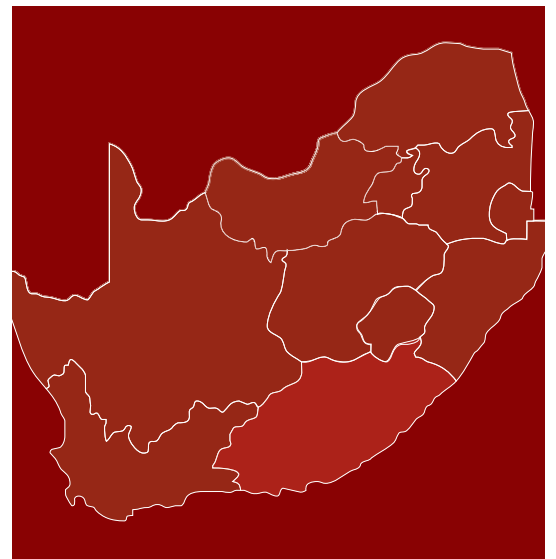
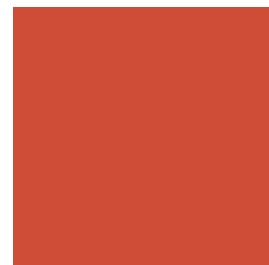
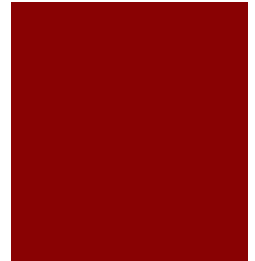


Second National HIV Communication Survey 2009

Findings from EASTERN CAPE



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iii. Acronyms

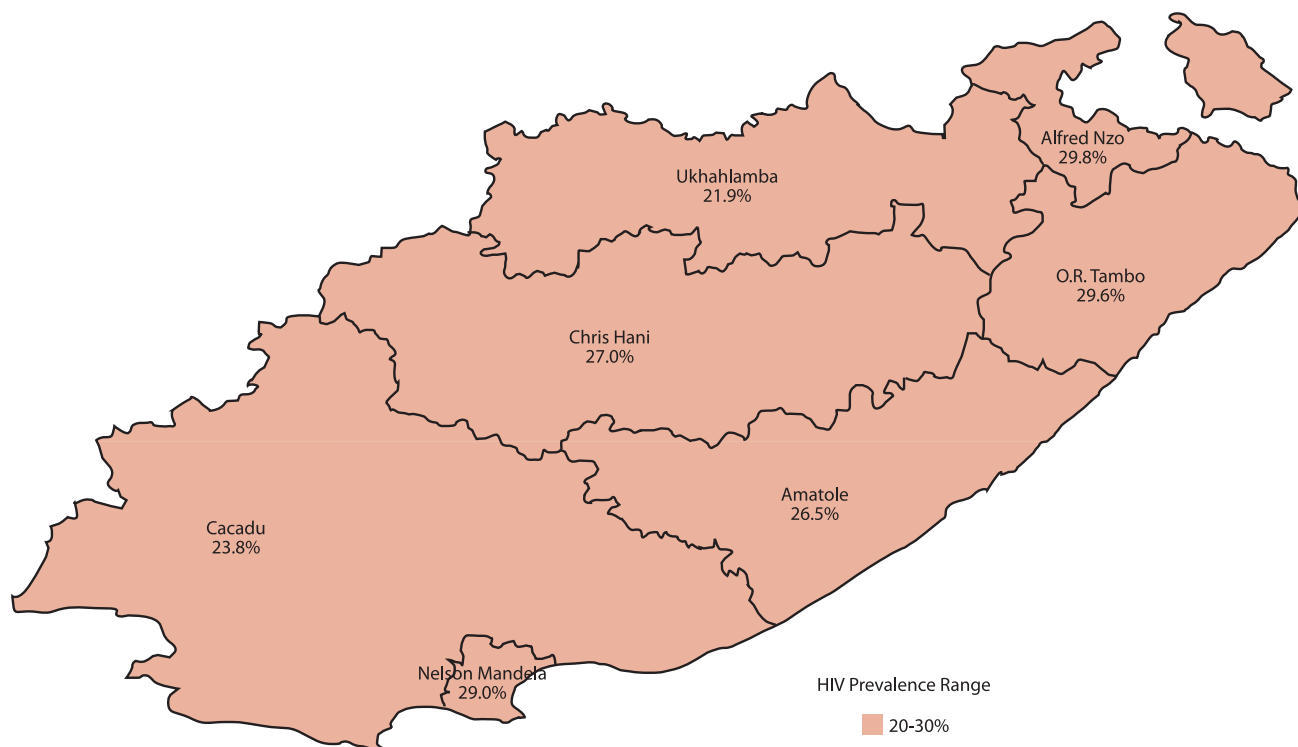
| | |
|---------------|--|
| AIDS | Acquired immune deficiency syndrome |
| ANC | Antenatal clinic |
| ARV | Anti-retroviral medicines |
| HCP/s | HIV communication programme/s |
| HCT | HIV counselling and testing |
| HIV | Human immunodeficiency virus |
| MCPs | Multiple and concurrent partnerships |
| MSPs | Multiple sexual partners |
| NCS | National HIV Communication Survey |
| PEPFAR | United States President's Emergency Plan for AIDS Relief |
| PLWHA | Person living with HIV and AIDS |
| PLWHAs | People living with HIV and AIDS |
| PMTCT | Prevention of mother-to-child transmission of HIV |
| TB | Tuberculosis |
| TV | Television |

