backdrop for respondents' comments interviewed for this research.

In terms of South African reports and research conducted relevant to this research, the following have been utilised:

- The South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005

- [1]The first Communications survey (2006) conducted by the Centre for AIDS Development and Research (CADRE), Johns Hopkins University through HCP, USAID, PEPFAR, South African Department of Health and the Soul City Institute
- A selection of research reports from Government (Khomanani campaign), Soul City, loveLife and Centre for AIDS Development and Research (CADRE)

Primary data collected for this report was based on an exploratory research method. Semi structured interviews were conducted with key respondents identified based on their experience and expertise in the field of HIV communication. Interviews were guided by a selection of questions crafted to allow for a thematic structuring of the interviews. This structure was then applied to each interview to provide an opportunity for respondents to raise pertinent issues which were deemed relevant and important to the topic under study. These encouraged respondents to express their opinions based on their particular experiences within the context of HIV and AIDS prevention communication in South Africa as well as on the continent. The interview guide used is provided in Appendix one of this report.

In order to ensure an accurate reflection of opinions and arguments made by respondents, interviews were recorded with the permission of respondents. Although credibility and reliability of qualitative data cannot be subjected to strict statistical standards used for quantitative data, a number of measures may be used to measure validity and reliability (Libarkin, J.C., & Kurdziel, J.P., 2002). Such measures include credibility, transferability, dependability and conformability. In the process of designing and conducting interviews, the author has attempted to meet these criteria as far as possible by accurately and honestly reflecting findings as they were recorded

[1] This survey was conducted in 2006 and presented as a preliminary report to an open forum of industry players on 6 November 2006, Johannesburg.

during interviews. In order to further satisfy these criteria, triangulation of data sources was achieved by including organisations from Government, the NGO sector as well as from international donor organisations.

2.5.2 Sampling and Selection

The selection of the sample of interviewees for this research was informed by the three stakeholder groupings, whose perspectives are critical in understanding what the implications of differing strategies are for HIV prevalence. The logic for selecting persons within organisations is informed by the type of information the research attempts to elicit. Interviewees were targeted at three functional levels: campaign senior managers, communication practitioners responsible for crafting communication strategies and individuals responsible for campaign evaluation. There may be some instances where two or more functions are performed by the same individual, in which case additional individuals at relevant levels of the organization were interviewed. Access to these individuals was facilitated through my professional network, and dealings with these organisations over the past three years, whilst working in the HIV/AIDS arena. A list detailing respondents' names, organisations and position within each organization is provided in Appendix two of this report.

2.5.3 Presentation and Analysis of Data

Within the context of this research, the use of both primary and secondary sources was utilized with the intention to provide a backdrop for the presentation of responses from interviews. In order to provide structure to the presentation and analysis, the themes under which the data is presented and analysed follows the research questions in a thematic fashion. Although these pre-determined themes are used to present the data, due to the nature of the semi-structured interviews, sub-themes emerging from interviews lend additional structure.

The core theme centers on the communication strategies for prevention, and have been further divided into elements relevant to strategies for purposes of the presentation of data. Subsections under this theme include current prevalence rates in South Africa, audience exposure and awareness of key programmes and impact of programmes on knowledge and behaviour of HIV related behaviours. Support themes are presented and analysed and include funding and cross funding issues impacting on programme strategies and prospects for a nationally coordinated strategy and structure.

The secondary data presented consists of quantitative results from national surveys, and has been selected purposefully to align with the themes and subsections under which interview responses are presented. The selection of specific sources of data derives its validity from the fact that the sources are credible and both the processes and results have been subject to the research standards of the HSRC and NDoH.

In terms of analysis and discussions, findings are discussed thematically, with reference made to literature used in the literature review. The author's own arguments and understanding of findings also form part of the discussions.

3 CHAPTER 3 - LITERATURE REVIEW

3.1 APPROACH TO LITERATURE REVIEW

The review of the literature relevant to this research will be discussed thematically, covering the following themes:

- Conceptual framework of HIV prevention communication;
- Analysis of key stakeholders strategies: Government, NGO's and the international donor community;
- Analysis of the collective impact of prevention communication on behaviour change and prevalence rates;
- International approaches and experiences with HIV prevention communication.

Discussions under each thematic area focus on the key issues which the literature highlights. A brief discussion is presented to demonstrate the relevance of these issues to this research topic.

3.2 THEORIES AND MODELS OF HIV AND AIDS COMMUNICATION

Communication for HIV prevention has become an integral and critical component of HIV/AIDS prevention strategies (Family Health International, 2002. Airhihenbuwa, C and Obregon, R. 2000). The theoretical basis for HIV communication is rooted in the traditional models of health communication, which falls within the discipline of social psychology and communication and is borrowed from traditional health communication methodologies and health promotion theories (UNAIDS, 1999; Airhihenbuwa et al, 2000). Prior to 2000, the dominant theories of health behaviour change, such as the Theory of Reasoned Action, Health Belief Model, AIDS risk reduction model etc, all focused primarily on individual behaviour (UNAIDS, 1999., & Airhihenbuwa, C et al, 2000). With the urgency for more effective prevention

interventions to stem the spread of the disease, traditional models for behaviour change, particularly in the context of developing nations, came under scrutiny as prevalence rates in many countries, particularly Sub-Saharan Africa, continued to rise. [2]In 1997, communication practitioners, governments and international stakeholders from Africa, Asia, Latin America and the Caribbean regions began to collaborate to find new models to guide the development of prevention interventions. The key finding from this process was that traditional models of behaviour change neglected to consider contextual factors, or the social, economic and political environments, which not only impact on the nature and spread of the disease, but on the health behaviours and choices individuals make within those contexts. Further, the report found that externally driven strategies, as apposed to in-country developed strategies, focused on short term, narrowly focused interventions.

Airhihenbuwa et al (2000) further highlight the flaws in the earlier approaches, particularly where "family, group or community locus of decisions" is largely neglected. These traditional theories, according to Airhihenbuwa et al (2000), are not relevant in the contexts of Africa, Asia, Latin America and the Caribbean, where "self-effacing cultures" are present. Further, in the context of these cultures, an approach to both evaluating and planning health behaviour interventions needs to be attuned to such nuances. Thus, the issue of "cultural sensitivity" must be at the core of "health communication and health promotion theory and practice". Contextual considerations also need to be extended to the definition and use of media, to include the non-traditional forms prevalent in non-western societies. These may include folklore, storytelling and many other "non-structural but established oral channels for transmission and confirmation of messages within communities (Airhihenbuwa et al, 2000).

[2] Communications framework for HIV in 1999, UNAIDS and Penn State university documented the process and their findings as a UNIADS publication entitled "Communications framework for HIV/AIDS. A new Direction"

The findings of both the USAID (1999) report and Airhihenbuwa et al (2000) point to the complexity of HIV communications which need to focus on contextual applicability and dispel the view that a linear, predictable relationship exists between knowledge and behaviour. The call is thus for coordinated, contextualized, long term and localy developed interventions. Within the context of these two key findings, suggestions that countries need to drive their prevention programs in a coordinated and focused manner begin to emerge.

Further to the abovementioned design and implementation approaches is the consideration of the epidemiology of the disease specific to the various settings within countries (Parker, W., Rau, A., & Peppa, P. 2007). Parker et al (2007) emphasized that communication interventions need to be cognisant of the "epidemiological changes" occurring in sub-groups and sectors within countries. This issue has not been raised in review of other literature, and may well indicate that a deeper understanding of communication specifically for HIV and AIDS has been enhanced.

3.3 ANALYSIS OF KEY STAKEHOLDERS STRATEGIES: GOVERNMENT, NGO'S AND THE INTERNATIONAL DONOR COMMUNITY

The following section is a review of the issues relating to the three key stakeholders in HIV communication. It is important to note, however, that the separation of these stakeholders into three discreet groupings is at best artificial, as the degree of cross funding and level of collaboration between the groupings makes separation difficult. Still, each grouping has distinct strategic thrusts and characteristics, which are important and contribute to giving an overall picture of the stakeholders involved in HIV Communications.

3.3.1 Overview of Government strategies

South Africa launched its first comprehensive strategic plan for HIV/AIDS in 2000, for the period 2000 to 2005 (National Department of Health, 2005). The plan presented a strategic framework for interventions and identified four key areas of prevention, treatment, care and support, research, monitoring and surveillance, and legal and human rights issues. The plan emphasized prevention interventions as an important element for managing the spread of the disease. This plan, however, was not specifically designed for communication interventions (Parker et al, 2007).

Government's first communications strategy, however, preceded the HIV/AIDS plan, with the introduction of its Beyond Awareness campaign, which was launched in 1997/8 (Parker, W. 2002). A number of developmental and communication activities flowed from this. In 2001, Government launched a more comprehensive campaign to deal with HIV/AIDS, Sexually Transmitted Infections (STI's) and Tuberculosis (TB), coined [3]Khomanani. The second cycle of the Khomanani campaign ran from 2004 to 2006, and fully supported the objectives of Government's five year strategic plan. The Khomanani campaign has positioned itself as, amongst others, a Government brand which is participatory, with a sound theoretical basis with specific goals and objectives (Khomanani, 2004). Programming is developed around objectives, with a two year review cycle with an emphasis on building partnerships across government departments, the private sector as well as with other public organisations.

The Khomanani approach takes the shape of an integrated communication strategy, with a mix of mass and smaller media as well as community based action, through outreach programmes. The campaign uses extensive formative research to inform

[3] The Khomanani campaign uses a range of service providers which focus on different media, tenders are issues every 2 years, and strategies reviewed within the same two year cycle

programming, and pre-testing and programme evaluation as ongoing feedback mechanisms, which it describes as an “evidence based approach” (Khomanani, n.d.)

The 2006 research report on the syndicated survey for Khomanani refrains from making reference to the impact on behaviour, and limits results to changes in knowledge and attitude. This may begin to signal a general understanding of the inherent difficulties in evaluating behaviour change interventions (Khomanani, 2006).

At the time of writing this proposal, Government was in the process of evaluating tender submissions for the next Khomanani tender, with the 2004 to 2006 campaign being extended until the new tender has been awarded.

3.3.2 Overview of International Donor Community

The international donor community has played a significant role in HIV programmes globally as well as in South Africa, not only in monetary contributions, but in terms of shaping the content and structure of prevention campaigns. According to a budget brief by the Institute for a Democratic Alternative in South Africa (IDASA), the US Government provides the largest funding for HIV/AIDS progammes in South Africa, estimated at R886 million rand between 2001 and 2006 (Ndlovu, 2005). In terms of the Global Fund for AIDS, Tuberculosis and Malaria, 55% of the total approved grants is targeted for South Africa, estimated at R248 million. This brief raises an important issue around the spending of these funds, i.e. that spending of donor funds has been “slow compared with Government funding for two reasons”. The first is that donor funding has to be spent within the confines of pre-determined activities and with specific objectives, often clashing with the objectives of Government. The second reason sited is that there is a lack of capacity within Government to spend the money.

The sentiments reflected by Ndlovu (2005) in the IDASA budget brief have been echoed by others, who are particularly critical of the approach that international donors take to spending within countries. Some of the key criticisms of international donors include the centralized process of agenda setting for interventions (Parker et al 2007), quantitative indicators selected for measuring outcomes and the nature in which funding is disbursed, often bypassing Government structures.

In as far as these criticisms are demonstrable, a review of the United States funding requirements through the President's Emergency Fund for AIDS Relief (PEPFAR) as the largest donor, provides a case in point. In particular, PEPFAR funding, within the context of traditional "ABC" approach, has been channeled largely to support "Abstinence" and "Be Faithful" messaging, downplaying the "Condomise" messaging. This approach has been criticized as having particular religious and moral underpinnings, as apposed to an effective and substantiated approach to prevention (AVERT, 2006). PEPFAR has also recently begun to de-emphasise mass media interventions in favour of other media. PEPFAR also places significant importance on quantitative indicators to measure the success of interventions, with very little focus on qualitative measurement.

The relevance of these issues for this research lies in the fact that objectives of individual donors have implications for the realization of a comprehensive and coordinated approach to HIV prevention strategies in the country. In the context of a heterogeneous populace and considering the complexity of HIV and AIDS communication, this has presented challenges for many organisations which are dependant on funding from international donors.

3.3.3 Overview of NGO's

HIV communications in South Africa is largely NGO driven, with a number of large campaigns, spanning just over ten years, and a whole host of smaller scale campaigns

driven at provincial or regional levels. As mentioned earlier, NGO's characteristically operate on the strength of funding they receive from a mix of funders, ranging from Government to a range international donor countries and organisations, through a variety of aid agencies (Ndlovu, 2005). The most notable campaigns which have dominated HIV communications at a national level include Soul City and loveLife. Each of these campaigns are briefly discussed below, looking broadly at their strategic thrust and focus areas.

