

Presenting the evidence for Social and Behavioural Communication

A brief collation of some of the evidence from a number of surveys and meta-analyses to show that social and behavioural communication is effective, economical and a vital component of a combination HIV prevention response. This document was written by consultant Thomas Scalway, with inputs from Johns Hopkins Health and Education in South Africa (JHHESA), Health and Development Africa (HDA), Soul City, Love-Life and Community Media Trust (CMT).

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Presenting the evidence for HIV Communication

HIV Prevention has changed dramatically in the last couple of decades, from blanket information dissemination and fear tactics in the 80's through to today's complex combination prevention approaches that blend behavioural, biomedical and structural approaches. Much has been accomplished, with lowering infection rates in a number of countries and a decrease in the kinds of behaviours that can fuel HIV epidemics.ⁱ This document shows how long term social and behaviour change has been brought about and how a number of positive trends have been maintained.

Despite these successes, more needs to be done. Levels of infection are still high, there are mixed levels of knowledge of HIV, and much harmful behaviour persists. Some working in the response to HIV are wearying of doing business as usual, and are looking for new solutions that can make a lasting and significant difference. Clinical HIV prevention methods are being intensified, such as medical male circumcision (MMC), post exposure prophylaxis (PEP), and prevention of mother to child transmission of HIV (PMTCT). While these methods are both timely and effective, those working with HIV communication are having their budgets cut, their programmes de-prioritised and the usefulness of their contributions questioned.

This paper makes the argument for communication. While recognising the importance of clinical methods, it shows that HIV communication is effective, cost-effective and a crucial counterpart to clinical HIV prevention interventions. In countries such as South Africa, HIV communication programmes are relatively small players compared to their commercial partners. In 2008 to 2009, for example, they were functioning on a combined budget that is around one fourth of that spent marketing alcoholic drinks within the country. Despite the small budgets, these HIV communication programmes have had measurable results in achieving something much more complicated than a straight commercial sell.

Some examples of impact:

- Across a number of studies in different countries, condom use is shown to be 18% higher among those exposed to mass-media interventionsⁱⁱ
- Condom use for protection of pregnancy among African women rose 13% due to condom promotion campaignsⁱⁱⁱ
- 701, 494 South Africans would have been infected with HIV if they had not practiced an HIV prevention behaviour^{iv}
- In South Africa, condom use 23% higher among those with high exposure to Siyayinqoba Beat It!^{v1}
- In South Africa, people were 17% more likely to use a condom if exposed to Soul City *One Love*^{vi}
- 5% more South Africans that could recall Scrutinize ads were faithful to their sexual partner^{2vii}

¹ *Siyayinqoba Beat It!* is a weekly TV show that promotes positive living and HIV prevention. A report on the impact of Siyayinqoba beat it! on HIV AIDS showed that the Siyayinqoba Beat It programmes reached 47% of the national population.

- 14% more South Africans exposed to Khomanani were tested for HIV than those not exposed.³ ^{viii}

Social and Behavioural communication programmes deploy a number of methods to achieve social and behavioural outcomes. As well as aiming to change behaviour and the pre-determinants of behaviour, social and behavioural communication is used to *maintain* positive behaviours, attitudes, norms and other social processes conducive for HIV prevention. Goals and objectives are defined that stimulate positive and measurable social and behavioural changes amongst specific audiences and can promote the uptake of services. Mass media components are reinforced with interpersonal communication, community outreach and mobilisation, and a number of forms of information dissemination, education and dialogue. Much of the evidence cited here is for mass media communication, but more data is now being gained on the effectiveness of other types of communication.

The communication programmes described in this document aim to tackle specific aspects of knowledge, motivation, attitudes, norms (or ideational factors) or behaviours in a way that will have a knock-on effect in terms of reducing new HIV infections. This means the evidence cited in this document is not focused on reduction of HIV incidence. However, it does show both the impact of communication programmes in terms of social or behaviour change, and also the clear evidence that these social and behaviour changes are reducing incidence in South Africa and a number of other countries. This is important to understand, as the argument over whether communication works is often one revolving around whether it achieves impact.

