

Re-appraising youth prevention in South Africa: The case of loveLife

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Background

LoveLife was launched in September 1999 as “the most comprehensive effort to positively influence adolescent lifestyle” in South Africa. Developed under the initiative and core funding of the Henry J Kaiser Family Foundation, it brought together, under the patronage of South African first lady, Zanele Mbeki, a number of funders and implementing partners with the core aim of reducing “the incidence of HIV among 15-20 year-olds by 50% over the next *three to five* years”. This was to be achieved through “a brand-driven, sustained multi-dimensional national programme focusing on making condom usage part of youth culture; establishing adolescent friendly reproductive health services as an integral part of public health services; education, community outreach and institutional support” (loveLife, 2000a:2).

Early funding partners were the Bill and Melinda Gates Foundation and Old Mutual with other core partners being the Department of Health, the National Youth Commission, UNICEF, the Sowetan and SABC. Implementing non-governmental organization partners were the Planned Parenthood Association of South Africa (PPASA), the Reproductive Health Research Unit (RHRU), Advocacy initiatives, Media Training Centre (MTC) and the Health Systems Trust (HST) (loveLife, 2000a).

By 2003 the implementing consortium was reduced to three organizations –PPASA, RHRU and HST operating under the auspices of a board of directors chaired by Professor Loyiso Nongxa of the University of the Witwatersrand and operating “in partnership with the Henry J Kaiser Family Foundation”. (loveLife, 2003a:4). Funders in 2003 include the Nelson Mandela Foundation, the South African government (which committed R75-million over three years in 2001), and the Global Fund for AIDS, TB and Malaria (which has committed \$80-million over five years, and has provided an initial tranche of \$12-million). Partnerships with Old Mutual, the National Youth Commission and Sowetan have fallen away and currently partnerships that provide ‘major in-kind support’

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currently include the SABC, Independent Newspapers and Times Media with additional corporate support being provided by Avis, Comutanet, Mondi Paper, South African Airways, SpoorNet, Ster-Kinekor, UUNet and Vodacom.

A national advisory board of more than 30 individuals is chaired by former Gauteng premier Tokyo Sexwale² and a technical advisory group comprising eight members, six of whom are US-based,³ provides “ongoing guidance on programme strategies, interventions and messages”. Further to this arrangement, “independent external review is provided by an expert panel chaired by Professor Tom Coates, Head of the US-based Centre for AIDS Prevention Studies” (loveLife, 2003a:10).

The context

Since the outset of the organisation’s activities, loveLife publications have painted a dismal picture of the HIV/AIDS context in South Africa. In providing the contextual justification for the *loveLife* intervention, it is noted that:

- “Already more than 4-million South Africans (10% of the population) are HIV positive. Conservative estimates are that in excess of 10 million South Africans will die of AIDS in the next 5-10 years” (loveLife, 2000a:1);
- “In the past year, the rate of HIV infection among adolescents aged 15-20 years increased by 65%” (loveLife, 2000a:1);
- “More than a third of babies annually are born to mothers under 18 years of age” (loveLife, 2000a:1);

² Mrs Zanele Mbeki chaired the advisory board until 2002 and was replaced by Tokyo Sexwale (Chairperson of Mvelaphanda Holdings) in 2003. Remaining advisory board members include Dr. Manto Tshabalala-Msimang (Minister of Health), Cheryl Carolus (CEO, South African Tourism), King Goodwill Zwelithini, Beatrice Marshoff (MEC for Social Development, Free State), Connie September (Member of Parliament), Eric Molobi (Kagiso Trust Investments), Dr. Bongani Khumalo (Chairman, Transnet), Saki Macozoma (CEO, Nail Media), Justice Edwin Cameron (SA Appeal Court), Marcelle Golding (CEO, e-TV), Judi Nwokedi (SABC), Zindzi Mandela (EO, Zee-Zee Productions) Moegsien Williams (Editor, The Star Newspaper), Maria McCloy (Editor, Black Rage Productions), Nina De Klerk (Executive Director, Association of Advertising Agencies), Prof. Njabulo Ndebele (Vice Chancellor, Univ. of Cape Town), Prof. Barney Pityana – (Vice Chancellor, UNISA), Mercy Makhalemele (Director, Tsa-Botosogo), Irene Mennel (Trustee, Nelson Mandela Children’s Fund), Archbishop Njongonkulu Ndungane (Deputy Chair and Anglican Archbishop of Cape Town), Archbishop Buti Tlhagale (Catholic Archbishop of Johannesburg), Molefe Tsele (General Secretary, South African Council of Churches), Anu Nepal (Attorney), Angela Ludek (TV Presenter), Kim Engelbrecht (Actress), Eugene Mthethwa (Musician), Penny Lebeane (Radio Presenter), Paul Mnisi (Radio Presenter), Shanti Aboobaker (Student), Smanga Mnisi (Student), Hemphyl Matjeke (Student), John Roos (Student).