Soul City

The Soul City – Institute for Health and Development Communication (IHDC) was launched in 1992, and subscribes to the principles of the World Health Organisations's Ottowa Charter, which states that "health is a product of a range of inter-sectoral actions that include building an enabling environment, advocacy for health public policy, community action, developing personal skills and re-orientating the health services towards the health promotion approach" (Soul City website). The strategy is informed by Soul City's own brand of social change model, and is described as "an eclectic integration of existing models of social and behaviour change" (Soul City, 2001). Soul City uses a multi-media approach for its programming, with a strong emphasis on "edutainment" as a launch pad for all other media.

The process for developing HIV communication is underpinned by extensive formative research, allowing for engagement with key stakeholders and audiences, ensuring that the communication is needs-based and in line with target audiences' knowledge and opinions.

The stated target audience for Soul City's HIV/AIDS programming is the youth and women in marginalized sectors of society. In terms of programme evaluation, Soul City conducts evaluations after the completion of each series, evaluating all media

formats i.e. television and radio drama and print materials. Key variables measured are audience exposure, changes in knowledge, attitudes, perception and behaviour. Evaluations are largely quantitative, conducted by a [4]Soul City in-house research team as well as external parties.

The Soul City approach to HIV communication is described as a unique strategy, using "three interlinked units of change: the individual, the community and the broader society" (Tufte, 2001). This approach may be placed within the paradigm of the communication framework developed through a consultative process by participating developing countries under the auspices of UNAIDS, described earlier under section 5.2. As Tufte (2001) argues, this makes for a sound and contextually sensitive theoretical basis for Soul City's programming.

The loveLife Project

loveLife is the largest HIV campaign in South Africa, aimed primarily at the youth, and has enjoyed the largest proportion of funding, with an estimated R200 million per year (Bechan, n.d.). Launched in 1999 as "the most comprehensive effort to positively influence adolescent lifestyle", the loveLife project received its core funding from the Henry J. Kaizer foundation, bringing together a range of partners and additional donor funding. According to loveLife strategy [5](loveLife, n.d), loveLife seeks to "substantially reduce the HIV infection rate among young South Africans – and to establish at the same time a new model for effective HIV prevention among young people". loveLife's approach integrates three key components:

- Innovative nationwide youth-focused media campaigns of unprecedented scale and intensity,

[4] For the Soul City Series evaluations, a mix of internal and external evaluators were used. Some of these include Community agency for Social Research,

[5] Retrieved from http://www.lovelife.org.za/corporate/index.html

- Face to face outreach through service and support programmes,
- Extensive monitoring and evaluation of the programme's impact and results, with independent external oversight.

Early evaluation data suggests that loveLife is already having a significant impact on adolescent sexual behaviour and that it could help curtail South Africa's staggering AIDS epidemic [6](loveLife,n.d).

The loveLife campaign, despite its stated achievements in terms of programme outcomes and impact on youth risk behaviour, has come under much criticism (Peng, 2006). As argued by Parker (2005), there are a number of key areas which are problematic with the loveLife approach. Key amongst these is:

- lack of sound theoretical basis for programming, (Coulsen, 2002),
- validity of impact targets set in terms of number of new infections the campaign would prevent through its campaigns, specifically its lack of formative research to establish baseline levels of HIV infections,
- misrepresentation of HIV prevalence rates and statistics,
- the assumptions made that loveLife programming will in isolation of a multitude of other prevention programmes halve the number of infections,
- the often "dismissive and competitive" tone of loveLife assertions evident in their publications and situational analyses,
- methodologies and reporting of evaluations conducted by loveLife.

3.4 ANALYSIS OF THE COLLECTIVE IMPACT OF PREVENTION COMMUNICATION ON BEHAVIOUR CHANGE AND PREVALENCE RATES

The South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005 (HSRC, 2005) provides a comprehensive, research

[6] Retrieved from http://www.lovelife.org.za/corporate/index.html

based national picture of the current situation of HIV/AIDS in South Africa. In order to gain an objective insight into the impact made by an array of prevention campaigns, this report becomes a key document.

Key findings of the communication elements of the HSRC report are highlighted below. The first two points refer to HIV communication campaigns in general. The following points refer to specific gaps in communications.

- "As a product of diverse sources of information, HIV communication may be divergent and even contradictory. In addition, formal communication campaigns have different emphases and may also produce conflicting information"
- "Evaluations of HIV campaigns and programmes have largely been focused on particular interventions, with evaluations not sufficiently taking into account audience exposure to multiple interventions/campaigns…"
- There exists a false sense of security in terms of perceived risks, and it is recommended that prevention campaigns need to address this in the general population
- There are gaps in terms of reach, specifically in rural and informal locality types. The mediums that reach these areas of the country thus need to be emphasized, especially radio
- Within each particular audience, there is no programme which has exclusive reach, with a considerable amount of overlap, particularly within youth audiences, to the exclusion of older audiences (i.e. 50 years and older)
- In terms of specific gaps in knowledge, notwithstanding the emphasis and focus on these areas by national campaigns, the following areas are of particular concern: the relationship between partner reduction and risk, the risk of mother-to-child transmission, a cure for AIDS and the relationship between HIV and AIDS.

This HSRC report makes an important point in its conclusion: “When communication campaigns are assessed in relation to HIV prevalence and behaviour response, it is clear that, in spite of massive investment, there has been inadequate progress in addressing HIV prevention”. This conclusion is particularly relevant to this research as it points precisely to the underlying problem statement, i.e. what the implications of differing HIV communication strategies are for national HIV prevention.

Further, Swanepoel (2005) argues that South African HIV campaigns have not been successful in changing HIV/AIDS related behaviour. Swanepoel (2005) notes, however, that due to the lack of process evaluation and empirical data, an in-depth analysis of the success of campaigns is not feasible, and that campaigns have not been “systematically and comprehensively evaluated for their impact”. These statements appear to be in contrast to the claims made by national campaigns, such as Soul City, loveLife and Khomanani that evaluations are indeed done regularly and with the appropriate amount of rigor.

3.5 INTERNATIONAL APPROACHES AND EXPERIENCES WITH HIV COMMUNICATION STRATEGIES

In the African context, Uganda is often sited as a unique case, where HIV prevalence steadily declined from 21% to 9% between 1991 and 1998 (Low-Beer, D. and Stoneburner, R.L. 2003). In an analysis of the Ugandan case, and drawing from approaches in Thailand and the United States gay community, Low-Beer et al (2003) concludes that the successes in these countries’ behavioural responses are due to the following factors:

- Although the responses of each of these countries was unique, the response was widespread and coordinated
- None of the countries followed a set of internationally approved and costed intervention elements

- Countries were able to translate HIV prevention on their own country contexts, mobilizing social and political capital, from Government to communities, encapsulating a horizontal response

The selection of this literature to represent international experience was intentional, as it presents a unique approach as an alternative to the internationally driven strategies of PEPFAR, UNAIDS and other international organisations which fund and drive in- country strategies from an external perspective. As a commonly sited case, the Ugandan experience demonstrates that a timely and decisive response based on contextual understanding has positive implications for overall HIV prevention.

A broader view of the communication interventions in Africa is offered by Parker et al (2007)[7]. This study was done in 2006, and surveyed eleven African countries' prevention communications interventions. The following points summarise the key findings related specifically to communication:

- Prevention goals and strategies need to be prioritized and led by national Governments to achieve short term goals, with the disproportionate infection rates among youth as a priority. Individuals' lifetime number of partners and reducing partner turnover needs to be included in such goals
- High levels of response to condom promotion has not had the expected impact on prevention, which means that the correct and consistent use of condoms needs to be emphasized
- Prevention messaging needs to shift from an emphasis on the youth only, to include older age groups
- Prevention communication also needs to include the needs of PLHA, commercial sex worker and men who have sex with men.

[7] This report was released in early 2007, and offers an insightful review of intervention programmes in 11 African countries, including South Africa. Findings of this report are critical to this research as it begins to link epidemiological factors with communication strategy.

This report makes a general and over-arching observation about the lack of epidemiology-led prevention communication strategies in Africa. Strategies thus need to be focused on "reducing national and sub-national prevalence among the population" (Parker, 2007). Further, the report stresses the importance of using evidence-based impact to demonstrate success, rather than relying on "presumed impact".

3.6 SYNTHESIS OF LITERATURE REVIEW

The literature reviewed above indicates a number of salient points for this research. Firstly, the evolution of communication theory in the field of HIV is occurring rapidly, with widespread influence and contribution to the body of evidence on this subject, including lessons from developing countries like Uganda. Continued research is also essential to inform communication strategies, specifically research which tracks epidemiological changes and allow for messaging to remain relevant and nuanced. Secondly, it would seem that consensus is to still be reached on whether HIV communication in South Africa has been effective in changing HIV related behaviour, with NGO's presenting opposing views to national, independent surveys. Thirdly, the literature seems to indicate that current prevention communication in South Africa has not achieved the anticipated reduction in prevalence rates, despite large investments in these efforts. Of particular importance is the findings of the Parker et al (2007) in the review of communication interventions in Africa, pointing out important gaps in the general approach to prevention communication, and provides key recommendations going forward. This research will thus seek to understand what informs different strategies and the overall implications of these on prevalence in South Africa.

4 CHAPTER 4 - PRESENTATION OF DATA

4.1 APPROACH TO PRESENTATION OF DATA

This chapter presents the key findings from both primary and secondary data sources utilized in this research, synthesized under themes as per the research questions viz: HIV and AIDS communication prevention strategy, funding and cross funding issues and prospects for a national coordinated HIV and AIDS strategy. In order to provide a context and a reference point for the research participants' comments and opinions interviewed for this project, quantitative data from relevant national surveys and studies are presented. Results from these surveys and studies serve the purpose of providing a picture of the status quo with regards to issues relevant to this research. Comments and opinions presented here are the outputs of face-to-face interviews with key respondents engaged at various levels in HIV and AIDS communication programmes, who have shared their professional experiences from working in this field.

Each theme will be presented separately and will in general take on the format of a mixture of quantitative and qualitative findings. A brief description of each theme is provided, outlining the issues explored during the interview process. Respondents' comments are presented as they relate to specific issues raised within the context of the above mentioned themes.

4.2 HIV AND AIDS COMMUNICATION PREVENTION STRATEGY

The data presented under this theme will focus on issues related to current prevalence and will explore results from national surveys conducted to evaluate the impact of communication prevention programs in terms of audience reach, knowledge, attitude and behaviour change. Comments and opinions from interviews conducted for this

research will be presented in light of these survey results, with an attempt to explain the outcomes of communication programs. Particular focus will be given to the reasons why different approaches have been taken by the key communication programs and what the implications of these differing strategies have had for overall prevention as evidenced by prevalence rates.

There is currently an abundance of quantitative data available on HIV and AIDS. The data presented here, and which has particular relevance to prevention communication, are from key sources as follows:

- South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005. This study is the second of this nature; the first was conducted and published in 2002.
- First South African National HIV/AIDS Communication Survey - 2006. Data presented here reflect results from the preliminary report published in November 2006.
- National Department of Health – Antenatal study: 2001 -2005.