The problem

In the 30 plus years since the discovery of the virus that causes AIDS, a virus that is entirely preventable, 60 million people worldwide have been infected with HIV and 2.7 million were infected in 2008^{ix}. In the same year, 2.0 million people died of AIDS related illnesses, bringing the total number of AIDS related deaths to around 25 million^x. A number of influential people, particularly those within the donor community, have started to question whether some of the core elements of the response to the epidemic are having real impact. Health communication programming is particularly under threat. Budgets have already been dramatically reduced among South Africa's leading HIV communication organisations. In 2010, JHESHA has undergone a 3 million USD budget cut from 2009 funding levels. Soul City has had its funding dramatically cut. It applied for \$8.0 million over three years and was only awarded \$1.8million with no guarantee of future funding following this year. The South African government's Khomanani Campaign ended in April 2010. At the time of this paper there was no clarity as to the future of the Khomanani campaign, meaning social and behavioural communication is largely left to civil society groups and external donors.

A recent presentation made to SANAC gave three scenarios for HIV funding. If funding was cut, it suggested, and hard choices had to be made, many core elements of health

² Scrutinize is a campaign run by JHESHA and partners. It was launched in 2008, involves a series of short animated TV commercials known as animerts.

³ Khomanani is the government sponsored campaign on HIV, TB and STIs using a range of channels including TV, radio, print and interpersonal communication.

communication programming would be the first to be axed, including community level and mass media communication interventions^{xi}.

In countries around the region, communication is being de-emphasized while clinical HIV prevention is scaled up. HIV communication work is also increasingly orientated towards the promotion of biomedical interventions. A recent media audit by Synnovate in Kenya^{xii} showed that mass media messaging on HIV prevention is mainly focused on the promotion of male circumcision. The same media audit showed that the promotion of condoms, partner reduction or other prevention behaviours was not getting nearly as much media coverage as circumcision, partly because the donors were funding less communication in these areas. This may have deleterious consequences for HIV prevention in general, including partner reduction and condom use.

Debates on the value of communication for HIV and other health interventions have been ongoing for many decades but two important new developments are occurring. The first is that there has been a considerable expansion within the clinical toolkit for HIV prevention, including PEP, PMTCT, MMC and the use of HIV treatment as prevention. In earlier years, communication and condom promotion were the only methods available to those trying to stem the flow of new infections. With these new clinical prevention methods, and the promise of further additions such as vaginal microbicide gels and pre-exposure prophylaxis, this is no longer the case. The second development relates to the interpretation of evidence. There is confusion as to how to interpret the findings of different studies relating to communication, and a growing desire to base interventions on the kind of straightforward evidence that clinicians are most comfortable with, is undermining the legitimacy of HIV communication programming.

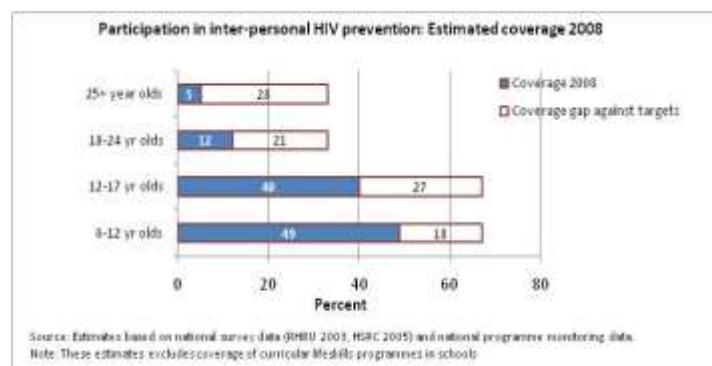
A number of common assumptions and ideas underlie questions on the effectiveness of HIV communication programming. These include the notion that success in relation to HIV prevention can only be measured at the level of impact on HIV incidence. There are challenging perspectives on what constitutes scientific evidence of success. Another assumption is that SBC has been rolled out at a duration, scale and intensity required to make a significant difference. Further, while biomedical HIV prevention interventions are clearly a vital part of the efforts to stop new infections, the notion that they can be scaled up in isolation from SBC is also misguided.

Communication and HIV prevention

One of the challenges of any assertion that social and behavioural communication (SBC) does not work is that there is not a single country where it can be said to have been fully tested. As Piot writes in the Lancet in 2008, HIV prevention has not been taken to the level of scale or intensity required to turn the tide of the pandemic.^{xiii} While the reach of mass media communication on HIV may be around 90% in countries such as South Africa, the fact that 90% of the population is exposed to at least one mass media HIV prevention intervention is no reason for complacency. All the evidence suggests a high dosage of media exposure over a sustained period garners the most significant results.^{xiv} Importantly, there is still only partial coverage of interpersonal communication, community based communication and other more

targeted methods. Sustained communication through a number of channels is required for meaningful impact on HIV prevention.^{xv}

Figure 1. Estimated participation in interpersonal HIV prevention services, 2008



Implementing the National Plan for HIV Prevention, Breakthrough strategies for the Department of Health 2009 – 2013, David Harrison, 2009

According to Piot and colleagues, “Prevention work takes the longest time, is largely outside of health services, and has no “quick win”.^{xvi} As Coates notes, the “aggregate effect of radical and sustained interventions of behavioural change of a sufficient number of individuals at risk is needed for successful reduction in HIV infection”.^{xvii} This kind of scale or intensity is rarely found in national prevention programming.