³ This includes Dr Judi Auerbach, Director of Behavioural and Social Sciences at the National Institute of Health; Dr Mary Bassett, Assistant Commissioner, New York City Department of Health and Mental Hygiene; Dr Willard Cates, Executive Director of Family Health International; Dr Robert Fullilove, Associate Dean, Columbia University School of Public Health; Dre Helene Gayle, Director, HIV/AIDS and TB, the Bill and Melinda Gates Foundation; Dr Malegapuru Makgoba, University of Natal; Dr David Serwadda, Professor of Infectious Disease Epidemiology, Makerere University Institute of Public Health, Uganda; and Dr Debrewok Zewdie, Global HIV/AIDS co-ordinator, World Bank.

- “Rape, violence and coercion are common features of adolescent sexual behaviour” (loveLife, 2000a:1); and
- “Condom usage among South African males has remained almost unchanged at around 10% over the past five years” (loveLife 2000a) and “...95% of South Africans are aware of HIV/AIDS, but risk-reducing behaviour – specifically condom use – has remained almost unchanged for the past decade” (loveLife, 2000c:5. See also loveLife, 2001b:12; loveLife, 2000c:2 and RHRU, 2001a:6)

The above extracts give insight into a common feature of many of loveLife’s publications and publicity materials – the use of unreferenced research findings to construct a sense of urgency in relation to the South African HIV/AIDS epidemic, and to convey the sense that little has been achieved in any previous or parallel interventions. Moreoften than not, the findings, projections and contexts inferred are inconsistent with research studies available at the time. For example:

- “...10 million South Africans will die...”: It is unclear how a baseline of 4-million infections in 1999, could translate into a death rate in excess of 10-million 5-10 years later – just under a quarter of the South African population. No research could be found that confirmed such an alarming estimate. In fact, *loveLife’s* own research report, *The impending catastrophe*, which was produced in early 2000, contradicts this assertion. For example, it estimates that a maximum of 635 000 persons would die of AIDS in 2010, with cumulative deaths between 2000 and 2010, in the worst case scenario, totaling approximately 5.7million (loveLife, 2000b).
- “...the rate of HIV infection increased by 65%...”: This appears to be a reference to the 1998 antenatal data which showed an increase of 65% over the previous survey for women under 20. However, analysis of antenatal data does not lend itself to analysis of trends through simply focusing on year-on-year changes and should be interpreted with caution. As was noted in *loveLife’s* own research, *Impending Catastrophe Revisited*: “The results of any given year should not be considered on their own. A result can occur by chance that can lead to the incorrect perception that the epidemic is much better or worse than it truly is. It is preferable to consider the trends in the epidemic over time” (loveLife, 2001a:36).
- “More than a third of babies annually are born to mothers under 18 years of age”: It is fairly obvious that total births amongst females under the age of 18, many of whom are not even sexually active, are unlikely to equate to a third of the total births amongst all women of reproductive age over the age of 18 – a group who are far more

likely to be sexually active with a far longer lifetime fertility. No research could be found to support this assertion.

- *“Rape, violence and coercion are common features of adolescent sexual behaviour”*: A number of studies had indeed pointed to the prevalence of rape, violence and coercion as part of adolescent experience of sex – for example the 1998 DHS found that 9.7% of 15-19 year old females had been persuaded to have sex against their will, and 4.9% said that they had been physically forced to do so. Females who had been raped reported that this was typically by an older person – for example a teacher or older relative. Kelly (2000), in a survey of adolescents and young adults in six South African communities aged 15-30 found in a that 23% of females and 3% of males had a partner 5 or more years older than themselves at first sexual intercourse. This noted, reducing rape, coercion and violence is not something that can be achieved through *loveLife’s* core model of promoting a positive approach to sexuality – which suggests that young people have high levels of self-efficacy and are able to control their exposure to HIV risk. Sexual violence and coercion cannot be simplified as a *behavioural* choice for adolescents. Rather, such experience is related to disempowerment, with perpetrators largely being older and empowered socially.
- *“Condom usage... almost unchanged at around 10%”*: It is unclear where this statistic was derived from,⁴ but it is at odds with research available at the time. For example, Kelly (2000) found that last intercourse condom use amongst non-cohabiting youth ranged from 22%-79% in six communities; the DHS summary report (1998) found that reported last intercourse condom use was 19.5% for females aged 15-19⁵; and Richter (1996) found in a survey of youth in three communities, that ever condom use was 38% for males and 21% for females, and amongst ‘ever’ users, 74% of males and 68% of females reported that they had used a condom at last intercourse.