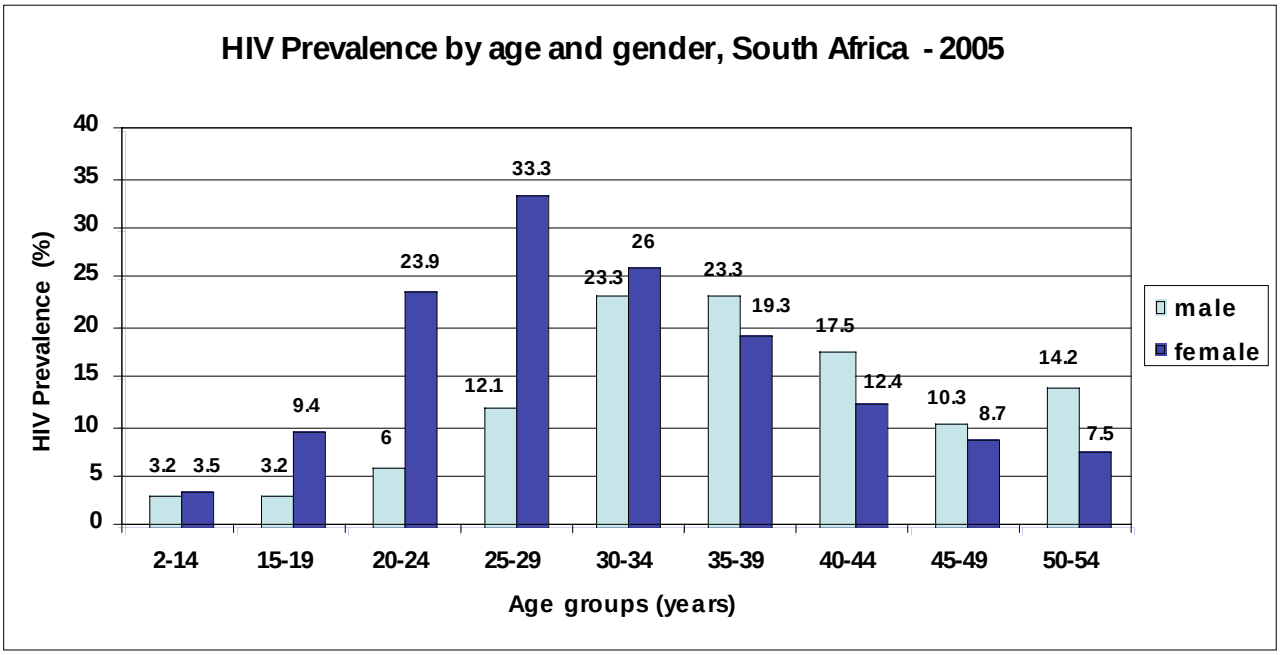
The above mentioned studies present nationally representative surveys, with the following key findings presented in the sections below:

- **National HIV prevalence rates** : 2005 prevalence rates per age group and gender, comparison of HIV prevalence rates in 2002 and 2005, and national antenatal prevalence rates over the last five years
- **Audience exposure and/or awareness** of the key HIV and AIDS communication programmes and perceived usefulness of key programmes
- Relevant **public knowledge of HIV and AIDS prevention** - using indicators developed to establish knowledge of key prevention behaviour per age group
- **Current levels of prevention related behaviour** measured by condom use at last sex and number of sexual partners as key forms of prevention-related behaviour

4.2.1 HIV Prevalence in South Africa

This section explores current prevalence rates as reported in the 2002 and 2005 national sero-prevalence study commissioned by the Nelson Mandela Foundation and published by the Human Sciences Resources Council (HSRC). A population-based probability sample was used to estimate HIV prevalence, including all gender, race and socio-economic groups. The chart below shows HIV prevalence rates by gender and age group.

Figure 1 HIV Prevalence by age and gender, South Africa, 2005



Source - South African national HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005

HIV prevalence rates are generally higher in females than in males below 35 years, with the highest rates in the age groups 25-29 years (33.3 % and 12.1%), 30-34 years (26% and 23.3 %), and 20-24 years (23.9% and 6%). Prevalence rates amongst men in age groups above 35 years are higher than that of females above 35 years. The greatest difference in prevalence rates between males and females is in the age groups 20-24 years.

In order to provide a comparative analysis of prevalence rates over time, the table below shows prevalence rates reported in the 2002 and 2005 HSRC study, presented by gender for all age groups.

Table 1 HIV prevalence rates by gender: 2002 and 2005

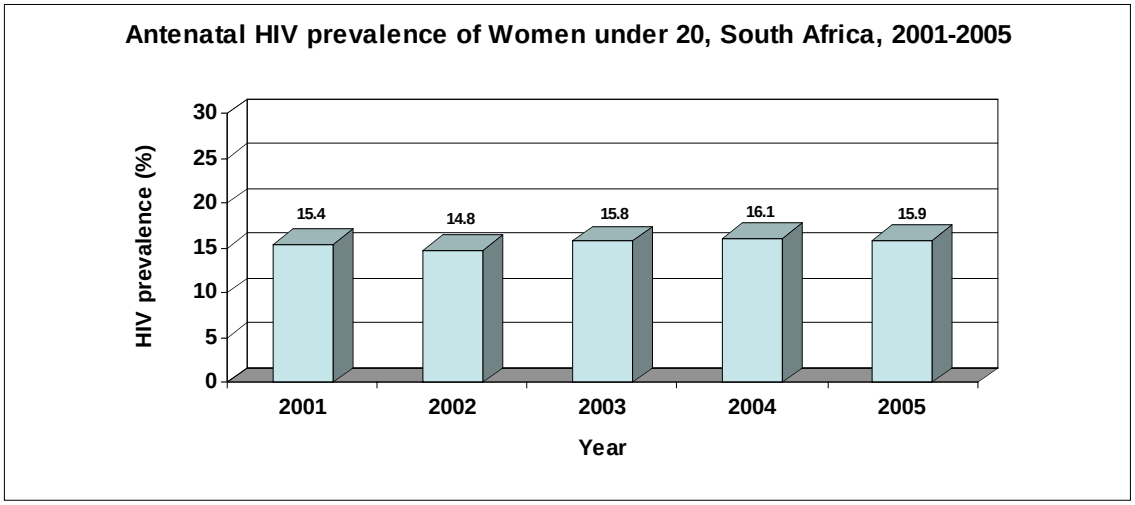
Age Groupings	2002		2005	
	Male (%)	Female (%)	Male (%)	Female (%)
2-14	5	6	3.2	3.5
15-19	4	7	3.2	9.4
20-24	8	17	6	23..9
25 - 29	22	32	12.1	33.2
30-34	24	24	23.3	26
35-39	18	14	19.3	23.3
40-44	12	19	17.5	12.4
45-49	12	11	10..3	8.7
50+	6	7.5	14.2	7.5
Average	12.3	15.2	10.9	15.7

Source - South African national HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2002 and 2005

In general the HIV prevalence pattern across the age groups has remained similar, where the highest prevalence is in the 25 -29 year group. Some significant changes in prevalence rates between age groups and gender have occurred between the two studies. Most notably, males in the 25 – 29 year group have decreased by 10% from 22% in 2002 to 12.1% in 2005. Female prevalence rates in the 35-39 age group has increased by 9% from 14% in 2002 to 23.3% in 2005. In the 40-44 age group, male prevalence has increased from 12% in 2002 to 17.5% in 2005 and female prevalence has decreased from 19% in 2002 to 12.4% in 2005. In the 50+ age group, male prevalence has increased from 6% in 2005 to 14.2% in 2005.

The chart below shows prevalence rates measured in pregnant women over a five year period.

Figure 2 Antenatal HIV Prevalence of Women under 20, South Africa, 2001-2005



Source: Department of Health

The highest prevalence rates were recorded in 2004 (18.1%). Rates dropped between 2004 and 2005 to by 0, 2 %. The greatest drop, however was from 2001 to 2002 (0,6%). Compare this with general population prevalence.

The section below presents findings from interviews conducted for this research as they relate to issues of communication prevention strategies in general, and the implications of the approach that key programmes have had on prevalence, knowledge and behaviour change.

When exploring the current status of HIV prevalence in South Africa [8]most respondents noted that there has been a general weakness in the South African approach to HIV and AIDS management. In particular, the lack of a clearly defined strategy, not only in terms of prevention, but as far as other aspects of HIV and AIDS are concerned was highlighted by these respondents. According to a repondednt from JHHESA, the degree of controversy around HIV and AIDS in South Africa in general

[8] Respondents are from JHUCCP, Soul City, CADRE and loveLife

has led to the polarisation of organisational interventions, carried over into the communications arena, leading to a disjointed approach. Further, this respondent commented on the lack of any attempts at cohesion, meaning that each organisation active in the field was "doing their own thing". In fact, one respondent from Soul City argued that leadership from Government was decidedly "negative" and "stymied the efforts [of other interventions] to come together". Messages from Government in the early phases of the epidemic "conflicted" with messaging from other programmes, and led to what one respondent referred to as "confusion". A number of respondents expressed the view that if Government's response was more "positive" and "coordinated" the course of the disease may have been significantly different. Respondents outside of Government generally agreed that, particularly early on, Government failed to understand some of the key issues, such as gender, and even more concerning, did not understand how do deal with these issues. Funding was thus channeled to treatment, to the neglect of prevention programmes.

A respondent from loveLife noted that in general there was a great deal of diversity in terms of programme strategy, which is not necessarily negative within a generalised epidemic. However, in the context of a "leadership vacuum" this diversity has been difficult to harness for the benefit of overall prevention. Instead, the lack of leadership led to some competition between programmes, where organisations competed for funding and believed that their own programmes would "turn the tide" of the epidemic.

Respondents[9] also noted that the high prevalence rates amongst women in the younger age groups and males in the older age groups meant that audience targeting was not effective and would need to be targeted more purposefully to specifically address this phenomenon. One respondent (from CADRE) explained that one of the reasons for this lack of focus and targeting was that the epidemic is viewed as

[9] Ibid

"generalized" in the population, meaning that prevention efforts are often applied with a "spray-gun approach", without sufficient attention being paid to vulnerable groups. For example, young women who may be "preyed on" by older men are not dealt with in the context of their unique circumstances. Some respondents pointed to the fact that this lack of targeting and lack of understanding of how to deal with gender issues in the context of HIV and AIDS has resulted in the increase in prevalence rates in both the younger women (20-24) and older men (40-44).

Some respondents argued that the slight decrease in prevalence rates evident in the antenatal study, between 2004 and 2005, could partly be explained by the success of campaigns which have focused on condom use. In particular, Governments own communication prevention programmes have emphasised condom use, while abstinence (A) and being faithful (B) messages to a large extent played second fiddle. Some respondents (from JHUCCP and CADRE) did, however, note that in order to impact on prevention and ultimately prevalence, communication programmes would have to go beyond ABC messaging, to encompass a more inclusive and targeted approach.

A respondent from loveLife put forward the argument that the ABC strategy may not be the most appropriate approach for prevention in South Africa. In particular, abstinence messaging in the traditional ABC approach assumes that individuals are in fact able to make rational choices about their sexual behaviour. In the South African context, where issues of coercion negate personal choice, abstinence messaging becomes irrelevant and even counter-productive.

The complexity of targeted communication in order to address the age and gender audience differences was noted by most respondents, with the diversity in approach across programmes being cited as a key reason for current prevalence rates. To add to these complexities, some respondents (from JHUCCP and CADRE) stated that there has been a mixing of messages, with some messages serving only to negate

other messages. Even efforts from Government in terms of an "accelerated prevention" approach have not yielded a corresponding decrease in prevention of new infections.

According to one respondent from CADRE, the varied success of prevention efforts may be attributable to the fact that communication strategies are generally inward looking in an environment where there is no accountability to a national strategy. Communication strategies are thus designed on the strength of the organization and its ability to mobilise funding, often giving rise to a competitive approach, with campaigns targeting the same audiences, seldom with coherent messages. Communication programmes, in addition to these varied approaches, also tend to neglect marginalized groupings and are not always epidemiologically led to respond to the heterogeneous nature of the disease in South Africa.

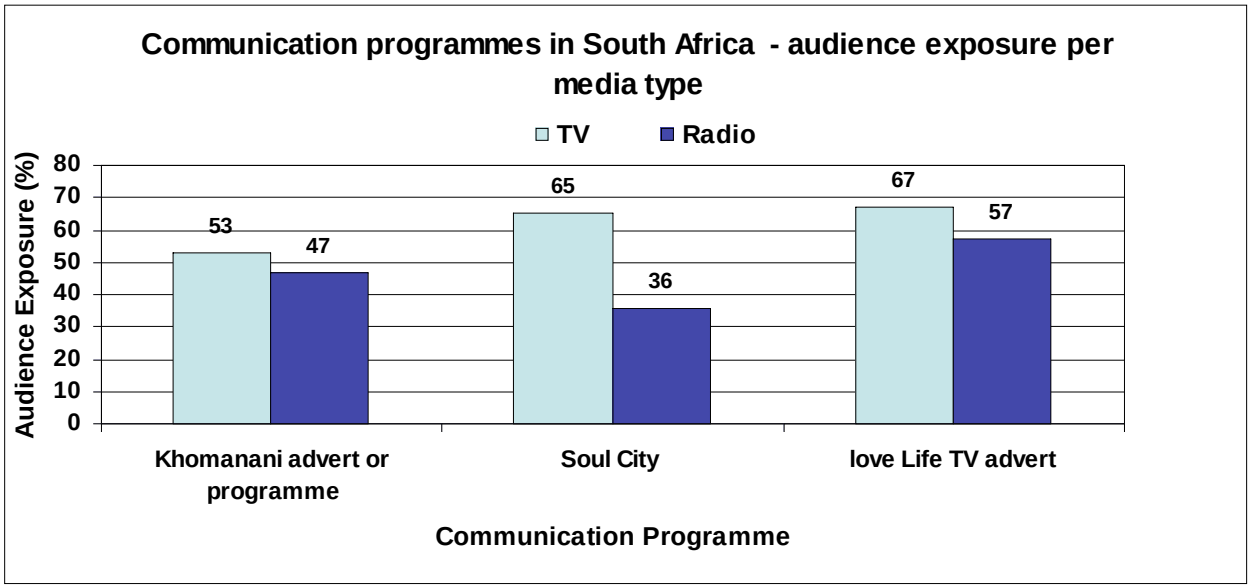
In general, most respondents outside of Government held the view that a combination of a lack of leadership from Government and the complexity and heterogeneous nature of HIV and AIDS in South Africa has resulted in the current high prevalence rates. Key arguments were also put forward by respondents that viewing the epidemic as "generalized", particularly in Government's conception of the disease, led to unfocused communication, leading to higher prevalence rates in vulnerable age groups such as younger women and older men.