In South Africa the argument is often made that there is now widespread knowledge of HIV. However, the surveys show that levels of knowledge are often superficial. In 2008 the percentage of people who had accurate knowledge of HIV (correct knowledge of sexual transmission of HIV and rejection of major misconceptions of HIV transmission among adults) was at only around 30% in both sexes and across all ages^{xviii}.

Social and behaviour communication is a primary or secondary means to achieving results in all areas of combination HIV prevention. SBC can directly engage, through a range of approaches derived from the social and behavioural sciences, with the actual behaviours that drive HIV infection. As a SADC committee noted, focused behavioural interventions may make a difference in concentrated low-level epidemics, but alone will not manage to curb the generalised and hyper-endemic epidemics of Southern Africa.^{xix} Communication can also address the societal-level determinants, such as gender inequality and the normative systems that are pre-determinants to HIV risk. For biomedical interventions too, SBC is an integral component. MMC needs promotion within a comprehensive HIV prevention package to ensure a full understanding of the risk-reduction benefits of the procedure and also to emphasise that this is not a “silver bullet” - men who are medically circumcised still need to use condoms and reduce the number of their sexual partners much like everyone else^{xx}. The same is true for the promotion of PMTCT, PEP and other biomedical interventions. The discussion about clinical HIV prevention interventions in relation to communication-based interventions does not revolve around an “either-or” scenario. Both can only work together, not in isolation from one another.

Questioning the evidence of HIV Communication

Simbayi, Bertozzi and other commentators have noted that there is insufficient evidence for the efficacy of SBC.^{xxi xxii} What these arguments tend to suppose is that HIV prevention as a process, or set of processes, can be equated to clinical vaccinations where a singular problem requires a singular intervention. The spread of HIV is tied to a range of human behaviours that are in turn shaped by a number of social, economic and other structural factors. The evidence that SBC works will never quite as simple or immediately compelling as that of male circumcision, PMTCT or the other biomedical interventions that SBCC supports.

For those with an empirical scientific background, the most persuasive evidence is produced through formal experimentation. Randomised controlled trials have long been employed to measure the efficacy in health initiatives and drug formulations. There are calls for “hard” RCT evidence for HIV prevention approaches. Unfortunately, these kinds of experiments do not lend themselves to communication programmes, where random assignment is not feasible or ethical.^{xxiii xxiv}

In a randomised controlled trial two randomly selected groups of people within a closely controlled environment are exposed to different interventions and the results are analysed. Normally, the groups used for such experiments do not adequately represent the entire population of interest. As a consequence, RCT experiments have high internal validity but very poor and unknown external validity. It is unclear how well the findings can be generalized to entire population. National level communication programs for HIV/AIDS prevention are normally evaluated by means of representative national or regional surveys. National sample survey data has very high external validity, but the data requires advanced statistical analysis with statistical controls (socio-economic and other confounding variables) to increase internal validity and draw a causal inference.

Randomised controlled trials do not alone give sufficient evidence for shaping HIV prevention interventions because HIV prevention requires addressing a range of factors along a causal chain. Taking one or two interventions focusing on specific parts of the chain (e.g. condom promotion) in a small-scale RCT study may not be meaningful when other upstream parts of the system remain ignored (e.g. gender related issues relating to condom use). National surveys often include many of these important, related measures and therefore can take many other sources of variation into account. Further, the use of RCT for field experiments under natural conditions often suffer from contamination, where members of the control and treatment groups interact or control group members find a way to get access or exposure to the treatment. Full scale communication interventions allow and encourage all members of the population to be exposed and then control statistically for the variables that determine “self-selection” into the exposed group. New statistical methods such as propensity score matching can now use representative sample survey data to construct statistically equivalent exposed and unexposed groups that can approximate the results that would have been found from randomized control groups (RCT). Ethics would also prohibit experimental (RCT) designs that put groups in danger, for example by withholding information or providing placebo-type information to control groups at risk of disease.

Assessing the evidence

Evidence that behavioural change is leading to fewer HIV infections.

