Key Findings of the Tsha Tsha Pilot Project at Two Correctional Facilities

HELEN HAJIYIANNIS

Centre for AIDS Development, Research and Evaluation

www.cadre.org.za

Partnerships

- Operational Agreement between CADRE and the Department of Correctional Services (DCS) signed September 2005
- Financial support provided by the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID)
- Thank you to Mr Patrick Coleman - Johns Hopkins University Centre for Communication Programs – JHU CCP; and Mr Wayne Alexander - Johns Hopkins Health and Education in South Africa – JHHESA for funding and direct support
- Tsha Tsha materials – videos and Guide – accredited by the DCS and CADRE recognised as a service provider to DCS

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Background

- Johns Hopkins University Centre for Communications Program under its Health Communication Partnership, SABC Education, Curious Pictures and CADRE have produced the award-winning television drama series Tsha Tsha
- Idea was to pilot an HIV/AIDS intervention model that uses entertainment-education among offenders and to assess the model's effectiveness in two correctional centres
- The Tsha Tsha Pilot Project is in line with the White Paper on Corrections (part of rehabilitation of offenders), as well as supports the Department of Correctional Service's comprehensive HIV and AIDS programme

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Scope of services

- **CADRE**: Provide 240 sets each of Tsha Tsha series one and two to the Department of Correctional Services (DCS)
- Provide 240 Guides to Tsha Tsha Series One to DCS
- Conduct an assessment of the Tsha Tsha intervention at two correctional centres (12 males, 12 females) - 24 offenders in total)
- **DCS**: To distribute the Tsha Tsha materials to 239 correctional centres across South Africa
- Set up systems for monitoring reach and frequency of exposure of offenders to the Tsha Tsha materials and participation in the project (at national level) and provide ongoing feedback to CADRE
- Ensure venue, refreshments, TV and VCR made available for pilot groups

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Outcomes

- Tsha Tsha materials were supplied to the National Department of Correctional Services for national distribution
- Two sites selected for pilot project: Leeuwkop Correctional Centre, Male Juvenile Section; Johannesburg Correctional Centre, Female Section
- Peer educators at each centre attended a 2-day participative workshop about how to use the Tsha Tsha materials to facilitate groups
- Opportunity to offer training for many participants: 42 female and 14 male peer educators were trained as group facilitators
- Decision to increase number of participants in pilot study due to overwhelming demand – 55 female and 26 male participants were involved in the pilot project
- Conducted pre- and post-assessment at two pilot sites

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Objectives

- To provide Tsha Tsha resources to correctional centres across South Africa and to assess its usefulness as an HIV/AIDS intervention at two correctional facilities
- Expanded dissemination: increase the number of people exposed to the drama series in non-broadcast environments
- Aim of the Tsha Tsha pilot project: to use the visual material with the guide, to facilitate discussion, debate, reflection and learning about HIV/AIDS and related topics

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Methodology

- **Quantitative:** baseline survey to measure: personal exposure to HIV/AIDS; exposure to educational television and radio programmes, helplines; HIV/AIDS knowledge and attitudes; perceptions of HIV risk in correctional centres; and voluntary counselling and testing.
- **Post-intervention:** survey was re-administered and analysis of findings focused on areas of expected change: HIV/AIDS knowledge and attitudes; and accessing helplines
- **Qualitative:** six focus groups were conducted pre-intervention and 8 focus groups were conducted post intervention to get a better understanding of the survey results, as well as participants' feedback about the drama series and the project

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Findings

- Personal relation to HIV/AIDS: Two fifths (42.5%) of the participants had attended an HIV/AIDS workshop in past year; the vast majority personally knew someone who died of AIDS in the past year (80.8%)
- Exposure to HIV/AIDS in mass media: most common medium is radio which is listened to by nearly two thirds (60.5%) of participants on a daily basis, followed by those who read a magazine daily (28.8%). TV is less likely to be accessed, with only 16.9% of participants watching TV daily
- Tsha Tsha is the television series that has been viewed by most respondents (68.8%), followed by Khomanani radio programmes and adverts (63.3%)
- Females more likely to watch Soul City (60.0%) than males (46.2%). Males (34.6%) more likely than females (19.2%) to watch Beat it - Siyanqoba