4.2.2 Exposure to and Awareness of Key Communication Programmes

The section below presents data comparing the largest national prevention programmes in terms of audience exposure and awareness of these programmes. A multitude of smaller programmes focusing on HIV and AIDS communication have been excluded in order to focus on larger national programmes.

The chart below shows the percentage of persons who have been exposed to the key programmes by the two most common media formats i.e. radio and television. Exposure in this instance refers only to instances where respondents have heard or seen a particular programme or advert, and is not an indication of effectiveness or impact on knowledge or prevention behaviour.

Figure 3 Communication Programmes – Audience Exposure

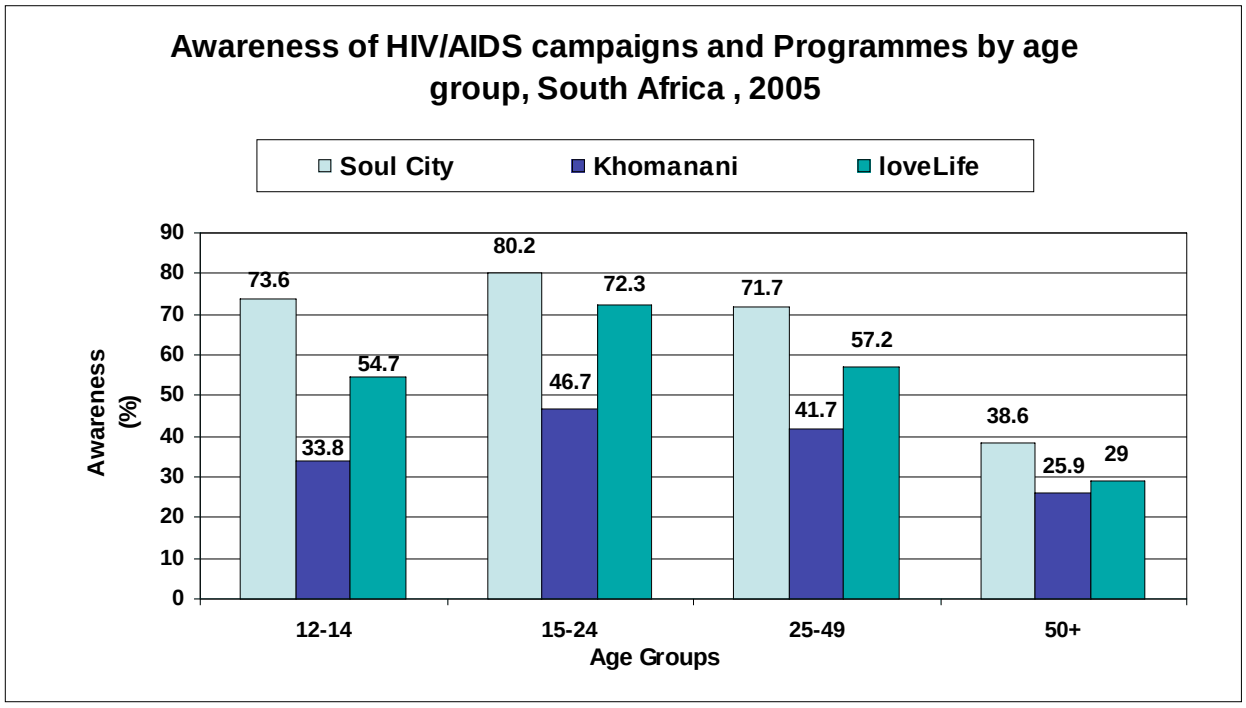


Source - South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2002 and 2005

In general, television programming has higher exposure than radio programming. loveLife and Soul City television programming enjoy the highest exposure, with 67% and 65% exposure respectively. loveLife radio programming enjoys the highest radio exposure (57%).

The chart below shows audience awareness of the key programmes by age group. This data is particularly relevant in the light of the difference in prevalence between age groups, and in light of the key age group related strategies of key communication prevention programmes.

Figure 4 - Awareness of HIV Campaigns



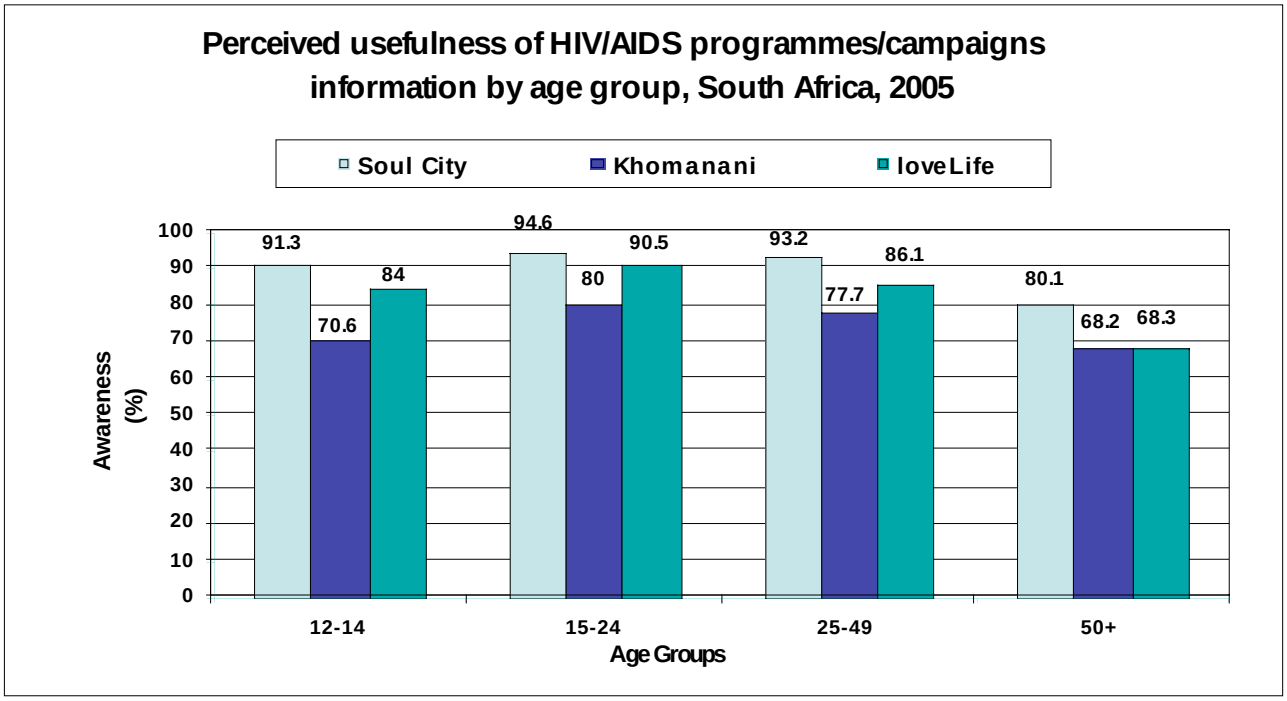
Source - South African national HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005 – HSRC

Soul City enjoys the highest awareness of its programming in all age groups, with the highest awareness in the 15-24 year age group (80%), followed by the 12-14 year age group (73.6%). The 50+ age group have the overall lowest awareness across programmes.

Perceived usefulness of programmes

The chart below reflects the perceived usefulness of the key programmes by respondents per age group.

Figure 5 Perceived usefulness of HIV/AIDS Programmes/ Campaigns



Source - South African national HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005 - HSRC

Perceived usefulness is high across all age groups, but generally lower in the 50+ age group and particularly higher in the 15-24 year age group. In general, Soul City programmes have the highest perceived value, followed by loveLife.

The section below presents findings from interviews conducted for this research project. Key issues explored with research participants include the evolution of communication prevention in South Africa and some of the key strengths and weaknesses of various programmes.

A respondent from CADRE described the evolution of communication prevention programming in South Africa as "eclectic and generally narrowly focused", particularly on target audiences such as the youth. All respondents interviewed acknowledged the great strides which have been made by the key programmes in the mass communication arena, but many were more skeptical about the appropriateness

and effectiveness of approaches used. Some respondents also recognised the importance of mass media as a vehicle for prevention messaging, but again cautioned against a single level approach to communication. One respondent from Soul City noted that many of the programmes which have been running since the early nineties have impacted on many people at different times of their lives and it is thus difficult to say which programmes have had the greatest impact. It was also pointed out by some respondents that exposure to mass media alone would limit the impact of prevention messaging, and that most programmes made use of other media formats as well as social mobilisation programmes. Respondents from Soul City, in particular, believed strongly that linking what audiences viewed on television should be carried over to what they heard on radio and read in information booklets and pamphlets. This means that messaging is consistent across media, and the strength of each media format is maximized in order to create in-depth knowledge and understanding of key messages.

A respondent from loveLife noted that in its approach, the use of billboards and other mass media early on was aimed at "grabbing" the attention of the youth audience, which could be later followed up with interventions at community level. This use of media was intended to first initiate a discourse within the target audience and subsequently drive audiences to services it provided on the ground. This approach was believed to use the mass medium not so much to change behaviour, but compliment face to face interventions aimed at both an individual and societal level. This respondent believed that this approach has allowed loveLife to eventually have a connection between different media types.

A respondent from JHUCCP placed emphasis on the understanding of how social cohesion impacts on the HIV related behaviour. Within this context, this respondent stressed that social mobilisation programmes were critical and should complement mass media messaging to provide the public with more than just knowledge, but

provide the tools within specific contexts for individuals to adopt the desired behaviour.

Respondents providing an international perspective of progammes in South Africa (JHUCCP and JHHESA) argued that local programme strategies have begun to adopt international best practice in the design and implementation of programmes. These respondents further argued that evidence-based strategies were becoming the norm after many programmes experienced limited successes when a rigorous research-based culture did not form the core of programme strategies. Many respondents (from CADRE, JHUCCP and Soul City) expressed the view that loveLife, in particular, set very ambitious targets against specific indicators, such as reducing the number of infections in young people by half over a five year period. However, prevalence rates continued to rise and stated targets were not achieved as their programming was not informed by sufficient formative research into the particularities of the targeted youth audience. The loveLife brand thus projected a young, cosmopolitan brand espousing "material values". Respondents in general believed that this brand image misrepresented not only youth in general but neglected to consider the heterogeneous South Africa youth across different geographical locations, class differences and economic strata. The result, according to respondents at CADRE and Soul City, was messaging which was complex, confusing and ultimately ineffective.

In contrast, most respondents outside of both Soul City and loveLife commended the Soul City approach on several levels. Firstly, respondents believed that HIV and AIDS programming within Soul City evolved from an understanding of health promotion theory, which is borne out of a strong research culture. Respondents from Soul City pointed out that their approach to programming is founded on tested models of health behaviour integrating health promotion theory into "five pillars of epidemiological evidence, supportive environments, enabling public health policy, social change theory and community action". The success of Soul City was thus attributed to this theoretical model coupled with a partnership forming approach.

Respondents within Soul City expressed concern about loveLife's approach which lacked many elements of best practice, in particular the lack of a strong theoretical framework which was largely devoid of research based strategies and ultimately "alienated other programmes". A respondent from CADRE declared that the lack of "progress" of loveLife programmes and criticism from many quarters, including donor organisations, has led to a change in their approach, with some efforts being made to engage with other programmes in order to learn and streamline messaging and prevention efforts.

4.2.3 Knowledge of Prevention

The table below shows knowledge of HIV and AIDS related prevention behaviour. The measures used here reflect the key prevention behaviours dominant in prevention communication in South Africa, and are generally used to measure the extent to which individuals are aware of risk related behaviour. Measures include both primary and secondary forms of abstinence. Respondents were grouped into three age groupings, with the middle age group including three traditionally used groupings.

