

ACCESS TO TELEVISION AS A SOCIAL INDICATOR FOR HIV PREVENTION

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Problem Under Study. *The measurement of the outcomes of HIV prevention programmes at national level is complex and expensive. The identification of affordable and meaningful indicators is an important, though challenging element of the management of HIV prevention programmes.*

Objectives. *The objective of this study is to explore the utility of ‘Access to a Television Set’ as an HIV prevention indicator.*

Background. *The SA DOD conducts an annual HIV KAP (Knowledge, Attitudes and Practices) Survey within the DOD community. One of the indicators included in the 2004 survey – at the recommendation of the Department of Social Development – was access to a television set.*

Method. *The Behavioural Surveillance Survey method, as recommended by FHI and UNAIDS, was followed. A national 10% sample of the employed DOD population was invited to complete a self-administered questionnaire addressing a range of HIV issues. 6.8% of the DOD (n=5,082) returned an adequately completed questionnaire. Items were combined into indicators and analysed using the chi-square test. Significance was set at $p < .05$.*

Results. *Of the 36 indicators measured, 27 (75%) yielded statistically significant differences between those who had access to TV and those who did not. In every case, those who had access to TV evidenced a more desirable response than those without – this is true for the knowledge, attitude and behavioural indicators, as well as self-reported STIs.*

Conclusions. *It would seem that having a television set is associated with better knowledge of HIV/AIDS, more positive attitudes towards safer sex, lower risk behaviour and reduced likelihood of reporting STIs. This indicator is affordable and simple to measure. It may help HIV prevention programme planners determine where to invest scarce effort and resources.*

Limitations. *This study is based on self-reported data within the military context (where, by definition, all respondents are self-employed). These results do not necessarily represent those of the general population of South Africa.*

Contribution. *A novel HIV prevention proxy indicator, which has been proposed by the Department of Social Development, has been empirically tested and found to be promising.*

Introduction. The measurement of the outcomes of HIV prevention programmes at national level is complex and expensive. Outcomes of prevention programmes typically involve attitudinal and behavioural change, which are usually measured through KAP surveys – Knowledge, Attitudes and Practices. Few government departments, NGOs, CBOs and FBOs have the resources and expertise to conduct such surveys.

The identification of affordable and meaningful indicators is an important, though challenging, element of HIV prevention programme management (UNAIDS, 2002). These indicators serve two main functions:

- ❖ They enable programme planners to identify vulnerable subpopulations for targeted interventions. In most instances, the indicators provide further insight into the nature of the vulnerability of these groups.
- ❖ They enable the effectiveness of programmes to be measured and evaluated. It is thus possible to see if prevention programmes are making a measurable difference to the communities to whom they are targeted. It is also possible to compare the relative efficacy and efficiency of two or more different programmes.

Objective. The aim of this paper is to explore the utility of ‘Access to a Television Set’ as an HIV prevention indicator.

Background. Over the past few years, the SA Department of Defence has been developing a monitoring and evaluation (M&E) system for its HIV programme (Van Breda, 2004b). The M&E system addresses five levels of indicators: input, process, output, outcome and impact.

A significant component of the DOD’s HIV programme is prevention, which includes prevention training, prevention projects and mass awareness. This component of the programme aims to reduce the incidence of HIV in the military community in South Africa – an impact indicator. The outcome indicator preceding the impact of reduced seroincidence is a reduction in risk behaviour (ie the application of the ABC principle) and improved attitudes towards safer sex.

During the development of the M&E indicators for our prevention programme, we were requested to incorporate indicators identified by the Department of Social Development as part of their M&E strategy for HIV/AIDS in South Africa. One of these indicators was ‘Access to a television set’

(Van Zyl & Wentzel, 2003). We thus incorporated the indicator into our annual KAP survey for 2004.

Van Zyl and Wentzel (2003) state of this indicator,

Being able to access information is important. The distribution of HIV/AIDS information takes place at a variety of levels and people derive knowledge from a variety of sources, for instance from television, radio, newspapers, magazines and billboards. Community information channels play an equally important role in disseminating HIV/AIDS knowledge, such as ordinary conversation or HIV talks given at schools.

The decision to select television as an indicator to measure access to the mass media is arbitrary, but given that television covers auditory and visual inputs, and since a number of important HIV/AIDS campaigns are shown on television, access to television has been chosen. A provisional analysis of data collected during the HSRC's HIV prevalence, behaviour and mass media survey suggests a relationship between watching TV, receipt of information on HIV and the reported behaviour change. This relationship is however tenuous and needs further analysis. Behaviour change is a complex issue and definitive statements should be approached with caution.