The evidence shows that behaviours are shifting in many countries, and this is resulting in a decline in HIV incidence. A study in Uganda (1996-2007) showed how national efforts to decrease or delay sexual activity, increase condom use and reduce the number of sexual partners were effective in preventing HIV nationwide. Young people were starting to have sex later, were more likely to use condoms and less likely to have multiple partners than in older cohorts^{xxv}.

A study of young people ages 15 to 24 in Zambia from 1995, 1999 and 2003, found that numbers of sexual partners was dropping, condom use was increasing and age of sexual debut was increasing. In this period HCPs were intensively promoting condom use, partner reduction and later sexual debut.^{xxvi}

A review of surveillance data between 1998 and 2003 in Manicaland, Zimbabwe among a population cohort of 9,454 adults found evidence for delay in the onset of sexual activity among adolescent men and women.^{xxvii} Numbers of young men and women ages 17 to 19 reported having commenced sexual activity almost halved. In the same period, HIV prevalence fell by 23% among men aged 17 to 29 and by 49% among women aged 15 to 24 years. One of the lessons here is that behaviour change is possible, is happening and is having a measurable effect on HIV incidence.

Locally, in South Africa, a study in 2005 shows that 701,494 people would have been HIV positive if they had not practiced some form of HIV prevention behaviour.^{xxviii} These are the same behaviours that health communication programmes (HCPs) were targeting.

Evidence that health communication programmes are changing behaviours.

Internationally, there is strong evidence that social and behaviour change communication works. Hornik notes in an October 2010 Lancet journal that the evidence for the success of mass media campaigns on a number of health areas, from tobacco through to safe driving, and including HIV, is now compelling. A recent meta-analysis of 72 interventions by Snyder and colleagues showed that media interventions successfully promoted condom use^{xxix}. Snyder finds that condom use is 18 percentage points higher on average among those exposed to mass media interventions for HIV prevention.

Cleland and Ali have noted a sharp growth in the use of condoms for protection against pregnancy among young women across Africa (from 5% to 18% between 1993 and 2001), which they attribute to HIV-related condom promotion campaigns^{xxx}.

Wellings assessed a series of European AIDS campaigns with major mass media components run in the early 1990s^{xxxi}. She found that campaign activity was directly related to trends in condom use among those with casual partners.

Gay et al found that mass media campaigns concerning gender equality as part of comprehensive and integrated services can increase HIV protective behaviours amongst

women.^{xxxii} They also state that mass media interventions can increase the numbers of individuals and couples accessing HIV counselling and testing^{xxxiii}.

Although the relationship is complex, and the contributing factors are numerous, it is possible to associate the intensification of HCPs with the overall decline of HIV incidence in many countries, including South Africa. From 1999 to 2009 there was a significant decrease in the number of new HIV infections in South Africa and this period coincides with the most acute health communication programming in the country.

In 2006 exposure to the 19 AIDS communication programmes investigated in that year's communication survey had a statistically significant effect on 13 of the 17 intended outcomes relating to HIV in South Africa.^{xxxiv} Controlling for a number of relevant variables, exposure to communication programmes was shown to increase the likelihood of:

- Using a condom to prevent HIV infection
- Condom self-efficacy (confidence to use condoms in a variety of situations)
- Discussion of HIV testing with one's sexual partner
- Discussion of HIV testing with friends
- Having an HIV test in the last 12 months
- Ever having an HIV test
- Helping someone sick with AIDS
- Knowledge of antiretroviral (ARV) treatment for AIDS
- Helping a child affected by AIDS
- A high positive attitude towards living with HIV and AIDS (reversed stigma)
- Ever participating in a community or church meeting where HIV and AIDS was discussed

The Second National Communication Survey of 2009 is the most recent and comprehensive study that can currently be drawn upon in investigating the impact of HIV communication in South Africa.^{xxxv} It used a sophisticated multi-stage sampling approach where 9728 participants between the ages of 16 and 55 years were interviewed using a structured questionnaire. Both uni-variate and multi-variate analytical methods were applied. Regression analysis was used to ensure that any reported changes could be attributed to the communication intervention and not to other interventions or associated variables that could have caused these.

It shows that communication programmes have had a positive and measurable effect on the knowledge, attitudes and beliefs that are contributory to HIV prevention. The survey shows that the exposure to communication programmes is also responsible for a number of positive behaviour changes, such as HIV testing and condom use. The survey has found some evidence that partner reduction messages, which are relatively new in the SA communications landscape, are having an impact with increased levels of knowledge of multiple and concurrent partners and some reported behaviour changes amongst the intended target audiences.