Whilst the above research ‘findings’ provided some sense of the organization’s perceptions of the research context, a sense of high drama was provided by the assertion that youth risk to HIV infection was inordinately high and that half of all young people South Africans under the age of 15 could die of AIDS. This is stated in a number of *loveLife* reports as follows:

⁴ In 2000, CADRE Research Director, Kevin Kelly requested information on the source of this statistic from a researcher attached to the *loveLife* programme. No reference could be provided. This statistic and assertion recurs in *loveLife’s* 2002 communication strategy which is published in a recent monitoring report (*lovelife*, 2003).

⁵ In relation to other condom studies, the rate of reported last intercourse condom use amongst females is generally lower than the rate for males.

“If the epidemic continues unchecked, more than 50% of South Africans under 15 today could die of AIDS – 6 million young people” (loveLife 2001b:9. See also loveLife, 2000c:1)

“Approximately 40% of South Africa’s population is under the age of 15. About 50% of infections occur before the age of 20. If dramatic action is not taken and current infection rates continue, half of all South Africans now under 15 could become infected with HIV” (loveLife, 2002a:1 and 2003a:1).

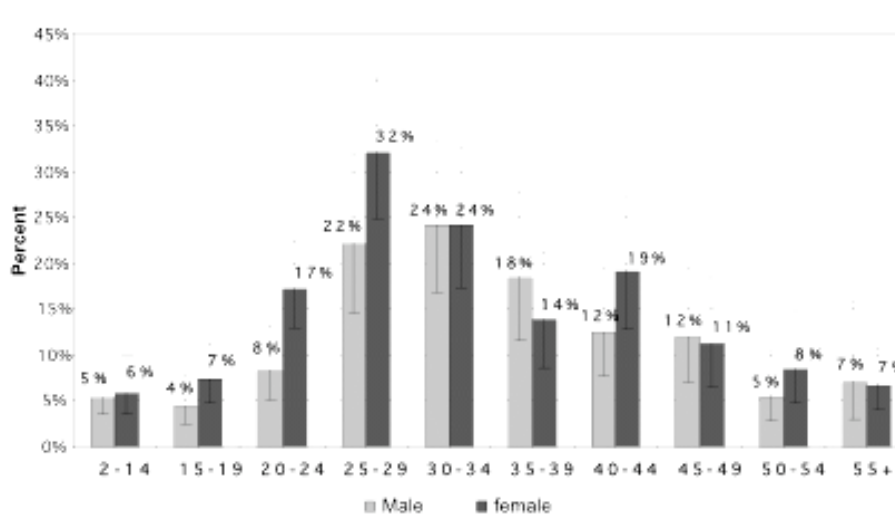
The notion that half of all young South Africans could become infected and die of HIV is unreferenced in loveLife 2001b and 2000c. However, in loveLife’s brochures (loveLife, 2002a:1 and 2003a:1) a reference is provided to the *loveLife* report *Impending catastrophe revisited* (lovelife, 2001d) which states:

“Approximately 15% of all South African adults ages 20 to 64 are currently infected and these levels could rise to 20%-23% by 2005 and 22%-27% by 2010. HIV is a disease that mostly affects younger people, with around half of all adults who acquire HIV becoming infected before they turn 25. Over 50% of these young people will die of AIDS before their 35th birthday” (loveLife, 2001d:6).

In *loveLife*’s brochures (2002a, 2003a) this paragraph, and related graph is reconstructed to give a very different meaning to that in the *Impending Catastrophe Revisited*. Firstly, the analysis quite clearly suggests that infections are likely to occur before the age of 25, not 20 as stated in the loveLife brochures. Furthermore, the analysis does not suggest that half of all youth will become infected. Rather, it notes that half of all persons who acquire HIV will do so before the age of 25, and of these, 50% will die before they turn 35. In other words, there is no support for the assertion that “half of all South Africans now under 15 could become infected with HIV”.⁶

⁶ In Harrison and Steinberg 2002, reference is made to an unpublished report by Steinberg and Kramer.

Figure 1: Prevalence of HIV by sex and age, South Africa 2002



A clearer picture of HIV prevalence has emerged since the release of the national cross-sectional Nelson Mandela/HSRC national HIV survey (HSRC, 2002:52) which shows HIV infection in all ages two years and older. Prevalence levels are markedly higher amongst adults than amongst youth, with high increases in prevalence occurring after the age of 20, peaking in the 25-29 year age group, and extending throughout adulthood. The graph demonstrates that HIV infection is far more likely to occur in the period beyond adolescence where levels of sexual activity and HIV risk are higher. Higher levels of HIV infection risk in the adult age groups are attributed to the finding that a large proportion of young people have not had sex before – ie. 75.1% of 15-17 year olds, 35.3% of 18-20 year olds and 21.0% of 21-23 year olds (Parker and Kelly, 2003). In the light of this finding, over and above emphases on prevention of infection amongst youth ‘as the driving force underpinning the epidemic’, it is necessary to also prioritise interventions directed towards adults in their 20s and early 30s.