Table 2 Knowledge of HIV prevention per age group

HIV Prevention	15-24	25-49	50+
Using Condoms	92.0	90.9	76.2
Sticking to one partner, being faithful	18.9	28.8	31.3
Reducing number of sex partners	5.1	7.6	5.4
Abstaining from sex	46.6	37.3	31.3
Avoiding contact with blood	26.0	21.8	18.6
Using drugs for PMTCT	1.4	1.3	1.2
Key knowledge questions	**15-24**	**25-49**	**50+**
If you have fewer sexual partners, you are less likely to get infected with HIV	49.0	50.3	56.5
Composite score of all other knowledge questions	79.0	79.9	74.8

Source: First National Communication Survey, 2006

The highest percentages of respondents across all age groups have knowledge of condom usage as a means of prevention, with the youngest age group having the highest knowledge of condom usage. Abstaining from sex (categorized as primary abstinence) has the second highest prevention awareness. Reduction of sexual partners (catergorised as secondary prevention) has the least awareness as a prevention behaviour, barring only using drugs for PMTCT. Only half of the respondents between 15 and 49 years are aware that fewer sexual partners reduces the risk of getting infected with HIV.

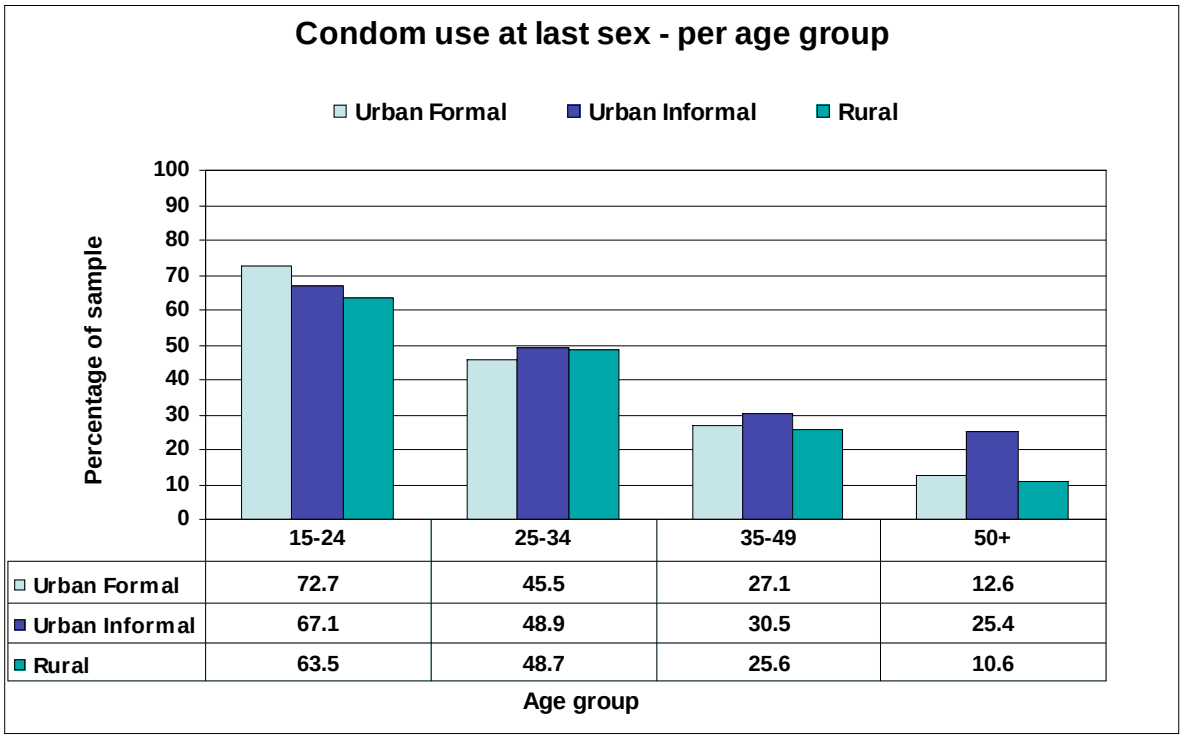
Comments from interviewees involved in research conducted for this research project all centre on the complexity of HIV and AIDS messaging, particularly the simplistic approach to ABC messaging which has been adopted by most programmes. Most interviewees agreed that communication around condom usage has largely been the central theme, evidenced by the high knowledge of condom use. The lower levels of knowledge of condom use amongst the older age group, however, indicates that targeting of this group has not been as intense. Respondents pointed out that this is a major concern, especially in the light of what some respondents refer to as the “older man, younger women phenomena”. Pitted against the higher prevalence rates among younger age groups, some interviewees (from JHUCCP and CADRE) argued that programme strategies were not adaptive to the epidemiology considerations, and are often constrained by many factors, such as funding obligations, making it difficult to respond timeously to changes in the disease on the ground.

Respondents from JHUCCP and CADRE also noted that the complexity of abstinence messaging, i.e. beyond primary abstinence, was not well articulated in general, resulting in lower levels of knowledge amongst the public. A prime example of this is the low levels of knowledge that reducing sexual partners can reduce the chance of getting infected. The nuancing of such complex and multi-layered messaging is in some instances, such as loveLife’s billboard campaigns, too complex for the target audience, while in some instances altogether neglected.

4.2.4 General prevention behaviour - as measured by condom use and number of sexual partners.

The use of condoms and the number of sexual partners, amongst others, are key measures of HIV prevention behaviour. The chart below reflecting condom use does not give an indication of the correct and consistent use of condoms, but shows the percentage of respondents who used condom at last sex. Condom use at last sex is indicated per geographic location and per age groups of respondents.

Figure 6 Condom Use at Last Sex



Source: First National Communication Survey, 2006

The highest condom use at last sex is in the 15-24 year age group, with urban formal respondents in this age group reporting the highest condom use at last sex. Condom use at last sex decreases in the subsequent age groups with urban informal groups generally reporting higher condom use.

The number of sexual partners per gender and age grouping in the last year and the last month is reflected in the table below.

Table 3 Number of sexual partners in the last year/month per age group

Sexual partners in the past year	Male 15-24	Female 15-24	Male 25-34	Female 25-34
None/ Secondary abstinence	16.6	14.5	9.6	12.3
One	50.2	72.9	66.4	81.4
Two	15.8	7.8	11.5	4.9
More than two	17.4	4.8	12.6	1.4
Sexual partners in the past month	**Male 15-24**	**Female 15-24**	**Male 25-34**	**Female 25-34**
None/ Secondary abstinence	32.3	32.6	20.8	25.0
One	56.9	63.8	71.3	72.8
Two	8.0	2.6	4.6	1.6
More than two	2.8	1.0	3.3	0.5

Source: First National Communication Survey, 2006

Most respondents in the FNC survey across all age grouping reported to having at least one sexual partner in the last month and in the last year, with more female respondents across the age groups reporting to have had at least one sexual partner in the last year and the last month. In general more respondents have had more that two sexual partners in the last year than in the last month.

The section below presents data collected from interviewees who participated in this research project. A key concern expressed by one interviewee from JHHESA is that knowledge does not necessarily translate into behaviour. This is evident in the difference between knowledge of condom use, shown in table 3 above, and reported condom use at last sex, shown in the chart above. This is particularly marked in the 24-50 year age group, where knowledge of condom use was 90% and average condom use at last sex was between 25% and 50%. Some interviewees felt that such discrepancies point to the programme strategies which neglect to consider cultural

contexts of messaging and are ultimately based on flawed theoretical frameworks or do not do enough research to inform particular messaging. A further concern expressed by at least one interviewee from JHHESA was that the data shown in the graph does not give an indication as to whether condoms were used correctly, and that this data needs to be enhanced with a qualitative investigation before success in this area can be conclusively claimed.

Some respondents (CADRE, JHUCCP and Soul City) held the view that messaging around partner reduction has been neglected in favour of messaging around condom use. The emphasis on condom use, particularly early on in the epidemic, was explained by some respondents as the lack of understanding of the epidemic and how to impact its advance. In fact one respondent from Soul City pointed out that Government's emphasis on condom use, while neglecting massaging around reduction of partners, was based on the belief that partner reduction would not resonate culturally with the public and was thus neglected early on. The failure of condom use to impact on declines in prevalence rates and the subsequent research pointing to the limited impact of condom use on prevalence spurred programmes to look at messaging beyond condom use. Various programmes, including government-led programmes, then began to question the validity of earlier beliefs, and began focusing on prevention messaging grounded in abstinence and being faithful.

A respondent from CADRE compared the South African approach with those taken by other countries in Africa, in particular Uganda, Zimbabwe, Kenya and Malawi. Prevalence rates in these countries have been steadily declining, which could be due to messaging which was not only consistent from the early stages of the epidemic, but focused on prevention aspects such as delaying sexual debut and reduction of sexual partners. This respondent pointed out that, in contrast, South African messaging was too narrowly focused on condom use and needed to gain a deeper understanding of key drivers of the disease to incorporate other prevention behaviours.

4.3 FUNDING AND CROSS-FUNDING OF COMMUNICATION PREVENTION PROGRAMS

This section deals with how funding issues impact on programme strategies and the implications of these issues for local programming, and represents responses from interviewees participating in this research project. Firstly, current funding levels are presented to provide the context for respondents' comments and opinions. Then international and local funder approaches are explored. This is followed by exploring the implications of these approaches for local programmes. Lastly, strategies employed by various local programmes to deal with funding issues are presented.

The table below shows funds earmarked for HIV and AIDS in South Africa from Government as well as from donor sources, as reported by the Organization for Economic Cooperation for Development (OECD).

Table 4 Earmarked funding for HIV/AIDS in South Africa

Funding party	Funding period		US$ millions		
	2000/01	2001/02	2002/03	2000/01 to 2001/02	2001/02 to 2002/03
Donor earmarked HIV and AIDS funds according to OECD	24.11	26.37	53.08	9.4%	101.3%
Government earmarked HIV and AIDS funds	30.97	39.96	79.46	29.0%	98.8%
Total earmarked HIV and AIDS funds (donor plus Government)	55.08	66.33	132.54	20.4%	99.8%
Donor aid as a share of total HIV and AIDS earmarked funds	43.8%	39.8%	40%		

Source – OECD/ USAID, 2004 in Ndlovu, 2005

The table above shows that for the period 2000/01, donor funds constituted 43.8% of total HIV and AIDS funds earmarked for that period, 39.8 % for the period 2001/01 and 40% for the period 2002/03. There is a nominal increase in donor funds between 2000/01 to 2001/02 of 9.4 percent. Funding earmarked for HIV and AIDS increased significantly from both Government and donor sources over the three years.

The first issue addressed with respondents was the level of alignment between funder agenda's and local needs, particularly as far as non-domestic funders are concerned. Respondents from international funding organisations (JHUCCP and JHHESA) declared that the approach taken by international funders was to a large extent driven by the country situation. In instances where countries have developed strategies and mechanisms to coordinate funding, international organisations in general attempted to work with Governments to align their programming within the parameters and guidelines set for that particular country. In South Africa's situation, where a clear strategy was not developed early on, funders were forced to develop their own strategies and then partner with local organisations to implement funder specific programmes. In such instances, funders will clearly define parameters and targets to be reached within a specified period of time. Respondents also noted that in South Africa a strong and active civil society had an almost confrontational relationship with Government, but that funders had to partner with these organisations as the only point of entry for agreeable partnerships to be formed.

Further, one respondent from JHHESA painted a picture of the South African funding landscape as being riddled by "chaos". Whereas the US funded programmes attempt to work through Government, many bilateral donors have entered the country and have basically done "what they want". Adding to this, many local organisations, in the absence of an effective coordinating mechanism to channel donor funding, have been irresponsible in their efforts to secure funding, often leading to instances where such organisations lacked the capacity to effectively deliver on contracts. This in turn

forced funders to place stricter controls in place, making it even more difficult for other organisations to access funding.

In terms of funding influencing local programme strategies, all respondents agreed that most international funders will place some restrictions on how funding may be used, but this varied greatly between funders. In general, the United States funding restrictions are more limiting, and are often driven by the ideological leanings, and were, to some extent, subject to the government of the day. European based funders, however, adopt a more "libertarian" approach, allowing local priorities to shape strategies and use funding according to the needs on the ground.

Respondents from JHUCCP and JHHESA, representing international organisations involved with US based funding, stressed that they have to a large extent had the freedom to engage with local organisations to operate within the guidelines and funding targets set by the US Government. This has meant that US funded programmes, within the context of South Africa, were able to collectively determine the needs on the ground, and develop programmes to address these needs. These respondents also pointed out that in some cases, funder agendas have conflicted with South African government guidelines. An example cited to illustrate this was the instance where a particular international organization, also operating in South Africa, was given a large amount of condoms for distribution in schools in participating countries. Condoms where shipped into South Africa, but the organisation could not distribute the condoms to schools, as this would flout the South African regulations. Respondents noted that this was the exception rather than the rule.