Method. The Behavioural Surveillance Survey method, as recommended by Family Health International (2000) and UNAIDS (2000), was followed. The 2004 study reported in this paper (Van Breda, 2004a) utilised a KAP instrument developed within the Department of Defence by a team headed by Ruth Bielfeld (2002). This was the third time the instrument was being used in a national military study, although the first time 'Access to a television set' was measured.

'Access to TV' was measured by a single item, which could be answered either 'Yes' or 'No', viz "Do you have access to a television where you live?" This item is considered a meaningful measure of the indicator definition, viz "The total number of respondents aged 15-64 interviewed during a survey who indicate that they have access to a television set" (Van Zyl & Wentzel, 2003).

A national ten percent sample of the employed DOD population was invited to complete the self-administered questionnaire. Quota sampling was used, with four dimensions, viz region, gender, rank group (which is closely associated with socio-economic status) and Arm of Service. Within each cell of the quota sampling frame, respondents were identified using convenience sampling.

A stratified sample would have been preferable, but concerns for stigma associated with targeted probability sampling, with the resultant reduction in response rates, outweighed the limitations of our nonprobability sampling design.

In 2004, 6.8% of the DOD community (n=5,082) returned an adequately completed questionnaire (representing a 68% response rate). This included uniformed and civilian employees of the DOD, but not their families. In proportion to the profile of the DOD workforce, the sample was largely male, with representation from all regions of the country and all rank groups.

Items were combined into indicators, addressing input issues (such as distance between home and work), output issues (such as exposure to HIV prevention programmes and knowledge of HIV prevention methods), outcome issues (such as attitudes towards using condoms and number of sex partners) and preliminary impact issues (namely, self-reported symptoms of sexually transmitted infections).

Indicators were analysed in SPSS 12 using the Mantel-Haenszel chi-square test. This test was selected because all indicators were categorical and ordered (Pett, 1997). Significance was set at $p < .01$.

Results. The majority of respondents (91%) reported having access to television where they live. This is probably indicative of the relatively high socio-economic status of the military community. After all, the entire population is, by definition, employed. Furthermore, younger soldiers (who earn less income) are more likely to live in military quarters where television is provided by the military itself (65% of those 24 years and younger, compared with 20% of those 25 years and older).

Of the 36 indicators measured in our KAP Study, 27 (75%) yielded statistically significant differences between those who have access to TV and those who do not (at $p < .01$). In every case, those who had access to TV evidenced a more desirable response than those without. The table below provides a snapshot of ten of these indicators (definitions are provided at the end of the paper):

Indicator	Access to TV	No Access to TV	χ^2_{MH}	$p <$
HIV Programme Rollout ⁱ	49%	23%	110.2	.001
Perceived Threat ⁱⁱ	58%	35%	88.3	.001
No Incorrect Beliefs ⁱⁱⁱ	57%	42%	37.8	.001
Knowledge About Condoms ^{iv}	49%	33%	38.8	.001
No Negative Attitudes Towards Condoms ^v	57%	43%	30.5	.001
HIV Test ^{vi}	90%	83%	26.6	.001
Value-Based Orientation ^{vii}	86%	65%	135.2	.001
Abstain/Faithful ^{viii}	71%	60%	21.4	.001
Acceptance of PWAs at Workplace ^{ix}	57%	46%	21.1	.001
Sexually Transmitted Infections ^x	6%	15%	46.4	.001

This table illustrates substantial differences between those who have access to television and those who do not – differences up to 25 percentage points.

Discussion. Having access to television clearly is a significant indicator in HIV prevention. The difficulty lies in explaining what role having access to a television plays in HIV prevention and based on this role to determine what we should be doing about it.

It is probably plausible that having access to a television may be associated with greater exposure to the many mass media HIV prevention programmes that are presented by the various broadcasters (Reproductive Health Research Unit, 2004; Shisana, 2002). This in turn may result in improved knowledge (Ganczak, Boron-Kaxzmarska, Leszczyszyn-Pynka, & Szych, 2005) and probably also improved attitudes towards people living with HIV and AIDS and towards safer sex. This may, in turn, be associated with reduced risk behaviour (Meekers, Shapiro, & Tambashe, 2003; Oyediran, 2003) and ultimately with a reduction in STIs. Indeed, probably all of the significant differences reported in the above table, bar the first one, could be related to exposure to mass media programmes on television.

These data suggest, therefore, that ‘Access to television’ is a helpful HIV indicator, in that it is a proxy measure of exposure to mass media. If the mass media programmes have demonstrable efficacy – which was not the purpose of this study – then it would seem reasonable to conclude that those with access to television are less vulnerable to HIV infection than those without.