Context of the HIV Epidemic in Eastern Cape Province

According to the 2009 Statistics South Africa mid-year population estimates, Eastern Cape Province is home to 6.6 million people¹. The 2008 *South African national HIV prevalence, incidence, behaviour and communication survey* (HSRC survey) reports that HIV prevalence in people aged 2+ years in Eastern Cape is 9.0% (95% CI: 7.2, 11.2). In people aged 15-49 years, the estimate of HIV prevalence rises to 15.2% (95% CI: 11.9, 19.1). This estimate is comparable to those obtained in 2005 (15.5%, 95% CI: 12.1, 19.8)².

The Eastern Cape province is the fourth least affected province in South Africa. Although there is relatively little difference between the districts. In 2008, the Alfred Nzo district had the highest ANC prevalence of 29.8%, followed closely by O.R. Tambo district (29.6%) and Nelson Mandela district (29%) respectively (Figure 1).

Figure 1: HIV prevalence distribution among antenatal women by district in Eastern Cape Province, 2008



Source: Antenatal Survey, 2009

A large number of people living with HIV and AIDS (PLWHAs) have reached the stage of illness and need to access treatment programmes. HIV prevention programmes remain a cornerstone of the HIV response in the province but treatment, care and support interventions are also critical. Social and behavioural communication is required to reinforce and extend behaviour that contributes to HIV prevention. Such communication supports the promotion and uptake of *biomedical prevention* interventions, while addressing the socio-cultural barriers which may impede the uptake of prevention interventions.

Communication also positively promotes self-efficacy and personal behaviours that reduce the risk of HIV infection, such as limiting sexual partners and condom use. Communication campaigns seek to tackle beliefs, attitudes and social norms that fuel risky behaviour – such as values that contribute to the notion of women-as-property and legitimise forced sex. Social and behavioural communication is also essential in ensuring the uptake of and adherence to essential care, support and treatment interventions. A major element of this is the reduction of stigma which can be a barrier to individuals seeking healthcare and other help.

¹ Statistics South Africa (2009) Mid-year population estimates. Statistical release P0302.

² Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V, Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S & the SABSSM III Implementation Team (2009) South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers? Cape Town: HSRC Press



Executive Summary

Background

The Second National HIV Communication Survey (NCS) examined the impact of HIV communication programmes in South Africa on improving knowledge and reinforcing positive beliefs, norms and attitudes, which in turn sustain or bring about behavioural change in relation to HIV prevention, care, support and treatment. The intention of this report is to assist policymakers and planners in the design of future HIV communication strategies and programmes in the Eastern Cape.

Methods

A national quantitative survey was conducted between June and August 2009. The survey involved approximately 10 000 respondents in all provinces of South Africa and was designed to be representative of 16-55-year-olds across all race groups. Of the total sample, 1,155 were from Eastern Cape. The questionnaire covered socio-demographic characteristics, exposure to various HIV communication programmes and HIV and AIDS knowledge, attitude and behaviour indicators.

Findings and recommendations

This evaluation has generated a large amount of invaluable data to contribute to an evidence-based response to the HIV and AIDS epidemic in the Eastern Cape. The following conclusions can be drawn:

Media access and reach

Access of media

- Radio and television were the most popular mass media consumed by people in the Eastern Cape, with over 85% of people watching TV or listening to the radio. SABC 1 was the most frequently watched TV station, followed by eTV and SABC 2. Given the high reach and frequency with which these are accessed in the province, these channels have the potential to reach many people with HCPs.
- Women were more likely to access newspapers and magazines than men were. These may be useful media through which women in the province can be reached.
- The most common languages spoken in the Eastern Cape was isiXhosa. Over 80% of people reported understanding isiXhosa and 58% reported understanding English. Languages spoken and understood should be considered in designing communication programmes.