Comparing the situation between 2006 and 2009 in South Africa illustrates some general trends. Since 2006 there has been an increase in knowledge about faithfulness and partner

reduction as means of reducing HIV infection risk as well as a decline in the number of people reporting multiple sexual partners (MSPs) in the past year. There has also been a significant increase in numbers of people accessing in HCT. All these trends may be attributed to HCPs addressing these behaviours during the preceding year.

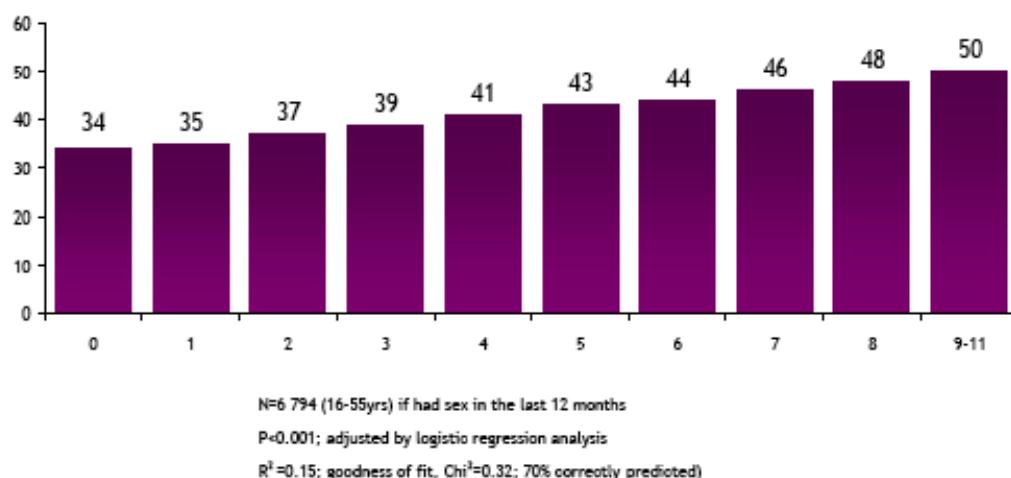
Comparison of selected findings, NCS 2006 and NCS 2009	2006 (%)	2009 (%)
Had sexual relationships in the past 12 months	82.2	80.3
Knowledge that faithfulness prevents HIV transmission	26.0	39.1
Knowledge that reduction of number of partners can prevent HIV transmission	6.7	12.2
HIV counselling and testing, % of people who have ever tested	47.1	61.4
Multiple partners in the last 12 months	16.5	11.4

Evidence for the impact of HIV Communication in South Africa on specific areas of HIV prevention

Condom Use

Correct and consistent condom use is an important element of HIV prevention, and has been central to many health communication programmes within South Africa. In the National Communication Survey, HIV Communication programmes were found to increase levels of condom use. These were measured in relation to exposure to 11 HIV communication programmes.^{xxxvi} Condom use increased uniformly from 34% among those with no exposure to HCPs to 50% for those exposed to 9-11 programmes. The fact that the relationship between levels of exposure and condom use increases monotonically (in a linear and uniform pattern) demonstrates a causal relationship between the communication interventions, and condom use.

Figure 28: Percentage condom use with at least one partner in the last 12 months by the level of exposure to eleven HCP



National Communication Survey, 2009.

The 2009 evaluation of *Scrutinize* showed that exposure to *Scrutinize* was associated with condom use. People were 5.6% more likely to use a condom in the last 12 months if they had been exposed to *Scrutinize* (based on propensity score matching to estimate the controlling for a number of variables).^{4xxxvii}

Some 55% of the population with high exposure to *Siyayingqoba Beat It!* used a condom at last sex to prevent HIV, compared to only 33% of people who had low or no exposure to *Siyayingqoba Beat It!*^{4xxxviii}

More young people who were highly exposed to *Khomanani* knew that condoms could be used to prevent HIV (89%) compared with those who had low exposure (84%) and those who were unexposed (77%).^{4xxxix} The pattern through many of these evaluations is one of dose response: the bigger the dose, the greater the response.

From the evaluation of Soul City Series 9, which was part of the *OneLove* Campaign, it was found that those exposed to the Soul City *OneLove* Campaign elements were 17% more likely to report condom use as compared to those not exposed, controlling for other variables^{xl}. An earlier evaluation showed that Soul City print was responsible for a 21% increase in condom use with a regular partner^{xli}.