How then, could we utilise these findings in HIV prevention programmes? There are perhaps three main programme implications for this study:

- ❖ Firstly, 'Access to TV' could be used to identify vulnerable communities. In the SA DOD study, those demographic groups that have less access to television (eg younger employees, unmarried people, those who live far from their partners, etc) are also more vulnerable in terms of knowledge, attitudes and risk behaviour. There may, therefore, be merit in utilising statistics from Trade and Industry, Demographic and other household surveys to identify communities that have low levels of television access as more vulnerable to HIV infection.
- ❖ Secondly, since this study suggests that 'Access to TV' may be associated with greater exposure to mass media prevention programmes which may well be effective in reducing HIV infection, there may be value in regarding ownership of (or at least access to) television as a defensible intervention in its own right.
 - Community organisations and local governments may find that increasing the availability of televisions at community centres, shops, bars and shebeens, health clinics, etc may contribute to a reduction in HIV incidence.
 - Furthermore, the Department of Trade and Industry and the Department of Communication may consider addressing the costs of television sets and television licences, as part of their intersectoral contribution to HIV prevention in the macrocommunity. Already, we see an increase in ownership of televisions – up from 27% in 1994 to 45% in 2002 in rural areas (Jooste, Shisana, & Simbayi, 2003).
- ❖ Thirdly, government and donor funding of mass media prevention programmes delivered through television could regard this study to provide indirect support to the efficacy of this medium in HIV prevention. They could consider increasing funding support for these programmes to increase the airtime that HIV enjoys. In this regard, the Department of Communication could also consider increasing the attention local programmes give to the issue of HIV, in both entertainment and educational productions.

Conclusions. It would seem that having a television set is associated with better knowledge of HIV/AIDS and HIV prevention, more positive attitudes towards safer sex, lower risk behaviour and

reduced likelihood of reporting STIs. This indicator is affordable and simple to measure and may help HIV prevention programme planners determine where to invest scarce effort and resources.

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Indicator Definitions

- ⁱ **HIV Programme Rollout** is defined as the reported rollout of the SA DOD's HIV prevention programme at unit level, in terms of condom availability, presence of HIV posters and pamphlets, and implementation of World AIDS day activities. Respondents are entered into the numerator if all these conditions are present.
- ⁱⁱ **Perceived Threat** is defined as the perception that HIV is a real threat to oneself, which suggests a degree of readiness to protect oneself from the threat. Respondents are entered into the numerator if they know that AIDS exists, know that there is no cure for AIDS, know that AIDS can affect all race groups, know that AIDS cannot be cured and know that AIDS is not a disease that only homosexuals get.
- ⁱⁱⁱ **No Incorrect Beliefs** is defined as the rejection of the most common myths about HIV. Respondents are entered into the numerator if they know that you cannot tell if someone has HIV just by looking at them, know that a sangoma or

faith healer cannot cure AIDS and that HIV cannot be transmitted by sharing eating utensils with someone living with HIV or AIDS.

^{iv} **Knowledge about Condoms** is defined as knowing correct information about the use of condoms. Respondents are entered into the numerator if they know that oil-based lubricants cannot be used on a condom, that condoms will not harm your health, nor the health of your partner, nor the health of an unborn child, and know that condoms cannot be used more than once.

^v **No Negative Attitudes Towards Condoms** is defined as the absence of negative attitudes towards using condoms. Respondents are entered into the numerator if they do *not* feel that if they asked their partner to use a condom s/he would not have sex with them, that condoms slip or tear and are therefore a waste of time to use and that using a condom is an insult to their partner.

^{vi} **HIV Test** is defined as having had an HIV test, whether or not voluntary, at any time in the past. Respondents are entered into the numerator if they answered 'Yes' to either "Have you ever had a blood test for HIV/AIDS before?" or "In the last 12 months have you asked for an HIV/AIDS test?"

^{vii} **Value-Based Orientation** is defined as the adoption of a value-based and spiritual orientation to life. Respondents are entered into the numerator if they report that they stand up for what they believe is right, have control over their own behaviour, value their spiritual life and think about what is right and wrong when they make decisions.

^{viii} **Abstain/Faithful** is defined as people who report abstaining from sex or being monogamous during the past 12 months.

^{ix} **Acceptance of PWAs at Workplace** is defined as a positive attitude towards working or living with people who are living with HIV/AIDS. Respondents are entered into the numerator if they report that they would be prepared to work alongside someone who has HIV/AIDS, that they would feel happy to share a room with someone who has HIV/AIDS during a military or other course and that their feelings towards a friend would not change if they learned that their friend had HIV/AIDS.

^x **Sexually Transmitted Infections** is defined as the self-reported presence of symptoms of STIs in the past six months. Respondents are entered into the numerator if they report genital discharge in the past six months *or* genital/anal ulcers in the past six months. For this indicator, unlike the others mentioned in this table, a *low* score is desirable.