Lovelife and HIV prevention

The *loveLife* intervention operates on a R200-million annual budget and involves a diverse range of activities centered around a national level communication campaign incorporating broadcast, print and outdoor media. Other components include: telephone helplines for youth and adults; event-based activities including ‘love-tours’, a ‘love Train’ and *loveLife* games; service provision through a relatively small number of community-based Y-centres and adolescent friendly clinics; peer education incorporating youth and ‘GroundBreakers’ who are also involved in yacht trips (eg. to Antarctica, Rio

and up the African coast); and a programme focusing on parents. The programme's communication activities focus on promoting 'positive sexuality' via a 'lifestyle brand' that combines communication about sex and sexuality with the promotion of consumption of fashion items, music, film and branded goods. It is these activities, combined with identification with the *loveLife* brand that are intended to halve youth HIV incidence.

There are a number of problems with *loveLife*'s core HIV prevention goal. Firstly, no research establishing baseline levels of HIV infection was conducted at the outset making it impossible to measure any declines of HIV at the 1999 launch baseline. Rather it is suggested that baseline data will be inferred through national surveillance comprising:

"...a comprehensive, integrated national baseline from existing data sources and its own national sample surveys among South African teenagers."

The timeframe for further research is further outlined as follows:

"This will provide the evaluation benchmark for two major national sample surveys of the adolescent population in loveLife's third and sixth years, 2002 and 2005, which will assess changes in communication about sex and HIV, sexual behaviour and related HIV and STD infections and pregnancy rates." (loveLife 2002a:10)⁷

Elsewhere, a longer timeframe is suggested. For example: "*loveLife* combines high powered media with service delivery, institutional support and outreach aimed at halving the incidence of HIV infection among 15-20 year olds by 2007..." (Harrison and Steinberg, 2002:4). The 2002 brochure refers to "*cut[ing] the HIV infection rate among young South Africans by 50%*" (2002a:1) whilst the 2003 brochure rephrases the goal as "*substantially reducing the HIV infection rate among young South Africans*" (2003a:1).

The lack of baseline data alongside shifting timeframes of impact make it impossible to assess the intervention's parallel goal of "*establish[ing] at the same time a new model for effective HIV prevention*" (loveLife 2002a:1).

Previous and parallel interventions

Implicit in the assertions that *loveLife* will halve HIV 'incidence' amongst 15-20 year olds and 'establishing a new model for effective HIV prevention' is the notion that the

⁷ This same description occurs in the 2003 version of the brochure, but in the case of 'national surveillance' no reference is made to the year's 2002 and 2005, thus leaving the timeframe of the surveillance more open-ended.

loveLife intervention will bring such changes about monocausally. This monocausal concept is evident throughout *loveLife*'s many brochures and reports, and is perpetuated by scant reference to any other HIV prevention activities targeting youth in South Africa – of which there are literally thousands. Where such references do occur, they are situated within a framework of failure and negligible impact. The monocausal concept is perpetuated by the use of unreferenced statistics (as discussed above) which suggest that nothing has worked, but also more explicitly. For example:

“Moving beyond the failed ‘do or die’ messages of the past... loveLife combines well-established public health approaches with innovative marketing techniques, reaching young people by speaking in a language young people relate to and understand; using a tone of optimism, rather than relying on scare tactics⁸ – which have little credibility with youth; harnessing the power and influence of South Africa’s youth culture,⁹ including television, music and sports to promote healthy living” (loveLife 2002a:3; 2003a:3)

With regard to the assertion that previous South African campaign messages were ‘do or die’, the organization’s proponents appear to be unaware that HIV/AIDS communication over the previous decade had been strongly located within a framework of strategies and guiding principles that were specifically against fatalistic AIDS messaging. Prior to 1995, this orientation was framed within the work of a wide range of HIV/AIDS organizations active in the anti-apartheid movement through a comprehensive national AIDS plan developed the National AIDS Convention of South Africa (NACOSA). This document framed subsequent communication activities. During 1995-2000, provincial HIV/AIDS communication activities were co-ordinated via AIDS media forums which were also represented nationally as part of the National AIDS Communication Forum (NCF).¹⁰ This forum operated under the auspices of the national HIV/AIDS, STD and TB Directorate of the Department of Health.

⁸ It is worth noting that *loveLife*'s interpretation of the scare tactic framework is somewhat flexible when applied to the organisation's communication strategy – the 2003 campaign, which implores youth to ‘be there’ for the 2010 World Cup Soccer states: “...the fact that if today you are under the age of 20 you have a 50% chance of getting HIV – that’s a one in two chance! And even with access to AIDS treatment your expected lifespan could only be around 38 years.”