A study in 2005 showed that being exposed to *Tsha Tsha*⁵ was also associated with 9% greater condom use at last sex, and being 6% more likely to use VCT to find out HIV status.^{xlii}

HIV Counselling and Testing

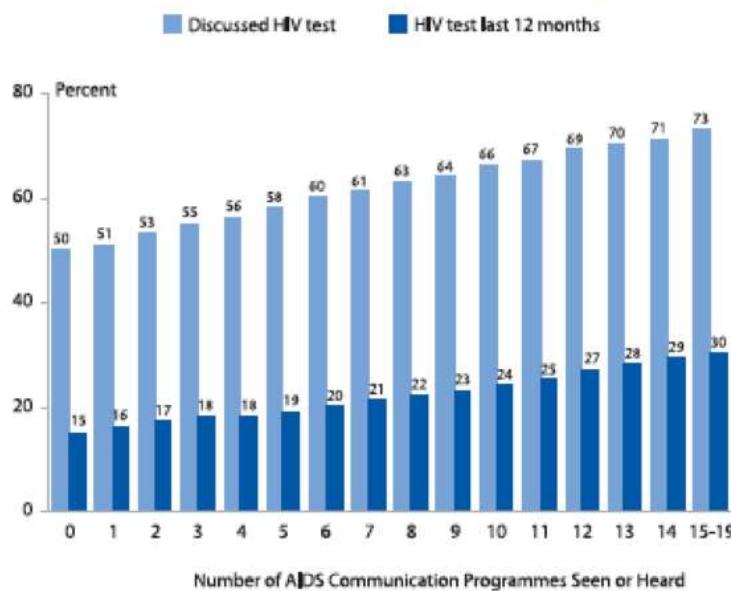
In the National Communication Survey 2009, levels of exposure to 11 HCPs are shown to directly influence levels of HIV counselling and testing. HCT increased from 33% from those with no exposure to HCPs to 42% among those exposed to nine or more communication programmes.

In 2009 the data showed that those who had discussed HIV testing with friends or sexual partners were more than twice as likely to undergo testing as those that did not have these discussions.^{xliii} A study in 2006 showed that 15% of those that had not seen any HIV communication programme have been tested for HIV, compared to 30% of those who have seen or heard the programmes 15-19 times.^{xliv}

⁴ Comparison of the differing levels of effectiveness and cost benefit of the organisations mentioned here is not possible due to the different kinds of programmes implemented and variations of data gathered.

⁵ *Tsha Tsha* is an entertainment education television drama series focusing on young people.

Percent who have discussed HIV test with sexual partner and who had an HIV test in the last 12 months by the cumulative exposure to 19 AIDS communication programmes



The National Communication Survey 2009 also showed a significant dose response in relation to disclosure of HIV status. 32% of those not exposed to any health communication programme shared their HIV test results with their sex partner, compared to 49% of those exposed 9-11 times.

Some 50% of people with a high exposure to *Siyayingqoba Beat It!* discussed HIV testing with their friends compared to only 29% of people who had low or no exposure.^{xlv}

Just over half of those not exposed to *Khomamani* (57%) had been tested in the past 12 months compared with 71% of those highly exposed.^{xlvi}

An evaluation of *Soul City series 7* showed that the series was highly successful in achieving a number of outcomes, including a 5% to 8% increase in people tested for HIV in the preceding year.^{xlvii}

An assessment of the impact of HIV communication programmes needs to recognise the causal chain linking distal and proximal HIV prevention factors. For example, those who watched *Scrutinize* (and could correctly answer questions about it) were far more likely to discuss HIV with a friend or sexual partner. Only 35% of those who could recall anything about *Scrutinize* had discussed HIV with their friends, compared to 53% who could clearly recall *Scrutinize* TV ads^{xlviii}. 72% of those who had discussed HIV in the last 12 months were tested for HIV in the same period. Only 19% of those who had not discussed HIV at all in the past 12 months were tested. So the fact that South Africa's leading HCPs are getting people talking about HIV and HCT marks an important contribution to increasing the numbers of people getting tested for HIV.

Multiple and Concurrent Partners

Having more than one sexual partner increases the risk of HIV infection, particularly in a country with a generalised HIV epidemic, such as South Africa. The 2009 HIV Communication Survey found that there has been a marked increase in the knowledge levels of the risks of multiple concurrent partners from 26.0% in 2006 to 39.1% in 2009. The survey found that there has been a 4.5% decline in sexual partners, but no overall statistical effect for the health communication programmes in this regard. However, when the data was analysed for specific groups HCPs were shown to have a significant effect. 11.3% of women exposed to nine or more HCPs reported fewer sexual partners than in the previous year compared to 1.9% of women with no exposure to HCPs. These gains in relation to multiple partners can be linked to communication interventions in the country as many had started to place an emphasis on messages relating partner reduction in their programming.

