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From the Editor

As companies and organisations move into the phase of managing and grappling with the epidemic, the demand for hands-on, practical information that can be applied in the workplace has become significant. *AIDS Analysis Africa Online* is committed to responding to the needs of its readers and will continue to find stories, case studies and feature articles that could assist our readers in dealing with AIDS in the workplace. One such article is by Craig Kotze, a communication specialist focusing on behaviour change. His article focuses on the complexities of behaviour change communication, and he offers some tips on how to implement this critical strategy.



Pam Groenewald and Debbie Bradshaw's article on the official death statistics as they relate to AIDS offers some interesting insights into how the numbers are calculated and what may account for under-reporting with regard to AIDS deaths. The graphs definitely provide much-needed data that could be used as alarm bells in our own areas of work, but be cautioned - numbers should never be used without a thorough understanding of what they mean and how they have been calculated.

Don't forget to visit the *AIDS Analysis Africa Online* website at www.redribbon.co.za for archived articles, statistics and reports on HIV/AIDS in sub-Saharan Africa.

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Official death statistics under-represent AIDS as a cause in South Africa

By Pam Groenewald and Debbie Bradshaw

South Africa is in the grip of a severe AIDS epidemic with a national seroprevalence of HIV infection of 26.5% reported among women attending public sector antenatal clinics in 2002(1). A population based survey conducted in 2002 reported a prevalence of 11.4% in people 2 years and older (2). The numbers of reported deaths show an unabated rise particularly among young adults (3). However, under-registration and misclassification of deaths makes it difficult to estimate the actual number of deaths due to HIV/AIDS.



Death certification in South Africa has improved in recent years and coverage of adult deaths is now estimated to in the region of 90% (4). There has, however, been considerable uncertainty about the extent of AIDS mortality. The HIV status of the deceased is often unknown, or where access to medical records is difficult, misclassification to the immediate cause of death (e.g. tuberculosis, pneumonia, diarrhea etc) often occurs. In addition, doctors are often reluctant to state HIV/AIDS as a cause of death on the death certificate because of concerns about the maintenance of confidentiality, and the potential impact on bereaved families in terms of social stigma and the loss of funeral policy or life insurance benefits.

When taking into account only the deaths explicitly reflecting HIV/AIDS on the death certificate, the official statistics for 2001 estimates the proportion of deaths due to HIV/AIDS as 8.7% based on the sample reported in 2002 (5) and 2.1% based on the full data reported in 2005 (6). Higher estimates of 30% for 2000 are derived from mathematical modeling of the epidemic and include deaths from conditions resulting from underlying HIV infection (7).

The Burden of Disease Unit of the Medical Research Council has attempted to quantify the extent of underreporting of AIDS deaths by the official statistics, in a recent article published in AIDS (8). In this study the researchers compared the cause specific death rates, by age and sex, for 1996 and 2000/1 in order to identify those conditions where there was a noticeable increase in mortality and where the increase follows the same pattern as HIV deaths and are therefore likely to be misclassified HIV deaths. The excess deaths in the conditions following the distinct age profile in the increase were attributed to AIDS. (8). The cause of death data for 1996, which was used to compile the 1996 official cause of death report for South Africa, were obtained from Statistics South Africa (9). The cause of death data for 2000/2001 combined were obtained as the micro data records for the 12% sample of deaths officially analyzed by cause of death for the period 1997 to 2001(5). Under-registration of deaths was corrected for by using the all cause mortality rates calculated from the ASSA2000 Demographic and AIDS model of the Actuarial Society of South Africa (10).

The increase in the age specific death rates for HIV/AIDS, explicitly recorded on the death certificate, (Figure 1) showed a distinct age pattern with a marked increase of almost 7 per 1 000 in child deaths and a peak increase of 2.7 per 1 000 at age 30 - 34 years for women and 2.6 per 1 000 at 35 to 39 years for men (8).