⁹ *LoveLife* seem to be distinctly unaware of what constitutes youth culture in South Africa – particularly the fact that youth were integral to the political struggle. For *loveLife*, youth are repositioned from committed activists well capable of addressing urgent social issues in their communities to self-oriented individuals whose only relation to their contexts is through ‘television, music and sports’.

¹⁰ Initially the forum was called the National Media Forum

From 1997-2000 a primary function of the forum was oversight of national and provincial campaigns to ensure coherence between campaigns and adherence to communication guidelines. Training in communication was provided by the Beyond Awareness Campaign and included formal manuals and guidelines.

During the 1990s there were many national interventions that focused on HIV prevention amongst youth including condom social marketing conducted by the Society for Family Health; school-based lifeskills conducted by national and provincial Departments of Education and Health; television, radio and advocacy activities undertaken by Soul City; escalating condom procurement, combined with promotion and distribution undertaken by the Department of Health; dissemination of HIV/AIDS small media items through a national AIDS action office; expansion of a national tollfree AIDS helpline; and promotion and dissemination of the AIDS red ribbon.¹¹ In addition, at provincial and local level HIV/AIDS communication included diverse media campaigns, organisational and participatory activities.

These activities are ongoing and many have been expanded since the inception of *loveLife*. The HIV/AIDS communication and contextual environment in South Africa is complex, and young people (amongst others) engage with HIV/AIDS in a diversity of ways. Table 1 provides a framework for understanding this diversity. The various activities of the *loveLife* programme are included in this matrix. However, they do not necessarily predominate in any particular category. As the Nelson Mandela/HSRC survey noted:

“The South African HIV/AIDS and communication environment is a complex one, and there are literally thousands of purposive and non-purposive activities that take place at national, provincial and local level. It is complex to reduce behaviour, attitudes or knowledge to specific interventions – whether they are mass media, community level communication or interpersonal communication.” (2002:100)

¹¹ See Parker, Dalrymple and Durden, 2000

Table 1: Communication and contextual exposure to HIV/AIDS

Activity	Communication component	Examples
Purposive mass media (Typically conducted by governmental and non-governmental organizations, but includes purposive activities of broadcasters and other media formations)	Television, radio, print (newspapers, magazines), outdoor (billboards, mobile media – eg. buses, taxis, trains)	<ul style="list-style-type: none"> • Short duration advertisements or inserts, once-off programmes, talk-shows, drama series, documentary series in broadcast media • Advertisements, news and feature articles, regular columns, supplements in print media • Public relations activities and events linked to mass media dissemination • Outdoor advertisements
Non-purposive mass media	Television, radio, print	AIDS content within: <ul style="list-style-type: none"> • News programmes • Once-off programmes, talk-shows, drama series, documentary series • News and feature articles, regular columns, editorials and letters
Purposive small media	Leaflets, posters, booklets, brochures, manuals, videos, exhibitions, murals, signs, utility items	Typically print materials, but can extend to other approaches. Utility items include caps, T-shirts and badges/pins
Events	Community gatherings, sports and entertainment events	Events such as World AIDS Day, but also integration of HIV/AIDS into various sociocultural events, religious gatherings, etc.
Dialogue and direct experience and personal action	Purposive support systems; health systems; religious and cultural systems; sexuality, gender; legal and rights framework. Extends to direct experience of HIV/AIDS; activities related to HIV/AIDS; HIV/AIDS-related dialogue	Can include structured and purposive dialogue: <ul style="list-style-type: none"> • telephone helplines • lifeskills programmes • counseling, VCT, being HIV positive • interacting with HIV/AIDS workers, health service provision systems Can also include activities and experiences: <ul style="list-style-type: none"> • taking personal action – condom use, abstinence, monogomy • wearing a red ribbon • experiencing sexual coercion, violence and rape • knowing people with HIV/AIDS, attending funerals of persons who have died of AIDS • being orphaned, living in an affected family • HIV/AIDS related cultural practices • Arguments, conversations
Social action and mobilisation	Involvement in HIV/AIDS activities	Organisational meetings, working for organisations, taking part in protests and rallies, giving advice, caring for ill persons or orphans.

Although the broader context of HIV/AIDS communication and experience as described in Table 1 is seldom noted in *loveLife* publications, where this does occur it tends to be framed in a dismissive or competitive way. For example, in relation to the red ribbon, it is suggested that:

“Another critical insight of the focus group series was that young people were alienated by traditional HIV messaging (such as ‘ABC’) and were turned off by the red AIDS ribbon, equating that symbol with disease and death” (Harrison & Steinberg, 2002:26)

The research upon which this finding is based – a series of 24 focus groups of 12-17 year olds conducted by Kaufman, Levine and Associates in 1999 – has not been made available in the public domain. However, the above finding has strongly influenced *loveLife*'s practices in relation to the red ribbon which has purposely not been integrated into any of the organisation's activities or publications.