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Exposure to mass media

	Never		1 day a week		2 to 6 days a week		Every day of the week	
	M	F	M	F	M	F	M	F
Listen to radio	3.8%	14%	3.8%	12%	19.2 %	20%	73.1 %	54.0 %
Average	10.5%		9.2%		19.7%		60.5%	
Listen to community radio	40%	33.3 %	12%	10.4 %	24%	29.2 %	24%	27.1 %
Average	35.6%		11%		27.4%		26%	
Watch TV	40.0 %	78.3 %	24.0 %	4.3%	8%	6.5%	28.0 %	10.9 %
Average	64%		11.3%		7%		16.9%	
Read a magazine	20.0	18.8	16.0	25.0	28.0	31.3	36.0	25.0
Average	19.2%		21.9%		30.1%		28.8%	
Read a newspaper	15.4	20.8	34.6	37.5	23.1	22.9	26.9	18.8
Average	18.9%		36.5%		23.0%		21.6%	

Exposure to HIV/AIDS educational programmes

Programme (n=81)	Percent
Watched Soul City on television	55.6%
Listened to Soul City on the radio	47.4%
Watched Beat it – Siyanqoba on television	24.4%
Watched Tsha Tsha on television	68.8%
Watched Takalani Sesame on television	46.2%
Heard a Khomanani radio programme or advert	63.3%
Seen a Khomanani television programme or advert	53.2%

Pre- and post-intervention findings

- Same group of participants were involved in the baseline and post-intervention survey
- The intervention was expected to contribute to measurable changes in 3 main areas:
  - Helplines
  - HIV/AIDS knowledge
  - HIV/AIDS attitudes
- Six focus groups were conducted with the participants before the intervention and eight focus groups were conducted post-intervention – in order to gain deeper insight into the survey findings, as well as to understand participants' engagement with the Tsha Tsha pilot project

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Helplines called

Helpline called	Baseline % (n=81)	Post-intervention % (n=52)
AIDS Helpline	20.0%	30.0%
Stop Women Abuse Helpline	11%	30%
Childline	8.1%	30.8%
Life Line	8.1%	25.6%
Thetha Junction	8.1%	23.1%

HIV/AIDS knowledge

True or False	% at baseline	F pre	M pre	% post-intervention	F post	M post
Traditional healers can cure AIDS (false)	**64.2%**	65.5	61.5	**66.7%**	68.8	63.2
If you have fewer sexual partners, you are less likely to get infected with HIV (true)	**36.3%**	31.5	46.2	**24.5%**	16.7	36.8
You can be infected with HIV by touching a person with HIV/AIDS (false)	**91.4%**	92.7	88.5	**94.1%**	93.8	94.7
A mother can pass HIV on to her baby during pregnancy and childbirth (true)	**77.5%**	77.8	76.9	**88.2%**	87.5	89.5
A person with HIV can look healthy (true)	**91.3%**	88.9	96.2	**98.0%**	100.0	94.7
You can reduce the risk of HIV by being faithful to your sexual partner (true)	**81.5%**	81.8	80.8	**88.2%**	90.6	84.2
A woman can transmit HIV to her baby through breastfeeding (true)	**77.8%**	90.9	50.0	**84.3%**	96.9	63.2
If you use condoms every time you have sex you can prevent HIV infection (true)	**93.6%**	96.3	87.5	**96.0%**	96.8	94.7
If a person is raped, there are drugs that can prevent HIV infection (true)	**60.0%**	63.0	53.8	**68.6%**	59.4	84.2
Sexually transmitted infections increase the risk of HIV infection (true)	**81.0%**	87.0	68.0	**86.0%**	90.3	78.9
HIV can be transmitted by sharing a meal with someone who is infected with HIV (false)	**90.1%**	96.4	76.9	**92.2%**	96.9	84.2
It is against the law for a girl of 15 to have sex with a much older man, even if she agrees to it (true)	**81.5%**	78.2	88.5	**84.0%**	77.4	94.7
To prevent HIV infection, a condom must be used for every round of sex (true)	**84.0%**	94.5	61.5	**90.2%**	90.6	89.5
Average	**77.7%**			**81.6%**		