Exposure to *Scrutinize*, measured through the recall of *Scrutinize* ads, also relates to faithfulness to one sexual partner. 43% of those who recalled nothing of *Scrutinize* ads were faithful to one partner in the past 12 months, compared to 48% who could clearly recall *Scrutinize* ads^{xlix}. *Scrutinize* ran an advert on the acute infectious period. 24.9% of those who understood the ad had multiple and concurrent partners. This compares with 31.9% among those that did not understand this particular TV ad.

Further, watching *Tsha Tsha* was associated with a 16% increase in the practice of being faithful to one partner.^l

Abstinence

Abstinence as a prevention method for HIV transmission was mentioned by 44% of people exposed to *Siyayinqoba Beat It!* compared with only 32% of people who were unexposed.^{li}

When asked to name all of the ways they knew that HIV infection can be prevented, only 38% of young people not exposed to *Khomanani* mentioned abstinence spontaneously as compared with 55% of young people exposed to *Khomanani*.^{lii}

Watching *Tsha Tsha* was associated with a 12% increase in the practice of abstinence for a month or more.^{liii}

Other HIV prevention knowledge, attitudes and beliefs

There is a good amount of data to show that HCPs impact many other prevention attitudes and beliefs, and help increase overall HIV knowledge levels. Although there are too many examples to list here, a few samples of some of the evaluation results are listed below.

An evaluation of *Soul Buddyz* in 2006 shows that exposure to programmes is associated with an improvement of knowledge and attitudes.^{liv} 75.4% of children exposed to *Soul Buddyz* TV agreed that someone infected with HIV could look healthy, while 69% of matched controls with this statement. 89% of children who belong to a *Soul Buddyz* Club did not believe that AIDS is caused by witchcraft, compared to 82% of those not belonging to the clubs. 93% of children who had read the *Soul Buddyz* Grade 7 Booklet agreed that “it is true that HIV can be

prevented by using condoms”, compared to 76% in the matched control group - a 16% difference attributable to this intervention.^{lv}

73% of youth aged 15-24 who had seen *Heartlines* said they had learnt a lot about HIV and related sexual behaviours from the programme⁶. Almost two thirds of those who had watched *Heartlines* had discussed the films with others. Using propensity score analysis the evaluation found that *Heartlines* was accountable for an estimated additional 4.5 million values-related conversations^{lvi}.

In 2003, a study of *Lovelife* found that 82% of all youth said that the programme was a good thing for the people of South Africa. Among all youth in the country, 24% reported doing something as a result of hearing or seeing *Lovelife*. This included talking about *loveLife* or seeking out information on sex and relationships.^{lvii} Evaluations of *Lovelife* also demonstrated that the campaign was increasing the extent to which young people discussed sexuality and HIV (*loveLife* 2002)^{lviii}.

Soul City has been shown to have had a 16% improvement on measures of stigma. Soul City has also been highly successful in increasing a sense of community empowerment around addressing HIV prevention. Its television and print materials have been associated with a 15% and 13% improvement on this measure respectively.

Cost Effectiveness

An important element to any discussion of the value and impact of health communication relates to the relative cost benefit of different kinds of HIV prevention.

A study by Hogan and colleagues in 2005 assessed the costs and health effects of a range of HIV prevention interventions^{lix}. By using costs per disability life years, against biological and behavioural parameters, the study concluded that mass media was the most cost effective intervention at around \$58 US per infection averted. Peer education for key groups, such as sex workers, came in at second place. Treatment of STIs was around 5 times the cost of each infection averted at \$304 US, and school based education was at \$9448 US per infection averted. Prevention of mother to child transmission cost \$847 US per infection averted.

Scrutinize has some strong data that relates to cost benefit. The total cost of *Scrutinize* (minus production costs, which are not yet available) was 5.5 million USD shared between the main funder and private broadcasters in South Africa^{lx}. The cost to the donor per person reached translated to \$0.14 (R1.03) for each person reached through *Scrutinize*. The total cost per person reached translates into a cost of 0.29 USD (R2.10). The cost benefit analysis was also made for behavioural impact. For example once the statistics were analysed they showed that it costs 7.08 USD (R50.97) per additional condom user reached through the *Scrutinize* campaign. These include new users, those returning to condoms use and those sustained in condom usage due to exposure to *Scrutinize*.

⁶ Heartlines is a programme developed by The Mass Media Project in South Africa. The primary aim of the intervention is to promote reflection of people’s value systems and how these values are lived out in daily life. An evaluation showed that the broadcast reached 7.3 million adults.