Internationally the red ribbon has been central to promoting stigma reduction in relation to HIV/AIDS. It is actively promoted as a symbol of care and concern, as a symbol of hope and as a means of symbolic support to those living with HIV/AIDS.¹² In South Africa the red ribbon replaced the previous government's yellow hand icon in 1995. It has been integrated into all governmental HIV/AIDS communication material and continues to be actively promoted by South African HIV/AIDS initiatives. In 1999-2000, specific mass media campaigns were conducted by the Beyond Awareness Campaign, associating the red ribbon with the concept of care and promoting the wearing of red ribbons. Several hundred thousand red ribbon pins were distributed based on requests to the campaign's Action Office (including requests from youth clubs and schools countrywide) and millions of red ribbon stickers were distributed for use during HIV/AIDS events. In 2002 the marketing survey group Markinor included the red ribbon in their 'Top Brands' survey and found that over 96% of urban and 87% of rural respondents recognized the ribbon.¹³ A survey of commuters found that 48% had worn an item of clothing with an AIDS message or had worn a red ribbon. The Nelson Mandela/HSRC survey found that over 80% of urban respondents and over 70% of rural respondents had seen the red ribbon in their communities in the past year. Preliminary results from a survey of 18-24 year olds in three South African communities found that 36.6% had ever worn a red ribbon.¹⁴

¹² See www.unaids.org/hivaidsinfo/faq/ribbon.html

¹³ See Sunday Times, 29 September 2002

¹⁴ Forthcoming report on youth responses to the Tsha Tsha television series

Another Department of Health initiative, the national tollfree AIDS helpline has also been viewed competitively and with disdain by *LoveLife* and it has regularly been undermined. During 2000-2001 the Star newspaper regularly featured the AIDS helpline telephone number alongside articles dealing with HIV/AIDS. In October 2001, when *loveLife* entered into a contract with Independent Newspapers, it was required that *loveLife*'s ThethaJunction helpline be run "as a tag line on all HIV stories in all its titles"¹⁵, in effect replacing the newspaper's previous practice of running the AIDS helpline number as a free public service.¹⁶

More recently, a monitoring report entitled "loveLife 2002" contrasted calls received by *loveLife*'s helplines as follows:

"[ThethaJunction and Parentline] lines were open between 1pm to 9pm weekdays and 12pm to 5pm on weekends...The call centre managers reported that a total number of 2 405,504 calls were received in 2002, with a monthly average of 200,406; this total includes calls to both the youth and parentline... On average 40,000 calls were handled by call-centre operators monthly during 2002."

This is compared to the Department of Health's AIDS helpline as follows:

"As a comparison, the government national AIDS hotline which is a 24 hour/7 day a week service received an average of 12, 475 calls per month in 2002."

The above is a misrepresentation of data available from the AIDS helpline. For the period June to December 2002¹⁷ an average of 198,824 calls were received each month. Of these, an average of 168,893 calls per month were handled.¹⁸

Lovelife's comparison is problematic on a number of levels. Firstly, total calls to both of the organization's helplines have been added together and the comparison is made between the total calls to both services against those made to the national AIDS helpline on its own. Secondly, total calls to any helpline are not necessarily comparable given that helpline call rates are closely related to investments made in promotion of the helpline

¹⁵ Memorandum of agreement between *lovelife* and Independent Newspapers, 30 October 2001.

¹⁶ In a research exercise conducted by CADRE in August 2002, two dummy calls were placed to the ThethaJunction and AIDS helpline. Two scenarios were constructed based on the story of the day, to which the ThethaJunction number was attached – an article about the use of nevirapine. One call enquired about the use of nevirapine in pregnancy, whilst another enquired whether nevirapine could be utilized by PWAs. In both instances, ThethaJunction counselors could not provide basic information, and both referred callers to the AIDS helpline. AIDS helpline counselors were more substantially informed and were also able to refer callers to services in their area. The research was detailed in a letter to the press ombudsman in August, which was also referred to the Star for comment.

¹⁷ As a result of computer problems, total calls during 2002 cannot be calculated. The period June-December however, provides a good indication of call rates.