Reach of HCPs

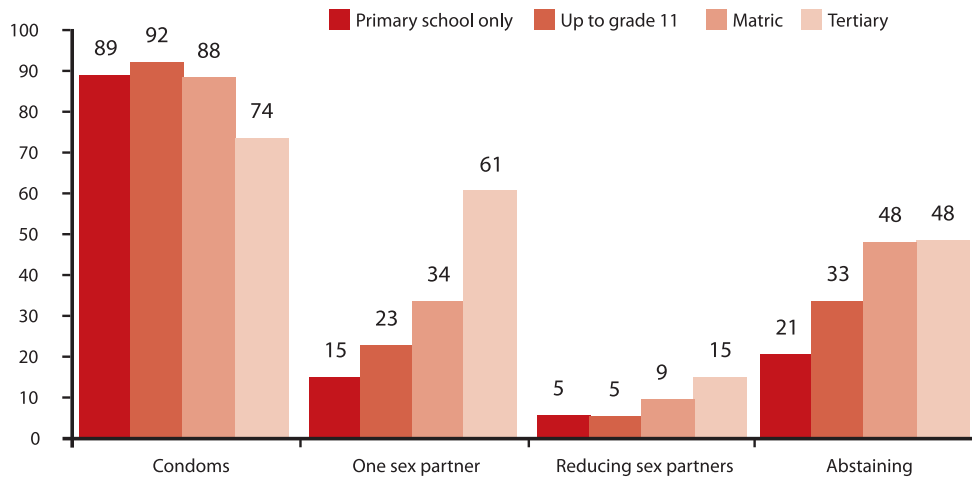
- Eighty seven percent of people in the Eastern Cape were reached with at least one HCP, with more younger people being reached than older people.
- It is important to consider the characteristics of those not reached in the province in order to tailor-make programmes and messages to reach these individuals.

Structural drivers of the HIV epidemic

Education

- Some 76% of people in the province had a secondary school level education or higher.
- People with higher levels of education were more likely to know about HIV prevention methods. There was a significant difference in the reported rate of condom use at last sex by education level.
- It is important to consider the target audiences' education levels in the design and delivery of communication campaigns in the province.

Figure 2: Percentage of people knowing about HIV prevention measures by education level



Employment

- The Eastern Cape exhibited high levels of unemployment, especially amongst women.
- This is important to consider given exposure to HIV messaging in the workplace as well as imbalances in disposable income, which can translate into transactional sex and other risk behaviours.

Socioeconomic status and poverty

- Wealth inequalities were particularly evident by education - with more highly educated people reporting a higher household wealth and socioeconomic status. People with up to primary school education reported a lower household wealth and socioeconomic status.
- This is likely to affect their access to information and sources of support. Poorer people were less likely to know that faithfulness, reduction in sexual partners and abstinence are methods to prevent HIV. Low socioeconomic status and poverty may also enhance the likelihood of alcohol consumption to cope with poverty-related stressors and in this context, may reduce women’s efficacy in relation to condom use in sexual relationships.

Violence

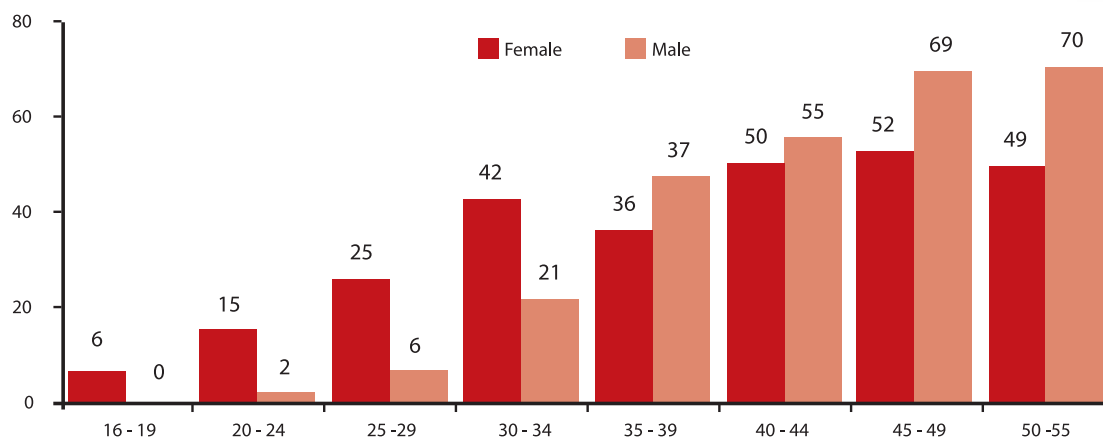
- This survey found that men were more likely to report being involved in physical violence than women.