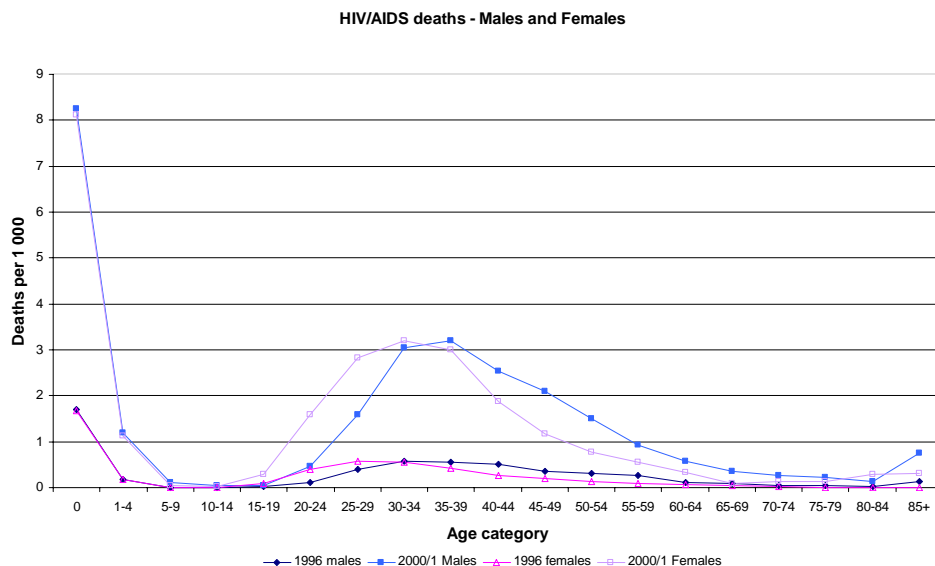


Figure 1. Estimates of HIV/AIDS death rates in 1996 and 2000/1 by age and sex, South Africa
 Source: Groenewald et al., 2005

The study found that there were 9 causes of death with increases that followed the distinct HIV/AIDS pattern and these were used to estimate the excess deaths attributed to AIDS. The difference in rates for the 9 selected causes, are shown in Figure 2.

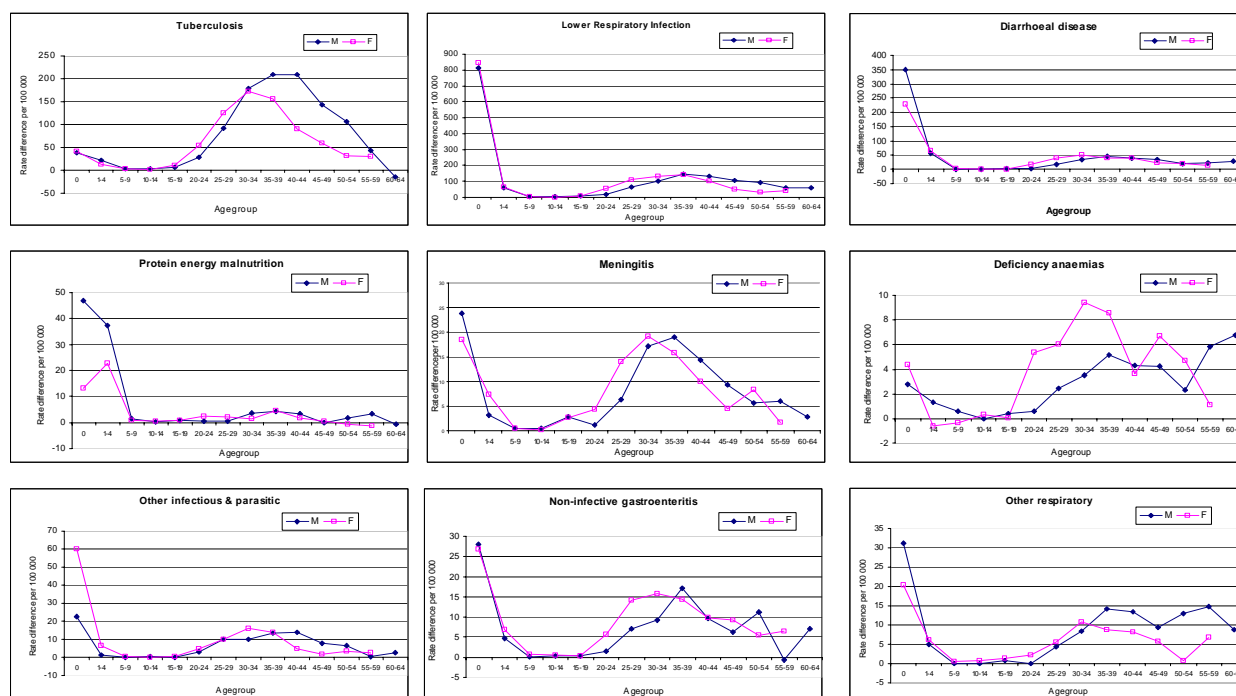


Figure 2. Difference in age specific death rates for selected HIV/AIDS related conditions between 1996 and 2000/1, South Africa.
 Source: Groenewald et al., 2005.

Using this method, the researchers estimated that there were 153 357 deaths due to HIV/AIDS in 2000, of which only 60 295 (39%) were reported as such on the death notification form. Tuberculosis, the majority of which is pulmonary, and lower respiratory infections account for approximately 80% of the additional deaths attributed to AIDS in adult males and 70% in adult females. In children under five years, lower respiratory infections, diarrhoea and protein-energy malnutrition account for approximately 85% of the excess deaths.