A cost benefit analysis was also developed for Soul City *Series 4* on a number of areas of impact, including violence against women. This analysis measured types of knowledge, attitudes and behaviours relation to violence against women. It showed that it cost \$16 US for each additional area of knowledge, 0.22 US\$ for each additional attitude and 6.92US\$ for each additional positive behaviour relating to violence against women^{lxii}.

The cost benefit data from these organisations and others points to the fact that health communication is a cost-effective measure when compared to all other HIV prevention methods, particularly clinical methods.

Importantly, preventing HIV infections is far cheaper than the treatment, care and support required for those infected with the virus. To illustrate this, Kincaid and colleagues calculated that the behaviour changes in South Africa that had averted 701,495 infections in 2005, had saved 5.6 billion dollars for ARV treatment in the longer term, or more accurately, they had saved 281 million dollars over the period of a year^{lxiii}.

The combined total cost for the five largest health communication programmes and all their subsidiaries and grantees is less than 30 million USD in South Africa. This is less than a quarter of the combined advertising expenditure of South African alcohol industries (\$130 million annually)^{lxiii}. This situation is particularly notable because HIV prevention is trying to achieve so much more than commercial advertisements.

Challenges to effective communication

Coverage of health communication programmes is still too partial and exposure to a combined array of mass media, community-based and interpersonal communication remains rare. Community-level engagement is still inadequate and too few people get to participate in sustained face-to-face programmes.

Not all health communication programmes are equally effective, and some do not employ high quality and robust technical approaches. Further, those working in health communication have often failed to create a cohesive community for the purposes of sharing data, materials and techniques. Competition and territoriality has often undermined efforts to create a shared language, a shared set of standards and a common body of evidence to advance the field. However, the joint undertaking of the National Communication Survey and the existence of the SANAC Communication Task Team has allowed for greater collaboration and coordination.

SANAC fails to recognise that communication practitioners represent a sector in the same way as there are sport's, men's and women's sectors. This means that in the absence of being recognised as a sector by the South African National AIDS Council means that this coordination is primarily limited to the main stakeholders in social and behavioural communication and excludes communication role players in other government departments outside of Health, provinces and districts.

One of the challenges is that although a certain amount of evaluation data now exists in South Africa on HIV communication and HIV prevention, this data is yet to be analysed. Such

analysis requires technical capacity relating to applied statistics and the resources to fund trained specialists to engage with the information already collected. Data-analysis is now a priority for the sector. Access to the data within national studies is also a challenge in some instances.

Conclusions

There is ample evidence that health communication programmes are having an impact and that South Africans are heeding the messages and taking action to avert new HIV infections. This is saving the country billions in future treatment-related costs. Communication programming has reached over 90% of the population of South Africa, leading to a significant improvement in HIV-related knowledge, attitudes and beliefs. It has also had a direct impact on a number of behaviours, including partner reduction, HIV testing and counselling and condom-use.

The debate over lack of evidence is founded on misunderstandings about the nature of HIV prevention. Averting new infections is rarely a one step process, where a single intervention will have measurable results at the level of HIV incidence. Insisting on the type of evidence of the impact of health communication programming that is comparable to that of clinical HIV prevention trials is counterproductive. It is inevitable, given the complexity of the behavioural, social, biological and structural level factors driving HIV, that there will sometimes be multi-stage causal chains that separate the individual programme level inputs from the final reduction of HIV incidence. HIV communication is clearly and quantifiably shown to impact on different parts of the chain and to play a vital role in HIV prevention.

One could usefully question how the situation would be had communication programming not been undertaken. For instance, condom use in 1998 was down at 8%^{lxiv}. Today a meagre amount of communication, relative to that undertaken by the commercial sector in marketing their goods and services, has helped increase levels of condom more than four-fold^{lxv}.

More work needs to be done and there are significant gaps and areas of weakness. Interpersonal and community-level communication still needs scaling up. Better leadership, coordination and technical capacity is required, particularly in relation to building the evidence-base for communication. Yet in light of the substantial contribution that HIV communication has made in the response to HIV, and the underinvestment faced by this sector, the clear priority is to make up the resources shortfall and to consolidate and expand efforts. The fact that much of the evidence available on health communication points to a dose-effect relationship suggests that the amounts of communication programming should increase rather than decrease.

Finally, it is clear that any move to sublimate communication programming beneath biomedical approaches is misguided and would undermine a balanced combination HIV prevention response. Both should be supported as working hand in hand. The hard-won gains of past and current HIV prevention efforts could easily be reversed if health communication is not continued and intensified.

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