Relationship status

- There were relatively low levels of marriage and cohabitation in the province, especially amongst men, who appeared to get married at an older age. This has implications for key messaging around sexual prevention and delayed sexual debut.
- Women were more likely to have sexual relationships with people they described as a spouse or main partner. Men on the other hand were more likely to describe their sexual partners in more casual terms.
- Sexual intercourse was more frequent in relationships that can be considered stable, however, even in relationships that can be considered casual, frequency of sex was quite high and occurred over an extended period of time



Figure 3: Percentage of men and women who were married or living with sexual partner by age group

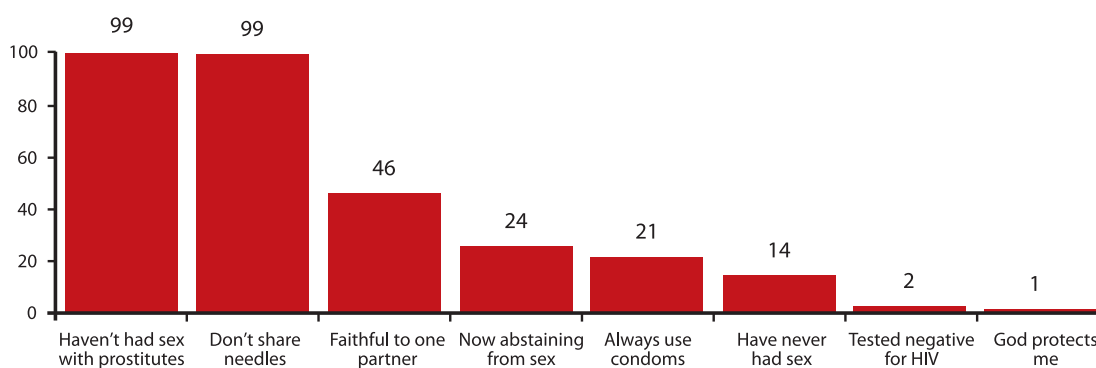


Behavioural Drivers

Perceived risk of getting HIV

- More women felt that they were likely to get HIV than men. Women were more likely to know someone who was HIV positive and to know someone who had died of an AIDS-related condition. These experiences might prompt women to consider and accept that they are likely to become infected. Another explanation is that a considerable proportion of women think or know that their partners have other sexual partners, and this would put them at greater risk of infection.
- The main reasons for people believing that they were not at risk of getting infected with HIV were not aligned with the drivers of the epidemic – heterosexual sex in the general population. HCPs may need to focus on aligning people’s risk perception with the drivers of the epidemic.

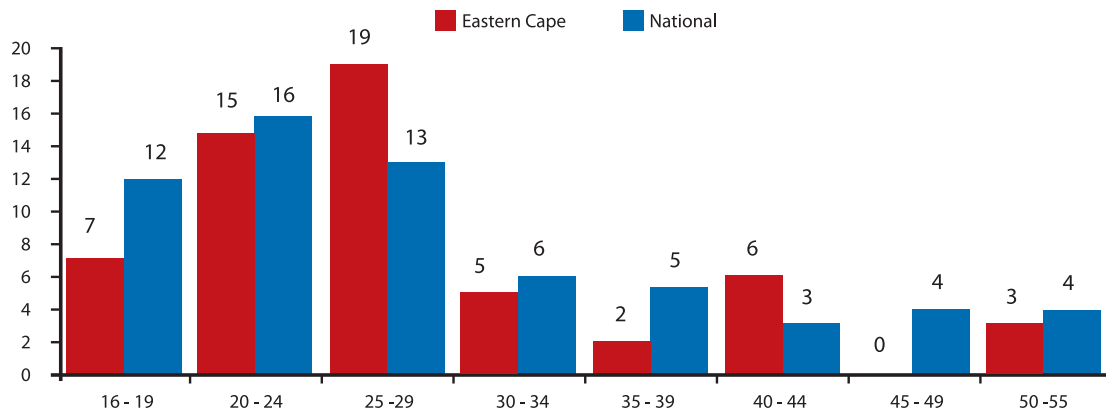
Figure 4: Reasons why respondents believed they were not at risk of getting HIV



Multiple sexual partners

- The data clearly indicate that men are more likely to have MSPs than women. Men aged 20-24 years from the Eastern Cape were more likely to have MSPs compared to men of the same age from South Africa as a whole.
- It is important for future HCPs to investigate innovative ways of engaging men on this aspect of HIV risk. Communication directed at men needs to be combined with the development of appropriate male-friendly services in the province.