Statistics South Africa has introduced a new coding practice. Details provided on the death notification forms are coded strictly to the ICD-10 codes and an automated identification of the underlying cause is used (ACME 2004.02) (11). In the subsequent official mortality report in which HIV/AIDS accounts for a much smaller proportion (2%) of all deaths in 2001, tuberculosis accounts for a larger proportion of deaths in the full data than in the 12% sample in 2001. Deaths due to 'certain disorders of the immune system' account for about 2.5% of deaths in 2000 in the full data in contrast with less than 0.02% in the sample data. The strict coding practice results in AIDS cases certified with synonyms or euphemisms such as 'acquired immunosuppression', being classified as 'certain disorders of the immune system', instead of AIDS if there is no other immediate cause recorded. If the immediate cause of death (eg. Tuberculosis) is specified with these synonyms or euphemisms, this will be identified as the underlying cause, in favour of a less well specified condition. Preliminary analysis of the full death data for 2001 suggests that approximately only 7% of the AIDS deaths were coded as such with the balance being coded to AIDS indicator conditions mainly tuberculosis (12).

There is significant under-reporting of HIV/AIDS deaths in the official South African death statistics, with the majority of HIV/AIDS deaths being reported as AIDS indicator conditions. However, the latest report released by Statistics South Africa shows that there has been a 57% increase in the number of registered deaths over the period 1997 – 2002, concentrated in young adults, especially women, between the ages of 20 and 44 years and children less than 5 years. Only a small proportion of this increase (about 10%) can be explained by population growth and increased completeness of death registration (about 5%). There have been marked increases in AIDS

indicator conditions, which together with evidence from the ante-natal seroprevalence surveys that HIV seroprevalence has been rising steadily during the 1990s, strongly suggests that AIDS is responsible for this increase.

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HIV and AIDS behaviour change – it's the individual, stupid!

Behaviour change is now the critical issue for HIV and AIDS interventions in cash-strapped business and governmental sectors that are also disillusioned by “HIV and AIDS fatigue”. Craig Kotze suggests approaches that may just crack this very tough nut.



Every HIV and AIDS intervention is about reducing the impacts of the pandemic on the company, community, nation and even the continent.

Yet the terminology obscures the fact that there is such a thing as company, community or national behaviour change. The perception is that changing behaviour applies only to the individual which is directed to reach critical mass and becomes measurable as company, community or national behaviour change.

The art of behaviour change communication is proactively “getting there fastest with the mostest”; using the full spectrum of strategy tools, including measurement, workplace programmes/interventions and behaviour-based communication for a definable and measurable result. More bang for the buck, if you like!

This extends to not only to convincing individuals of the necessity and desirability of changing risky, attitudinal and practice behaviours, but also providing access – in whatever measure – to support processes for them.

Gone are the halcyon days of “awareness”, when money was thrown philanthropically at the “AIDS problem” and success measured in the number of posters, condoms, brochures, adverts generated and once-off VCT campaigns that were held. Reminiscent of the “body count” approach of the US to changing “hearts and minds” in Vietnam, such superficial approaches actually undermine stated objectives. Witness, as a result, the growing HIV cynicism at just the time when South Africa still awaits the full bloom and impact of the pandemic.

A behaviour change strategy within the South African constitutional context is fundamentally a persuasion campaign. A good formula to provide the “DNA” for such a strategy is RR + Ch = Choice (rights/responsibilities information on identified issues plus channeling of individuals to practical access to support/services equals individual choice)

Generically, a behaviour change intervention should incorporate:

- **Information injection:** The rule is “no info flow = no go”! Identify health information resources based on demographics/logistics, and then develop appropriate communication vehicles and channels to flood your organisation with behaviour-changing knowledge which goes way beyond awareness!
- **Identify barriers (institutional, personal, attitudinal, practices) to desired behaviour change:** Use an HIV/AIDS & wellness knowledge attitudes and perceptions (KAP) study and a communication KAP study to identify them initially and create the baseline for goal-setting and measurement.
- **Measurement and monitoring:** Measure performance of the interventions against baseline objectives, incorporate tactical snapshot considerations into actions and continuously assess and snapshot interventions
- **Tipping points – issues and target audiences:** Strategy is the concentration of resources at critical points – know your target audiences and their issues to concentrate efforts for maximum resonance and credibility

- **Immersiveness:** Behaviour-changing knowledge must be seen to be universally relevant and useful beyond company or community boundaries
- **Behaviour change is macro and micro:** Peer educators and CEO's can develop and implement a behaviour change strategy in their environment, using appropriate methodologies for the same measurable goals.
- **Stakeholder inclusivity:** Behaviour-changing knowledge is useless if the source of information and strategy goals is not trusted by the target audience. This is often a case of the medium being the message and it begins with including all stakeholder representatives in a transparent strategizing, goal-setting and roll-out process.

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a Metropolitan AIDS Solutions Communiqué

Disclaimer

The views and opinions expressed in this publication do not necessarily reflect those of Metropolitan. As always, we encourage responses on any of the issues covered.

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