Another key problem area pointed out by one respondent from JHUCCP is the way in which funding is categorised for HIV and AIDS. Generally, funding categories separate out funding for prevention, treatment and care and support. This respondent felt that this categorisation was an artificial separation, leading to prevention being managed in isolation of treatment, care and support. Of particular concern was that

prevention was aimed largely at persons who were HIV negative, neglecting prevention in persons who were already living with HIV and AIDS. This respondent argued that that the management of prevention and treatment where not "mutually exclusive", and should in fact happen in tandem. In addition this separation of categories, where one organization is funded for a period of time to deal with a particular issue and reach specific targets, meant that organisations could not be flexible to respond timeously to changes occurring on the ground. This posed a serious threat to the relevance and appropriateness of prevention efforts in real time.

The PEPFAR funding model was explored with a respondent from CADRE in terms of the impact on local organisations. This respondent commented that the bureaucratic nature of the PEPFAR fund had serious implications for local organisations, particularly smaller, community-based organisations. PEPFAR funds flowing into the country meant that substantially more money was available for HIV and AIDS in South Africa, which could be accessed by smaller organisations. However, the PEPFAR funding requirements meant that organisations had to change their internal organisational structures. Organisations also had to fit their programming to align with PEFAR categorization, often conflicting with the particular needs within communities. Specifically, organisations have not been able to include psychosocial aspects of HIV and AIDS as this area is not included in the PEPFAR programme categorizations.

Another key criticism of the way in which donor funded organisations impact on local needs was pointed out by this respondent from CADRE. This respondent felt that often funders develop programmes and roll these out in countries irrespective of the epidemiology in the particular country. For example, programmes being rolled out which target sex workers are located along trucking routes and border posts, neglecting sex workers in other parts of the country, or leaving those needs to be addressed by other programmes.

This respondent also raised concerns about Government spending in general, as well as spending patterns of Government's Khomanani campaign. This respondent commented that Government was in fact not very "sophisticated" in its spending; resulting in many NGO funded programmes left unfunded for certain periods of time. The Khomanani programme has also been subjected to periodic gaps where no funding has been available, meaning that interventions which it supported on the ground had to be halted periodically. This respondent felt that perhaps Government needed to focus on leading the understanding of the epidemiology of the disease, leaving the implementation of interventions to local organisations. This would ensure that heterogeneity could be dealt with appropriately and would make targeting of vulnerable groups easier.

In the context of this funding landscape, the management of programmes was explored with respondents. In particular, this issue was explored in depth with respondents from Soul City. This organisation has been involved in HIV and AIDS programming funded from a variety of sources, including international donor countries and organisations, local government funding as well as corporate or private funding. Respondents felt that this mix of funding afforded the organisation the flexibility to channel funding into areas of their programming which were in the first instance evidence based and clearly defined in terms of need. The organisation thus developed strategies based on research and then approached various funders. Where funders have placed restrictions on how their funding could be used, the organization could utilize funding which was not restricted to a particular area. Funding from corporate or private organisations, as well as funding from European countries, was channeled into areas which were not funded by, for example, PEPFAR. Respondents felt that the relative size and track record of Soul City afforded them the "luxury" of being able to "bargain" with the various funders as to how funds will be utilized. Unfortunately, many smaller and less known organisations were not in this position, and often had to contend with restrictions placed on them by funders.

4.4 PROSPECTS FOR A NATIONALLY COORDINATED COMMUNICATION STRATEGY WHICH PROVIDES A NATIONAL FRAMEWORK FOR HIV COMMUNICATIONS?

This theme explores the prospects for a nationally coordinated prevention communication strategy for South Africa. The key issues explored with respondents participating in interviews conducted for this research centre on the following: Government's current role in providing a clearly defined strategy for communication prevention; what such a strategy should entail; the process of consultation which would produce a sound strategy; Governments potential role and its capacity to coordinate around a national strategy.

Most respondents (CADRE, JHUCCP and Soul City and loveLife) agreed that to date HIV management has been "leaderless", with one respondent referring to Government as being "rudderless". Despite earlier strategies developed by Government, communication elements were not explicitly included, and therefore did not provide guidance for local and international programmes, and consequently funding was not channeled toward prevention communication. As reported earlier, this lack of leadership has led to "confusion" in terms of messaging, and a focus on condom use to the detriment of other messaging. One respondent from CADRE commented that Government's approach to strategy development was flawed, as strategies were developed internally and then sent out for comments, often "lacking the fundamentals". This has made it difficult for other role-players to give feedback, resulting in weak strategy.

Going forward, all respondents agreed that Government had a key role to play. The first step toward a more coherent approach would be to develop a solid strategy for communication. Respondents agreed that such a strategy needs to be all inclusive, but should also be focused and be informed by research and the epidemiology of the disease. A respondent from JHHESA referred to the strategy as representing a "big

box", with all programmes fitting into the box, and ultimately being accountable to the national strategy. A respondent from CADRE felt that a national strategy needed to be explicit about interventions being epidemiologically led and be designed with an understanding of the heterogeneous nature of the disease across the country. In addition, the strategy should not marginalize vulnerable groups which have thus far not received any attention. These should include, amongst others, men who have sex with men (MSM), women in the prison system, migrant and seasonal workers who are especially vulnerable in areas such as the Western Cape.

Several respondents (from CADRE and Soul City) held the view that a national strategy should also be integrated with a regional approach, enabling Governments in the region to support each others' programmes and benefit from experiences within the region. Approaching HIV and AIDS in this manner would provide security within the region, where successful models could be used and adapted for individual countries.

A respondent from loveLife expressed concern about a strategy which is too prescriptive, arguing that this would in fact stifle the diversity which is inherent in current communication programmes. A prescriptive strategy would in fact "kill initiatives" by civil society organisations. The strategy should, however, identify specific groups which need to be targeted based on the drivers of the disease within such groups. Accountability to the national strategy should also not be to the extent where programmes are "immobilised". In essence then, this respondent argued for self determination within the strategy, governed by "professional standards" and grounded in "scientific research".

In terms of an envisioned role for Government in co-coordinating the implementation of a national strategy, respondents had varying opinions. Some respondents (from JHUCCP and JHHESA) argued that that Government should have an oversight role, keeping a close eye on different programmes to ensure alignment between

programmes and at the same time avoiding duplication, but allowing programmes to be evaluated by an external party. Other respondents from CADRE and Soul City thought that Government should define each organisation's role within a framework outlined by a national strategy, holding programmes accountable to a national strategy. Some respondents argued that a hands-on approach by Government may strangle interventions as programmes would be subject to the inner workings of Government, which do not enjoy the trust of many organisations. In fact, one respondent from Soul City went as far as to say that programmes may bow out of the HIV and AIDS arena should a national strategy be too prescriptive and conflict with an organisation's capacity and ethos. One respondent viewed Government's role beyond providing a national strategy as merely creating a forum in which different programmes can come together to collaborate and share experiences.

When exploring the constructs of such a forum or a Government-led coordinating mechanism, all respondents acknowledged that while in the past no efforts had been made to create such a structure, some "limping movements" are now being made toward this. A respondent from CADRE expressed concern about the "conceptualisation" of this, which in the past took the form of organisations coming together merely to share details of their interventions. This respondent noted that the premise on which organisations should come together should be to instead collectively decide what is needed as a country and further, "how to engineer a process where programmes have different models but have accountability to a central goal".

All respondents pointed out that there was a general willingness of various programmes to participate in a nationally coordinated forum, and have made several attempts to engage with each other. Respondents noted that in fact organisations outside of Government have provided the impetus thus far for coordinating a national forum of communication programmes, which were either not attended or poorly and sporadically attended by government officials. Respondents felt that political

conflicts within and between relevant government departments often hamper efforts to come together as an industry to effect what could be a coordinated and coherent approach. One respondent from Soul City held a different view from most of the other respondents, and in her view organisations should come together as "peers", share experiences with each other, and be accountable to each other as "peers".

In further exploring Government's role as coordinator, some (CADRE and Soul City and loveLife) respondents noted that Government did not have the capacity to play such a role. One respondent from Soul City argued that Government capacity was depleted by the large number of vacancies within the NDoH in particular. Another respondent from CARDE argued that officials within Government lacked an understanding of the epidemic, and in the context of a flawed consultation process, strategies emanating from Government are generally weak. Respondents differed in their perceptions about the capacity of various structures within Government to take on a coordinating role. One respondent from JHUCCP argued that the Government Communication and Information System (GCIS) could fulfill this coordinating role, while another respondent from Soul City argued that the GCIS was not sufficiently capacitated to play this role. This respondent (as well as the respondent from loveLife) suggested that the newly restructured South African National Aids Council (SANAC) may be better placed to coordinate programmes, as it is located in the deputy president's office and has an inter-departmental view of issues.

4.5 CONCLUSION

Survey results shown above clearly show that prevention efforts in South Africa have not had the desired impact on prevalence rates. In fact, within traditionally high risk groups, young women and older men in particular, the prevalence rates have shown little or no decline over a three year period. Respondents have pointed out that this lack of progress may be attributed to lack of coherence and leadership in the general

approach to HIV and AIDS in South Africa. While it is evident from surveys that in general awareness and exposure to the key programmes are high, respondents have expressed concern over the coherence of messaging and the ability of programmes to articulate complex HIV and AIDS messaging. The high levels of knowledge of condom use with a disproportionately low use of condoms points to two important factors highlighted by respondents. Firstly, the emphasis on condom use while neglecting messages around other key prevention behaviour is a cause for concern. Secondly, the gap between knowledge and behaviour has not been successfully addressed by programme strategies, ultimately leading to the lack of impact on prevention.

The funding landscape in South Africa has also been impacted to a large extent by the lack of a national strategy and efficient coordinating mechanisms. Within this context, funders have sought to partner with local organisations, either through some government partnerships, or directly with local organisations. As far as PEPFAR funded programmes are concerned, it is clear from respondents' comments that funding constraints have to some degree impacted negatively on programmes. Funded organisations have had to fit their programmes into PEPFAR determined categories, often to the detriment of the organisations structure and the needs on the ground. Government inefficiencies were also a key concern in terms of its ability to ensure continuous funding of not only its own communication programme, but non-government organisations which it funds. In an environment where prevalence rates are high, these sporadic interruptions of programmes are detrimental to programmes.

There appears to be general agreement that Government needs to play a more active role in providing a more coherent approach to prevention communication. Respondents believed that a compelling strategy, developed through a consultative process, needed to be in place to guide prevention programming. Further, there seemed to be overwhelming support for a national structure where role players could collaborate to ensure more coherence and alignment across programmes. While

opinions differed as to the exact role Government should play, and which structure could drive such a process, respondents indicated that they would willingly participate in an efficiently coordinated national communication forum.

5 CHAPTER 5: DATA ANALYIS AND DISCUSSION

This chapter seeks to synthesise the findings from surveys and interviews with respondents in order to highlight key issues presented above. The thematic structure followed in the previous chapter will be applied to the discussions below. The subsections presented in the first theme in the data presentation section above have been collapsed under the main theme. Discussions below will also reflect key inputs from the literature as they relate to issues raised by respondents.

5.1 HIV AND AIDS COMMUNICATION PREVENTION STRATEGIES

> "When communication campaigns are assessed in relation to HIV prevalence and behaviour response, it is clear that, in spite of massive investment, there has been inadequate progress in addressing HIV prevention".
>
> The South Africa National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey-2005.

The excerpt above forms one of the key conclusions of the above mentioned survey, and encapsulates the key findings of this research. Comparative quantitative data reflect, at best, a slight leveling off of prevalence rates, but also show a concerning increase in some age groups, particularly among young women. Overwhelmingly, the respondents interviewed for this research expressed concern about the way in which South Africa as a whole, represented by senior leadership within Government, has approached HIV and AIDS. The general perception is that the lack of early and decisive action and "denialist sentiments" expressed by Government has created an environment in which confusion about the scientific fundamentals; let alone how to prevent further infections, prevailed. This view is supported by many critics and is

evident in the literature both nationally and internationally. The regional network for equity in health in Southern Africa (EQUINET) argues that "Leadership and direction on HIV/AIDS in South Africa has been inconsistent and divisive and there is no doubt that the absence of strong and committed political leadership has compromised an effective response to the epidemic" (EQUINET, 2003). Kenyon et al (2001) put forward that Government's leadership has not been weak, but rather that it has been "misguided", especially Government's contradiction in publicly questioning the link between HIV and AIDS on the one hand, but promoting VCT and "breaking the silence" on the other hand. Kenyon et al (2001) argue that such contradictions would inevitably cause confusion, particularly where an understanding of the "connection between the social and biological factors responsible for ill health" needed to be created.