Figure 5: Percentage of men with more than one partner in the past month in Eastern Cape

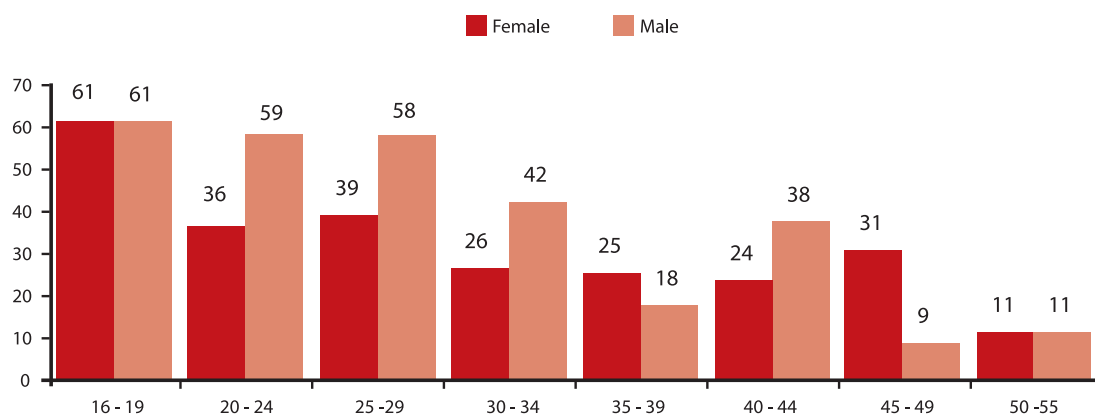


- A high number of people of all ages believed that cheating was pervasive in relationships. However, this impression was not borne out by the actual number of people with MSPs. HCPs may need to focus their efforts on challenging people’s beliefs that cheating is pervasive in relationships.
- The focus on MSPs in HCPs has been relatively new. In contrast, condom promotion programmes have been operating for about 20 years in South Africa and the gains have been gradual. But, it is not as easy to find and keep one main sexual partner as it is to obtain condoms to protect oneself from HIV infection. This is particularly the case in a society where stable relationships are not the norm.
- Reducing sexual partners may also be undercut by the option of using condoms to reduce HIV risk. Most people now know that condoms should be used to prevent HIV and may think that if they use condoms they do not have to reduce their number of sexual partners. It is therefore important for HCPs to continue to promote partner reduction and faithfulness, but to do so more explicitly within an approach of combining prevention methods.

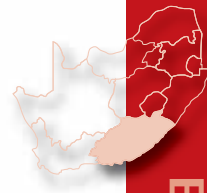
Correct and consistent condom use

- Knowledge of the importance of condoms as an HIV prevention measure was very high. Condom use has been promoted intensively over two decades in South Africa as the primary method of HIV prevention and rates of awareness are a measure of the relative success of these HCP efforts.
- Condom use is related to relationship status, with a greater likelihood of use in less stable relationships than in more stable ones. Although knowledge of condoms as a method of HIV prevention is very high in the Eastern Cape, condom use is uneven and it is evident that more nuanced messaging is needed to reach those who are not yet using condoms.

Figure 6: Percentage of sexually active men and women who used a condom at last sex by age



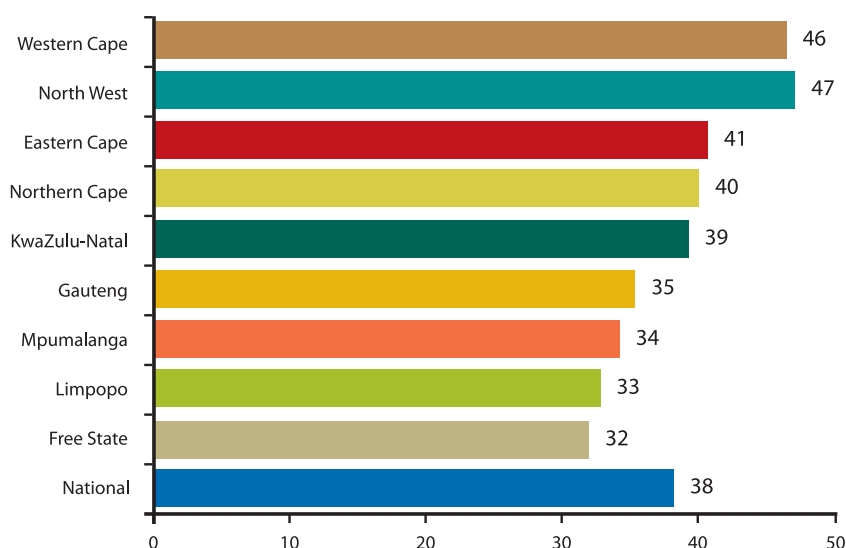
- The province cannot afford to lose ground on condom use, especially in the context of low levels of stable relationships among sexually active South Africans.