¹⁸ Personal communication, Nettie Craythorne, Counselling Centre Manager, AIDS Helpline, August 2002.

number. In *loveLife's* case, the organisation's R60-million per annum media budget has an obvious advantage. Thirdly, a comparison of the efficiency of calls received versus calls handled is more pertinent – in this instance, the AIDS helpline is considerably more efficient answering 84.9% of incoming calls, compared to *loveLife's* ratio of 19.9% – a point not raised in the *loveLife* report. Fourthly, *loveLife* make no mention of the ratio of 'hoax' or 'failed' calls to genuine calls to their helpines. 'Hoax' calls and 'failed' calls have bedeviled national tollfree helplines and a large proportion of calls received by the AIDS helpline, amongst other helplines (eg. Childline), are considered to be 'hoax' calls. 'Hoax' and 'failed' calls include silent callers, abusive callers and wrong numbers. The AIDS helpline have recorded data for calls answered that were 'logged' over the period January-December 2002. The ratio of hoax/failed calls to genuine calls on the AIDS helpline averaged 87% – ie. an average of 12,478 genuine calls are received each month. It appears that it is this latter number that *loveLife* have represented this total as the AIDS helpline's monthly total call average.

Whilst the above example is somewhat tedious to explain, it points to *loveLife's* selective and misleading use of data with the obvious purpose of painting a picture of *loveLife's* helpline services as considerably more efficient and appropriate than the national AIDS helpline.

Lovelife surveys

LoveLife have routinely conducted surveys of youth aged 12-17. In September 2000 a survey was conducted by the Henry J Kaiser Family Foundation and Kaufman Levin Associates (KLA). In 2001 a survey was conducted by BMI Sport Info of scholars aged 13-18 and in November 2001 a survey was conducted by Africa Strategic Research Corporation and the Henry J Kaiser Family Foundation.

The BMI Sport Info survey is not available in the public domain. The remaining two surveys are only available in the public domain in summary form.

The 2001 survey conducted by *loveLife's* founding funder, the Henry J Kaiser Family Foundation in collaboration with Africa Strategic Research Corporation¹⁹ is discussed below.

The 2001 survey has only been made available in summary form, and a number of points need to be raised regarding this report:

¹⁹ Given a possible conflict of interests in conducting evaluative research of one's own funded programme, it is to be expected that some effort would be made to ensure that an objective approach is adopted in the research process. In particular, caution would be exercised in developing research questionnaires, sampling respondents and interpreting results. No reference is made to possible conflict of interests.

- The overall survey methodology and approach to sampling, is confined to a single paragraph and there is little information for researchers who may wish to draw their own conclusions about the survey's representivity, generalisability or validity. For example, the survey is described as a 'nationally representative sample of 2204 youth ages 12-17.' The margin of sampling error is referred to as $\pm 2.3\%$ and 'for results based on subsets of respondents, the margin of sampling error is higher'. No information is provided as to whether the sample was weighted demographically.²⁰
- The data itself raises questions about representivity of the sample. In 2001, 41% of respondents reported that they had ever used the internet (30% for those living in rural areas). In comparison, *loveLife's* 2000 survey found ever internet use in the same age group to be 9%, whilst the Nelson Mandela/HSRC survey found it to be 14.4% for 15-17 year olds.²¹
- In 2001, 62% of respondents reported that they had heard of loveLife. 23% said that they had heard at a Y-centre (p35) although there were only seven operational Y-Centres countrywide at the time.

The 2001 research also makes extensive use of leading questions, ie. questions that are likely to result in desired answers. These questions were asked only of the 62% of respondents who had heard of *loveLife*. Examples include:

- Closed ended questions such as "Which of the following do you think most closely describes loveLife? – New healthy lifestyle for young South Africans (42%); HIV/AIDS education programme (34%); Sex education programme (18%); Condom Advert (5%)..." (p40);
- Use of generally positive statements alongside more extreme negative statements: "What did you think of loveLife? – "It made me think about making safer choices (73%); It was different and I was interested (73%); It reflected young people's aspirations and lifestyle (70%); It talked about sex in a positive way and I liked it (62%); It was boring and I was not interested (24%); It was vulgar and I did not like it (16%)..."(p41).

²⁰ Harrison and Steinberg (2002) allude to possible sampling errors in the surveys – "It should be noted that in both surveys (ie.2000, 2001), random probability sampling is done within a subset of 65 enumerator areas regarded as generally characteristic of all enumerator areas. This may be a threat to external validity of the findings (p18).

²¹ The figure for previous internet use in the Nelson Mandela /HSRC survey 2002 is based on a weighted cross-tabulation run August 2003. The 2001 'Census in Brief' notes that only 1.8% of African households have a computer, whilst the All Media Products Survey (AMPS) reports internet access to be...

- ❑ Use of closed ended ‘agree/disagree’ statements instead of a likert scale – “Do you think loveLife is... Good for the youth of the country (89%); Bad for the youth of the country? (11%)...” (p42).
- ❑ Use of very broad statements – As a result of loveLife have you talked to your friends/family/others about loveLife and/or lifestyle issues in general?.
- ❑ Use of questions that suggest a direct causal relationship between loveLife and complex sexual behaviours amongst sexually experienced respondents – “Has loveLife caused you to... Use condoms when having sex (78%); Limit/reduce your number of sexual partners (69%); Be more assertive in insisting on condom use (63%); Have sex more often (20%).