Deducing from some of the literature and interviews conducted, the environment created by the controversy around HIV and AIDS in South Africa clearly did not provide a platform from which effective prevention communication campaigns could be launched. Indeed, it may also be argued that this situation had far reaching implications for the way in which both domestic and international funding was managed. Further, the impact was also felt by civil society organisations, who in many instances viewed Government as obstructive to their efforts, resulting in an adversarial relationship with Government. By all indications, however, Government's stance and intentions to change this situation have been acknowledged and well received by many, albeit with some skepticism.

In the context where a clear strategy for communication for prevention, as well as the general management of HIV and AIDS, was lacking, organisations from various quarters began to take action fairly independently. Based on this situation, a strong argument may be made that the current prevalence rates may have been averted had leadership from Government been resolute and positive. This argument is supported by a number of respondents who pointed to other African countries which are

experiencing declines in rates in an environment where leadership stepped in early and put communication and education interventions in place. Strong leadership from Government may thus be said to be one of the single most important levers for impacting prevalence (The South Africa National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey-2005). Thus, in the first instance, prevention efforts have not been approached as a collective. Even with increasing amounts of investment in prevention channeled into programming, duplication and worse still, contradictory messaging is evident. Some respondents were particularly critical of the early approach taken by loveLife, which adopted a competitive stance and therefore attracted a large proportion of funding, only to flounder in its ability to reach its stated targets. Other programmes, while attempting to develop more solid strategies based on research and sound theoretical models, proceeded to implement their programmes fairly independently. Most respondents felt that while it was necessary for each programme to use different models and operate to their strengths, collaboration between programmes may have at the very least ensured consistent messaging and prevented duplication of efforts.

On issues of campaign strategies and messaging, many respondents noted that besides inconsistency of messaging, ABC messaging is, in particular, poorly developed. It would seem that in general most programmes used ABC messaging as a core strategy; however the complexity of messaging around abstinence and being faithful were approached too simplistically. It is important to note the distinction between making messages simple and clear enough for audiences, and approaching messaging in a simplistic way. The complexity of messaging arises from the multilayered nature of HIV and AIDS related behaviour. The widely used ABC messaging, while on the surface seems fairly simple, is open to interpretation, and has been interpreted differently within different settings. This is not to say that ABC messaging should not be nuanced to suit a specific group's sexual behaviour, in fact it is critical that it does. The problem arises when the same target group receives messaging from various sources which are conflicting and generally cause confusion. If one examines the

interpretation of ABC messaging, by for example PEFAR, which have been implemented through various programmes in South Africa, abstinence messaging for young people encourages delay of sexual debut and abstinence until marriage (AVERT, 2006). In many settings, this is not a viable option for young people, especially for women, who are vulnerable to sexual violence and coercion. Neglecting to educate young people on condom use and not providing them with condoms therefore does not make sense in those settings. The UNAIDS definition of abstinence refers only to abstinence and delaying sexual debut, and encourages the correct and consistent use of condoms by sexually active young people (AVERT, 2006). This approach offers a more realistic solution for young people in vulnerable situations.

While some significant strides have been made by programmes in South Africa to address the complexities around messaging, Kelly and Parker (2001) assert that several problematic areas remain in the behaviour change approaches adopted by South African programmes. Key amongst these are the "over-reliance on mass-media, under-utilisation of interpersonal channels of communication, folk media and informal communication, an overemphasis on individual-level behaviour, and the lack of audience-segmentation and tailoring of messages" (Kelly and Parker, 2001 in Swanepoel, 2005).

Whilst acknowledging the weaknesses in approach of programmes, it is my contention that at the very least, more research is been conducted, especially qualitative research which provides deeper understanding of target audiences, with an effort being made to use research findings in programme strategies. There are, however, key areas of concern which were highlighted in the interviews conducted and in the literature reviewed. loveLife programming is often singled out as one which has missed the mark in terms of understanding its audience and developing appropriate programming. Criticisms go beyond just the complexity of messaging which is based on a poor understanding of youth in South Africa, but extend to

loveLife's evaluative process and outputs (Parker, 2003). Parker in particular has been outspoken with regards to loveLife's evaluative processes and claims which have been made by loveLife. Parker (2003) asserts that loveLife has in fact misrepresented research findings conducted by a host of local organisations, including the NDoH, and have further distorted their own achievements by less than sound evaluative techniques (Parker, 2003). Similar concerns were expressed by several respondents from JHHESA, CADRE and Soul City, further confirming the validity of these criticisms. These factors, amongst others, appear to have tarnished the image of loveLife to the extent where the Global Fund, which has been its key funder since the outset, ceased its funding in 2005. In the period subsequent to this withdrawl of support, there are indications from respondednts that loveLife has checked its approach and has begun to seek a collaborative approach.

In as far as impacting on knowledge of HIV related behaviour is concerned; the evidence shows that knowledge of condom use as a preventative behaviour is generally high. This may be attributable to a range of programme interventions, as condom use has been the focus on many programmes from early on. However, the successes achieved by creating awareness and knowledge have had limited impact on behaviour, as evidenced by data showing condom use at last sex. This gap between knowledge and behaviour, not only in South Africa or with regards to HIV and AIDS, is a well known and documented challenge. Seemingly this gap has been identified in general in South Africa, evident in Swanepoel's (2005) assertion that "… South African HIV/AIDS campaigns indeed have some effect in changing beliefs motivating these problematic (risk) behaviours, but limited success in changing the behaviours themselves". Further, it is also clear that programmes in South Africa have failed to make an impact on risk reducing behaviour beyond condom use. As shown in table two, knowledge that sticking to one partner and reducing the number of partners is disturbingly low compared to that of condom use. This may well be a result of narrowly focused campaigns and inability to address the complexity of A and B messaging in a heterogeneous setting in a culturally sensitive manner.

5.2 FUNDING AND CROSS-FUNDING OF COMMUNICATION PREVENTION PROGRAMMES

This theme set out to explore the issues and challenges faced by programmes in South Africa within a funding landscape where various sources of funds, both domestic and international, have channeled large sums of money into prevention programmes. The aim is ultimately to understand what the implications of funding and cross funding issues are for prevention communication in South Africa. It is thus important to understand the link between how agendas are set in the context of funded programmes and how programmes have responded in this environment.

The departure point for this analysis is the consensus reached in the literature that the most effective programmes are those developed in-country with strong leadership from governments. As a basis for successful interventions, enabling health policy needs to be in place (UNAIDS, 1999). As discussed earlier in this report, South Africa lacked both "strong leadership" and enabling policy early on. This has meant that many internationally funded programmes set agendas externally. Although some form of international health liaison activities existed, the co-ordination of internationally funded programmes were in fact not provided with a clear framework for HIV and AIDS interventions. As explained by respondents involved in US funded programmes, this created some "chaos", with bilateral funders in particular operating without Government guidance. In general, internationally funded programmes have partnered with local organisations. This, however, has not meant that local organisations were able to design programmes outside of the broad guidelines enforced by funders. It is also generally accepted that funders place restrictions on how funds may be spent, with the US funded programmes being subjected to tighter controls.

The impact of such restrictions was explored in some detail with research respondents. A respondent from a PEPFAR funded programme, as well as a respondent from CADRE, was explicit about the impact of these restrictions on local programmes. In the first instance, categorisations imposed by PEPFAR funding tended to be artificial, forcing programmes to separate out prevention, treatment and care. This has had the effect of forcing organisations to fit their respective capabilities and expertise into these categories, which results in a fragmented approach on the ground. Arguably, then, even the presence of a "strong civil society' in South Africa, which is not the case in many other African countries, has not been effective in setting the AIDS agenda. A respondent from CADRE aptly described the situation as "money sets agendas". In particular, in the instance of PEPFAR funded programmes, the ideological leanings of the Bush administration toward a more conservative approach to ABC messaging has meant that programmes have had to focus more on abstinence messaging which discourages sex before marriage. This unrealistic approach, as discussed earlier in this chapter, means that young people's options in terms of safe sex behaviour are neglected. Such values which are embedded in agendas have the effect of focusing efforts on messaging which is not necessarily relevant within the context where issues of coercion are a reality. In fact, the assumption that ABC messaging, largely punted by PEPFAR programmes, may not be the most appropriate strategy in this context may prove to be flawed. It will become important for South Africa as a collective to determine an appropriate strategy which encompasses the key drivers of the disease, with Government playing an active role in coordinating the development of a comprehensive strategy.

The question then arises as to how organisations deal with such restrictions. This was explored with respondents from Soul City, who, from their responses, is in a unique position of strength. The ability to negotiate with funders is derived from Soul City's funding model, which has funding streams from a diversity of funding, as well as their relative success and position within the continent as a success story. By the respondent's own admission, this is a unique and enviable position, one which many

smaller, community-based organisations cannot achieve, at least not in the short term or in the presence of larger, more established programmes.

Looking more internally, a picture of Government spending which is problematic emerges. From both the interviews conducted and literature reviewed, it is evident that Government's ability to spend funds allocated for HIV and AIDS, through its own funding mechanisms as well as funding from international funds, is ineffective. Admittedly, in some instances, spending of international funds is often delayed by "ring-fenced funds which come with strict conditions", often conflicting with local priorities (Ndlovu, 2005). Ndlovu (2005) argues that inefficiencies exist internally within Government which has been hampered by a weakened "health system and insufficient capacity of the Government to use the money". The impact of these inefficiencies negatively impacts the functioning of many organisations which receive Government funding.

This has in the past affected Governments' own communications programme, with the impact felt on a national level, but more concerning at local level where programme interventions are interrupted. At the time of writing this report, Government was still in the process of assessing tenders for the next cycle of Khomanani. Having said this, Government appears by all accounts to be addressing some of these issues, at least as far as the management of one of the largest funds for HIV and AIDS, malaria and TB viz. Global Fund. The recent restructuring of SANAC, now under the deputy president's leadership, has successfully secured funding under the current Global Fund round of funding. This bodes well for Government's credibility and will most likely restore some of the confidence lost in previous years.

5.3 PROSPECTS FOR NATIONALLY COORDINATED COMMUNICATION STRATEGY WHICH PROVIDES A NATIONAL FRAMEWORK FOR HIV COMMUNICATIONS

Respondents in general agreed that it is vitally important that Government play a role in shaping prevention communication, particularly in developing a national strategy which would provide a framework for communication in South Africa. Varying opinions emerged as to what this role should entail. It is also clear from respondents that the formulation of a national strategy which is strong and all inclusive will provide the platform for moving forward and impacting on the disease in South Africa. From respondents' comments, two key areas emerged which would need to be addressed in order to turn the tide. The first issue centers on the content of the strategy, with respondents providing clear opinions. Secondly, respondents felt strongly about the process which needs to be followed in both developing the strategy and the co-ordination of a national structure.

The importance of a national strategy based on national priorities has already been discussed, and the general consensus on this issue established. In terms of content, a national strategy has to be based on the understanding of the heterogeneity of the South African population, even within specific pre-determined audience groupings. Of particular importance is the understanding of the youth audience, targeted by most organisations, in terms of the heterogeneity of South African youth across geographical locations, race and economic status groups. The traditional youth bands which include 12-17 year olds is itself problematic, as the developmental gap between the two ages is larger than those in other age bands. An effective strategy will need to be cognisant of this to ensure that targeting of particularly vulnerable groups are adequately addressed. Further, and in line with key recommendations from the UNAIDS framework, epidemiological considerations must inform strategies to ensure that the manner in which prevention communication is approached is relevant. Messaging must

take into account the communication needs of vulnerable groups and must be appropriate for the particular phase in which the epidemic is in at a given point in time. Other underlying theoretical applications informing strategies must be in line with international best practices, incorporating tested, successful models for behaviour change.

A few respondents pointed out the importance of regional collaboration which can strengthen, not only country specific strategies, but also benefit regional security. This is particularly important in the context of the levels of HIV prevalence in Sub-Saharan Africa, where a collective approach and collaboration could positively impact on the epidemic, but also advance development. The issue of development is an important one in the light of the way in which HIV and AIDS is impacted on by poverty, social-economic conditions, education and the strength of health systems, and in turn impacts development. It would thus be critical that HIV and AIDS is dealt with as both a public health problem, as well as from a development perspective.