Intergenerational sex

- The greatest concern is the high percentage of women aged 16-24 years in relationships with men five or more years older than them. The Eastern Cape had the third highest rate of intergenerational sex when compared to other provinces and this is clearly a major factor in transmitting HIV to women in this age group since men of their own age have much lower rate of HIV infection.
- HCPs need to sustain messaging on the risks of these relationships.
- Qualitative research might assist to refine messaging and identify additional social interventions to reduce this pattern of behaviour.

Figure 7: Percentage of young women aged 16-24 reporting intergenerational sex by province



Transactional sex

- *Relatively few relationships* described by respondents in this study could be classified as *transactional*. However, this is likely to be an underestimate given that transactional sex is difficult to define and measure in a questionnaire.
- Programme planners need to evaluate whether to approach this area of risk behaviour primarily through use of the mass media or through more targeted forms of communication, focusing particularly on men.

Alcohol

- Men were most likely to drink alcohol heavily often and to report engaging in sex when they and/or their partner had had too much to drink. This occurred especially in less stable relationships.
- HCPs should focus mainly on men when addressing the link between alcohol and risky sexual behaviour.

Delaying sexual debut

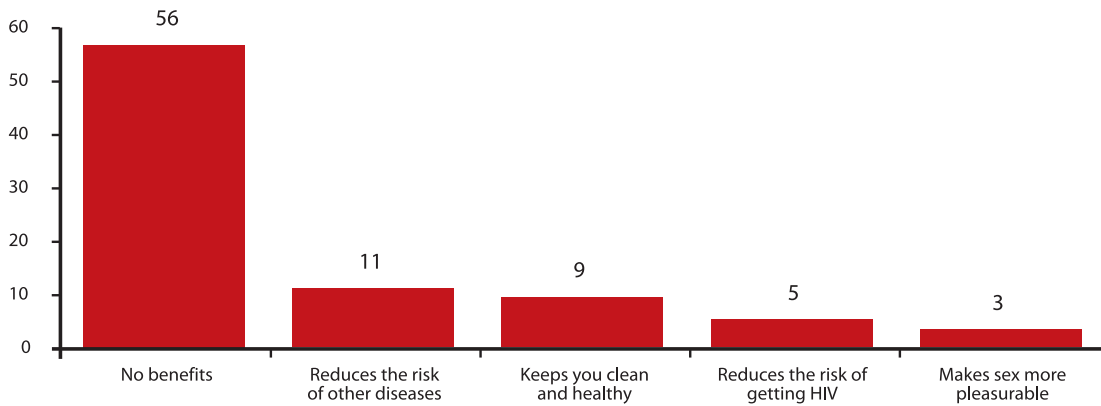
- Many young people held positive attitudes towards delaying sexual debut. However, a significant number of young women – who are particularly vulnerable to HIV infection – continue to start having sex early.
- Lasting relationships in terms of marriage and cohabitation are only formed later for many people. Delaying sexual debut may therefore not be a feasible option for young people.

Biomedical drivers of the HIV epidemic

Male circumcision

- Levels of *knowledge were low* in respect of HIV risk-reduction provided by *male circumcision*. Prevalence of male circumcision was high (73%). It appears that many young men are circumcised only after they first become sexually active. This means that some will accrue no benefits in terms of HIV protection.
- One of the concerns about male circumcision is that behavioural disinhibition may occur and that men who are circumcised may stop using condoms. The findings from this study are encouraging as the majority of participants indicated that men who are circumcised still need to use condoms.

Figure 8: Perceived benefits of male circumcision



- As the national male circumcision programme rolls out there is a need to increase awareness of the risk-reduction benefits of male circumcision.
- The point made earlier applies: specific prevention interventions need to be framed within a comprehensive approach to prevention. In addition to circumcision, such an approach would include partner reduction and correct and consistent condom usage.

Prevention of mother-to-child transmission of HIV

- HCPs have focused on increasing awareness of the risks of MTCT of HIV and knowledge about the risk of breastfeeding was high. However, less than 2% of people knew about exclusive breastfeeding as an option for reducing the risk of transmission.
- There is clearly considerable room for interventions to improve knowledge of safer feeding practices.