With regard to the latter questions, no explanation is provided regarding how *loveLife* might have caused respondents to behave in a particular way. Condom use, for example involves multiple steps including procuring a condom, having a condom available, and effectively negotiating condom use. Furthermore, how can complex behaviours be reduced to causality based on the extraordinarily flimsy pretext of ‘having heard of *loveLife*’? Specifically these questions obscure the complex factors that contribute to behaviour and also fail to address the wide range of exposures any individual respondent would have to the many influences described in Table 1. No attempt is made by the *loveLife* researchers to assess exposure to any parallel interventions or contextual experiences or to exclude the influence these might have had on respondents. Rather, all impacts are reduced to ‘having heard of *loveLife*’.

In the concluding analysis the researchers are careful to introduce caveats to the findings – “Reported behaviour change may or may not reflect actual behaviour change. Many youths who have heard of loveLife report that it positively influenced their attitudes and behaviours, yet this survey is limited in its ability to shed light on actual behaviour changes”. (p53)

Such caveats do however not appear in any way to influence the presentation of such findings. For example:

- ❑ The cover of the report includes the text: “Among sexually experienced youth who know about loveLife: 78% say loveLife has caused them to use a condom; 69% have reduced their number of sexual partners; 63% say they are more assertive in insisting on condom use.”²² Similar statistics were also propagated in a series of full page newspaper advertisements in the months following the release of the report. The response to the leading question “Did *loveLife* cause you to have more sex more

²² Conveniently also omitting the finding that loveLife ‘caused’ 20% of respondents to have sex more often.

often?” – to which 20% of respondents had responded in the affirmative is notably absent, as is any caveat about the limitations of such findings.

- LoveLife’s 2002 and 2003 brochures include the text “69% say lovelife has caused them to abstain from sex or reduce their number of sexual partners”(p2) sans caveats.²³
- Enthusiastic endorsement of the findings by the Henry J Kaiser Family Foundation in various reports and publications. For example, in an interview with Newsweek on July 5, 2002, Foundation CEO, Drew Altman reported that although it was too early to claim “ultimate success... the early evaluation results are incredibly encouraging and show *significant* numbers of young people abstaining from sex, delaying beginning sexual activity, limiting the number of partners, practicing safe sex generally”. In a briefing of US Secretary of State, Colin Powell on 24 June 2002, Altman was unreserved: “the loveLife program in South Africa, which is the world’s largest HIV prevention program for young people. And in a nutshell, it is a powerful combination of media messages nationwide and a broad range of services nationwide. All of them underscoring an upbeat message about positive lifestyles and responsible decision making, which is already starting to show results in terms of *significant* numbers of kids abstaining from sex, delaying having sex, reducing numbers of partners, practicing safer sex, and just moving their lives in a more positive direction...”.²⁴ In quantitative research the term *significant* is reserved for statistical tests for significance – tests which were not reported in the *loveLife* research report.

While internally conducted or supervised evaluative research is not unusual in HIV/AIDS interventions, there is clearly a burden of proof that has to be addressed given the obvious conflict of interests. One way around this would be subjecting the research findings to review by an independent review panel of senior researchers. Furthermore, being explicit about possible conflict of interest and being more transparent about findings and data would foster a greater sense of objectivity. This has not been the case in *loveLife*’s evaluative work.

²³ Apart from being sans caveat the findings for abstinence were 65%, not 69% (see loveLife 2002b:45);

²⁴ Transcript of meeting available at <http://www.state.gov/s/p/of/proc/tr/11639.htm>. Accessed September 2002.

Conclusions

LoveLife is an enormously well-resourced programme that includes considerable investment by the South African government, as well as a large commitment of funds but the Global Fund for HIV/AIDS, TB and Malaria. This review of the programme's approach points to a lack of rigour in the use of contemporary research findings, a dismissive and competitive approach to other South African HIV/AIDS interventions, and inadequacies in evaluative research.

LoveLife's brochures refer to a complex of advisory and technical review structures – including an advisory board of over 30 individuals, a technical review panel of eight highly qualified social and biomedical scientists, independent external review by an expert panel, and day-to-day management overseen by the Vice Chancellor of the University of the Witwatersrand. Yet, for all this expertise, there appear to be fundamental flaws in *loveLife's* evaluative research which do not appear to have been problematised.

Clearly there is a complex environment of interventions addressing HIV prevention amongst youth in South Africa. Clearly causal impacts on HIV incidence amongst youth cannot be reduced to a single intervention. Clearly, the undermining of parallel interventions is intolerable. Clearly, evaluative research of the programme should address possible conflicts of interests.

Clearly, if HIV prevention amongst youth in South Africa is to be addressed in a committed way, it must be addressed coherently and assessed objectively. We can ill afford a journey in the wrong direction.

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