South Africa is a relatively stable democracy, with a strong civil society and an ever increasing culture of participation. The development of an HIV and AIDS communication strategy would thus be subject to the mechanisms of policy formulation dominant within a democracy. Several respondents pointed out that a consultative process which includes all relevant role-players, including people living with HIV and AIDS (PLHA) is a key input for the development process. Accounts from respondents expressed dissatisfaction with Government's consultative process thus far, arguing that Government has made only cursory attempts to consult with role-players in the past. The strength of a national strategy lies in the quality of the inputs from role-players, facilitated by an appropriate and all inclusive consultative process. Respondents all agreed that merely calling for ad hoc inputs into a strategy once it has been developed does not allow for fundamental issues to be raised early in the process. The concerns

expressed by some respondents that Government lacks precisely the understanding of the fundamentals of the disease cannot be addressed in the current process. An all inclusive process thus needs to be instituted in the early stages of development to allow for sufficient inputs into what would form the basis of are strategy.

Having reached agreement that a national strategy should be driven by Government, respondents offered different perspectives as to the exact role of Government in co-coordinating a national communication forum or structure which would bring programmes together at a national level. While all respondents agreed that such a forum or structure is necessary and would enable a more integrated approach, a number of concerns were raised with regards to Government's capacity to coordinate. Concerns as to the impact this may have on the individual organisations were also expressed To date, a national structure and strategy to which all programmes could be held accountable to has not been in place. Arguably, this is one of the root causes of what some have called "the failure of communication programmes" to impact on prevention. Some respondents thought that Government should drive a national structure, others felt that Government should have an oversight role, while a few thought that Government's role should be merely to lend legitimacy to the structure. One unique view was that this structure should consist of peers, who are accountable to each other. Whatever form such a structure takes, the importance of such a structure has been acknowledged, and would most likely be supported by most of HIV and AIDS communication programmes and role players. At the very least, the efforts currently being made by Government, albeit "limping", may signal a major shift in the approach to the epidemic, with the challenges faced demanding more ascendancy.

6 CHAPTER 6 – CONLCUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

This research set out to determine the implications of differing HIV/AIDS communication strategies on prevention in South Africa. In order to fully explore issues which may impact on programme strategies, it was necessary to explore the current funding realities which ultimately impact on various communication programmes. In order to reflect on what the way forward would be, the prospects for a nationally coordinated strategy and structure was investigated.

A qualitative research design was deemed most appropriate to gain a deeper understanding of what is evident in the existing literature and national surveys conducted in the last few years. This research benefited from an array of national survey results which enriched the presentation and discussions of the primary data collected by way of semi- structured interviews with key respondents.

The literature review conducted for the purposes of this report provides an overview of current theories and methodologies used in HIV and AIDS communication interventions. Literature highlighted current thinking and models which have been developed with international inputs, with the view to ensuring that HIV and AIDS communication strategies are based on sound conceptual thinking. It is clear from the literature reviewed that the complexity of prevention communication requires a collaborative approach with strategies based on three key tenets; an understanding of the context, epidemiologic drivers of the disease in different sub-country groups and approached at both an individual as well as a community behaviour change levels. Different stakeholder programmes were explored with a view to understanding each programmes' strategy. It is important to note that in general, programmes develop

strategies fairly independently. In order to begin to explore the implications of differing communication strategies, it was important to confirm the underlying assumption that programmes indeed have different prevention communication strategies. From the review of programme strategies as evident in the literature, it is clear that programmes develop strategies in isolation, often with similar target audiences and in general fairly similar approaches.

All programmes claim to develop research based strategies which integrate different types of media with community based interventions. Programmes also appear to target youth as their core strategies. The next question the research aimed to address is the impact the different strategies and general programme approaches have had on prevention in general. The HSRC study, as well as several other articles reviewed clearly asserts that in fact prevention communication in South Africa has been less than satisfactory, and in fact has often been "divergent and conflicting". Thus, as far as what the literature reveals, prevention communication has had limited success in achieving the stated goal of reducing prevalence in South Africa.

Experiences in other African countries were also explored, particularly in countries which have recorded steady declines in prevalence rates. Successes in these countries show that, inter alia, early and decisive leadership and political will to tackle HIV and AIDS head-on was a strong contributing success factor. Other key factors include indigenous strategies which were implemented at national and local levels, harnessing the strength of local community networks to foster ongoing dialogue and support.

Concluding remarks will address the research questions based on findings in the data collected and the analysis of the data.

6.1.1 What are the implications of differing HIV communication strategies on HIV prevalence in South Africa?

From the respondents' comments and survey results presented above, it is clear that prevention communication programmes have lacked the coherence and focus required to impact on prevention in South Africa. The lack of leadership and political will from Government has in the first instance created a vacuum in which programmes designed both internationally and locally have had to operate. The absence of a sound and clear national strategy for prevention communication has further hampered the ability of programmes to work within a framework which needed to provide clear goals and ensure consistent messaging. The current prevalence rates reflect that the combined impact on prevention communication has not had the impact warranted by the scale of investment and multitude of programmes dealing with prevention. It is also clear that in general prevention communication programmes, despite claims to the contrary, have not successfully addressed ABC messaging beyond condom use in order to impact on knowledge and behaviour to the extent necessary to impact on prevention.

These gaps in messaging have been further compounded by the lack of strategies which are epidemiologically led and show an understanding of the heterogeneous nature of the South African population. The lack of collaboration between programmes has also meant that lessons learnt by one programme were not shared with others, meaning that the same errors were repeated. This has created a cycle of poor results which feed into a lack of understanding in the strategy development process. The efforts and willingness currently shown by both Government and individual programmes to collaborate more formally are encouraging, provided that programmes can be critical in their analysis of their own programmes, and are indeed open to constructive critique by others.

6.1.2 How do the current funding realities of HIV communication interventions impact on stakeholders' strategies?

The premise for this question was based on a common understanding that funding issues, to various degrees, impact on programme strategies. Various sources of literature, particularly the communication framework developed by USAID, have highlighted the importance of locally developed strategies based on local priorities and needs on the ground. From the data collected it is clear that a significant amount of funding comes from international sources. The opinions expressed by respondents confirms the notion that funders' agendas have impacted on local programming, meaning that programmes are to a large extent shaped by funders' agendas, particularly in instances where organisations are not well positioned to access funding from alternative sources. In the context where a national strategy is absent, programmes are particularly vulnerable to the constraints placed upon them by funder requirements. This does not bode well for coherence of programming, where country priorities should inform strategies in a manner which respond to needs on the ground. Given the complexities alluded to earlier, programme coherence is critical, and must be achieved in order to impact on prevention.

6.1.3 What are the prospects for a nationally coordinated communication strategy which provides a national framework for HIV communications?

The need for national strategy has emerged as a common thread in the literature review as well as the data collected in this research. In fact, the absence of a communicating strategy in South Africa could be said to be one of the root causes of the lack of decline in prevalence rates. With the complexity of communication around HIV and AIDS, even with the enthusiasm and investment made by many parties, it is understandable that current problems around prevention have emerged. The pressing

need for this strategy cannot be over emphasized. The urgency with which the spread of the disease needs to be addressed further underscores its importance.

As far as the content of this strategy is concerned, a number of elements are critical. A deep and multi-layered understanding of the disease needs to be developed; epidemiological factors need to form the basis of the strategy, and the heterogeneous nature of the population needs due consideration. Coupled with this, as many respondents argued, is an all inclusive consultative process. The lessons learned and the experience gained by the multitude of organisations involved in prevention communication will need to inform the strategy. Again, complexities involved and the needs on the ground will make for a more comprehensive strategy.

The consultative process, however, should not be confined to the strategy development process. As the epidemic changes and new information becomes available, a national strategy should evolve to reflect such changes. The ability of programmes to continuously connect with each other will ensure that programming remains relevant and responsive to such changes. The argument for Government to coordinate such a forum is still questionable, and the solutions offered by respondents indicate to some degree a lack of confidence in Government's ability to lead this process. However, there is an overwhelming willingness of the programmes involved in this research to participate in such a forum, which confirms its importance. The perceived lack of Government's capacity is concerning and will likely see the more prominent programmes taking the initiative in leading the coordination of a national forum. This may, however, not necessarily detract from the value of a national forum, provided that participation from Government is consistent and from an appropriate level.

6.2 RECOMMENDATIONS

This research was conducted within the confines of prevention communication in South Africa. While prevention is a critical component in the management of HIV and AIDS, it is important that a comprehensive approach is taken. South Africa has since 2002 produced a comprehensive approach to the management of HIV and AIDS, however, a clear prevention communication strategy has not formed part of the country's comprehensive plan. It is thus the recommendation of this report that planning at a national level incorporates the communication elements critical for prevention. Arguably, such a strategy will begin to address many of the problems relating to differing communication strategies highlighted in this report.

A general assessment of the effectiveness of prevention programming has been made based on quantitative surveys. These survey results show that the impact on prevention has not been significant, and that programming is in fact problematic in many areas. In order to critically evaluate impact on knowledge and behaviour, comparative qualitative programme evaluation may be valuable in determining more critically which elements of communication programmes have had impact on behaviour change. Many organisations, however, do not have access to the resources and capacity needed to conduct this level of research. Pooling of resources and skills at a central level for periodic evaluations and research which is shared and housed in a central repository for access to all organisations, may alleviate the constraints which many organisations are faced with.

While almost all programmes have incorporated an element of research and evaluation, the quality of research and evaluation may still be questionable. It is critical that strategies are informed by continuous research, and equally important that programme evaluations are statistically sound to justify the impact of claims made by programmes. Such evaluations not only further inform programme strategies and

assist in developing local best practice while providing a benchmark for communication programming, but help to secure additional funding for successful programmes. It is thus important that national standards be developed for research and evaluation in the field of prevention communication and capacity be built within organisations to conduct research and objectively evaluate impact.

The wealth of experience and valuable lessons learnt by the many organisations active in this field holds extensive value for prevention communication in South Africa. The harnessing of this value at this point of the epidemic in South Africa is too critical to be left to Government, particularly at a time when much controversy still surrounds it. It is the recommendation of this report that the initiative shown by non-government organisations be developed into an all inclusive national communication forum which participates in the national strategy development process. Such a forum should also foster a culture of knowledge sharing and lessons learnt in an effort to establish greater collaboration between programmes. This will ultimately move the agenda of reducing prevalence rates forward, and in the long term positively impact HIV and AIDS prevalence rates in South Africa.

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8 APPENDICES

8.1 APPENDIX 1 : INTERVIEW GUIDE

- **What are the implications of differing HIV communication strategies on HIV prevalence in South Africa?**

    - What factors may have given rise to deferring HIC communication strategies in South Africa?
    - How have different strategies impacted on overall prevention in South Africa?
    - How is this evidenced - which sources of information carry the most in terms of evidence to measure campaign successes?
    - Which campaigns have had the greatest and least impact on prevention and why?

- **What underpins and informs each stakeholders' communication strategy?**
    - Which theoretical model/approach underpins your programme strategy?
    - Describe the consultation process in developing your strategy?
    - What are the key considerations when developing an HIV Communication strategy?
    - Which policy framework, if any, informs your strategy – what has informed your choice and what has been the implications of your choice?
    - Describe the overall process for formulation of your strategy.

- **How does cross-funding of HIV communication interventions impact on stakeholders' strategies?**

- What is the portfolio of your funding?
- How have different funding priorities influenced your strategy?
- How have you balanced funding priorities with your own programme priorities?

- **What are the prospects for a nationally co-coordinated communication strategy which provides a national framework for HIV communications**

  - Is there a role for a coordinated communication strategy?
  - What would be the broad scope of a national strategy?
  - Who would be the key driver – what value would the key driver give?
  - What would be the implications of a national strategy for
    - for each stakeholder group
    - HIV communications in general?

8.2 APPENDIX 1: LIST OF RESEARCH RESPONDENTS

Stakeholder grouping	Target organisations/ campaigns	Interviewee name	Position within organisation
Government	Directorate: HIV/AIDS and STI's	Ms Lusanda Mahlasela	Director of HIV and AIDS Prevention at National Department of Health
NGO's	Soul City	Dr. Sue Goldstein	Senior manager (Research, Resource Unit)
		Lebo Ramafoko	Senior manager – Soul City Series
	CADRE	Dr. Warren Parker	Managing Director
	LoveLife	Mrs. Grace Matlhape	Deputy CEO
International Organisations	JHUCCP	Dr Larry Kincaid	Senior Advisor for the Research and Evaluation Division and Associate Scientist in the Faculty of Social and Behavioral Sciences at the Johns Hopkins Bloomberg School of Public Health.
	JHHESA	Patrick Coleman	Regional Advisor and Managing Director
Total Number of interviews			**7**

Note : Two respondents from Government's Khomanani campaign were contacted for interviews but were not available before the submission of this report.