Table 1: Percentage of people knowing that formula feeding and exclusive breastfeeding can prevent MTCT

| | Males | Females | Total |
|--------------------------------|-------|---------|-------|
| Formula feeding | 8.0 | 10.0 | 9.1 |
| Exclusive breastfeeding | 1.7 | 1.4 | 1.5 |

- This is a critical area as new infections amongst babies are almost entirely preventable. New government guidelines on earlier initiation of ARV therapy for pregnant women and the introduction of a two-drug regimen for PMTCT will substantially reduce HIV transmission during pregnancy and labour. Safer infant feeding practices would complete the picture in terms of giving HIV positive mothers a great chance of rearing HIV-free children.

HIV counselling and testing

- Ever tested for HIV in the Eastern Cape was among the lowest reported in the country.
- More men than women reported being informed about their partner’s HIV status. People in more stable relationships were more likely to have seen their partner’s HIV test results than in people in less stable relationships were.
- There is room to improve testing, especially amongst men, in the province.

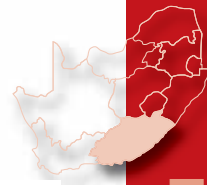
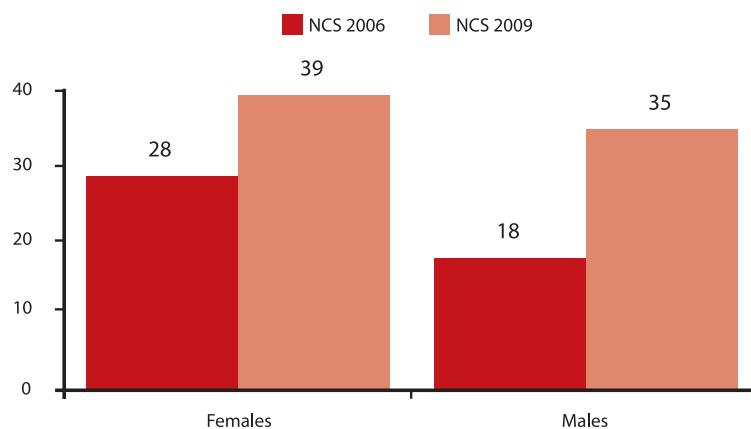


Figure 9: Percentage of men and women who have been tested for HIV in the past year in 2006 and 2009

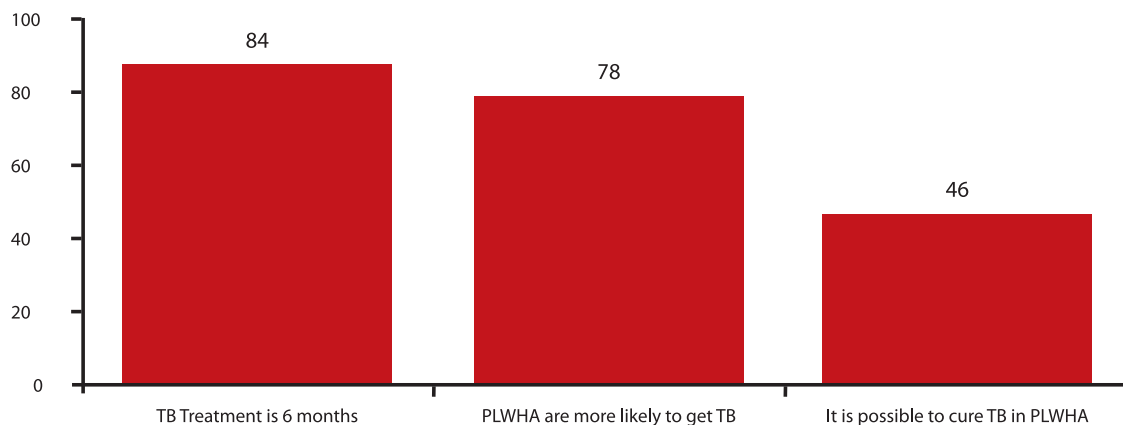


Treatment, care and support

Knowledge of TB

- Knowledge of the duration of TB treatment was high. This information has been a focus of a number of HCPs over the past few years and the high levels of knowledge are probably attributable to these interventions.

Figure 10: Percentage of people who correctly answered various questions about TB and TB drugs



- There were lower levels of awareness of the links between TB and HIV. This is to be expected as the TB/HIV link has not been a major focus of communication. There is therefore room to strengthen communication about TB and its link to HIV.

Knowledge of antiretroviral therapy

Table 2: Percentage of people who correctly answered various questions about ARVs

| | Frequency | Percentage |
|---|-----------|------------|
| People who know there is treatment for HIV | 2,653,796 | 82.5 |
| People who know that ARVs are a treatment for HIV | 2,263,381 | 85.3 |
| People who know that ARV treatment is for life | 1,731,972 | 66.0 |

- Knowledge of ARVs as treatment for AIDS was high and has increased considerably since 2006. *The increase in knowledge of ARVs is encouraging and is most likely due to messaging on this matter.*
- HCPs should seek to sustain these high levels of knowledge by continuing to feature specific ARV messaging.

Social Capital

Personal experience of HIV

- The HIV epidemic is highly visible in the Eastern Cape, with a high proportion of the population knowing someone who has HIV, someone who died of an AIDS related condition and/or caring for someone with AIDS.
- Personal exposure to HIV is likely to impact the extent to which HCPs are effective in the province.

Community participation and leadership

- The Eastern Cape has shown relatively low levels of community participation and leadership when compared with other provinces.
- Community participation should be encouraged and sustained in order to support both prevention and treatment initiatives in the province.

Stigma

- Eighteen percent of people in the Eastern Cape reported that they would be embarrassed to be seen with someone who everyone knows is HIV positive.
- Sustained messaging to address stigma is still needed in order to maintain acceptance of PLWHAs where this has been achieved and to reduce stigma where this persists.

Final comments

The significance of the study for those who design and fund local interventions lies also in its ability to identify gaps in progress. This helps to pinpoint specific audiences or specific messages that require attention in the future.

Annexure 1



Table 3: Comparison of key findings, Eastern Cape and South Africa

| | | National | Eastern Cape |
|---|-------------------------------------|----------|--------------|
| | | % | % |
| General | Mean age (years) | 30.2 | 31.9 |
| | Male | 48.7 | 43.8 |
| | Ever had sexual relationship | 88.7 | 89.0 |
| Knowledge of methods to prevent HIV transmission | Condom use | 85.6 | 89.5 |
| | Faithfulness | 39.1 | 25.5 |
| | Abstinence | 37.4 | 34.3 |
| | Partner reduction | 12.2 | 6.7 |
| Behaviour | Used condoms to prevent AIDS | 40.2 | 35.8 |
| | Used condoms at last sex | 39.8 | 34.2 |
| | HCT – ever tested | 61.4 | 60.0 |
| | HCT – tested in the past 12 months | 36.9 | 36.7 |
| | MSP in the last 12 months | 11.4 | 10.4 |
| | MSP in the last 12 months - Males | 20.1 | 17.8 |
| | MSP in the last 12 months - Females | 3.0 | 3.9 |
| | MSP - >1 partner in the past month | 4.9 | 3.9 |

Annexure 2

Table 4: Percentage of people in Eastern Cape Province and South Africa who were not exposed to any of the HIV Communication Programmes by socio-demographic factors

| | | National | Eastern Cape |
|--------------------------------------|---|----------|--------------|
| Gender | Female | 10.4 | 10.4 |
| | Male | 10.1 | 16.6 |
| Marital Status | Single | 8.1 | 10.7 |
| | Not married or living together but in a steady relationship | 5.4 | 9.3 |
| | Not married but living with sexual partner | 11.8 | 24.3 |
| | Married, living together | 14.3 | 17.5 |
| | Married not living together | 13.6 | 16.9 |
| | Divorced/widowed | 23.6 | 18.8 |
| Age Group | 16 - 24 | 5.7 | 7.8 |
| | 25 - 49 | 11.1 | 14.3 |
| | 50 - 55 | 21.8 | 24.7 |
| Had sex in the past 12 months | Yes | 9.2 | 12.2 |
| | No | 14.7 | 15.8 |
| Employment Status | Unemployed | 11.1 | 14.8 |
| | Employed | 11.4 | 12.2 |
| | Student | 5.2 | 9.1 |
| Education Status | Primary school only | 22.2 | 25.9 |
| | Up to grade 11 | 8.8 | 9.5 |
| | Matric | 6.4 | 6.3 |
| | Tertiary | 5.9 | 18.0 |
| Socio Economic Status | Low | 18.9 | 21.0 |
| | Medium | 5.2 | 4.7 |
| | High | 8.0 | 8.8 |
| Settlement Type | Urban formal | 8.1 | 9.3 |
| | Urban informal | 6.6 | 12.2 |
| | Peri-urban | 16.8 | 9.9 |
| | Tribal settlement | 11.2 | 15.1 |
| | Farming | 26.2 | 50.0 |