HIV/AIDS knowledge & attitudes

- The Tsha Tsha intervention appears to have made strong impacts in changes in attitudes of participants, with changes of more than 10% being noted for most indicators
- Changes are particularly notable in the areas where Tsha Tsha has a strong emphasis e.g., in portraying humanity and potentials of people living with HIV/AIDS. There are positive changes in these attitudes.
- Although there was some shift in the notion that AIDS was the result of sinning, this did not change markedly
- Existing knowledge levels were high and therefore not expected to change to a large degree. Overall, there was a small increase in the positive direction

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HIV/AIDS attitudes

How much do you agree with the following statements?	Baseline: Agree / Strongly agree	Post-intervention Agree / Strongly agree
Getting AIDS is [not] the result of sinning	63.0%	66.0%
AIDS should be talked about openly at funerals of people who have died of the disease	75.9%	92.2%
It is [not] a waste of money to train/educate someone who is HIV positive	82.2%	90.2%
People who know they are HIV positive should [be able to] have sex	63.1%	72.5%
A woman has a right to say no to sex if she does not want it	91.1%	92.2%
It is [not] okay for older men to have sex with girls younger than 18	79.5%	94.1%
If I told members of my family I had HIV, most of them would support me	65.0%	76.0%
I would [not] be embarrassed to be seen with someone who everyone knows has HIV/AIDS	65.8%	80.4%
Young people should not start having sex before the age of 18	85.0%	82.4%
When you learn that you have HIV, your life is [not] over	79.5%	90.0%
It is [not] acceptable for a man to have more than one girlfriend at the same time	80.2%	86.3%
People with HIV will [not] soon lose their friends	50.6%	64.0%
Average	**73.4%**	**82.2%**

Perceptions of HIV risk at correctional centres

- Male offenders identified 4 main categories of risk:
  - Sharing of needles and razors
  - Fear of blood spread through fights
  - Sexual intercourse between offenders (including rape)
  - Fear of sharing eating utensils
- Female offenders identified 6 categories of risk:
  - Fear of needles used in the prison hospital/clinic
  - Overcrowding (sleeping in same bed), sharing showers, cells
  - Sharing utensils and other personal effects
  - Exposure to blood through fights & helping people bleeding/sick
  - Exposure to blood through assisting women who give birth
  - Sexual intercourse between offenders

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Voluntary Counselling & Testing

- There was a high rate of ever have been tested amongst female participants - 81.5% compared to 19.2% of male participants
- Main reasons for testing for females were: ‘I wanted to know my status’; ‘I was pregnant’; ‘I was feeling sick’
- For men, main reasons for testing were: ‘I wanted to know my status’ and ‘I engaged in risky sexual behaviour’
- Main reasons for not having for tested for females were: ‘I was scared’.
- For males, main reasons for not testing were: ‘not ready to be tested’; did not think I am HIV positive’; ‘I trust my partner’

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Qualitative study

- Expected outcomes: identification with the characters & events; increase in knowledge about HIV prevention; positive changes in attitudes towards people living with HIV/AIDS; problem-solving skills; fostering of humane attitude and spirit of ‘ubuntu’; confidence in ability to overcome adversity
- Survey study and focus groups show the expected outcomes among participants
- Despite generally high levels of knowledge prior to the intervention, there were some offenders who did not have basic knowledge of HIV/AIDS and some who had misinformation which fuelled discrimination & fear
- There is evidence of positive change in attitude towards people living with HIV and examples of concrete changes that have taken place as a result of the intervention

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Qualitative study

- P: Tsha Tsha has taught me a lot because at a certain stage I was one of those people who hated people who've got AIDS and HIV. Because I didn't understand, really, I didn't have lot of knowledge or education that how can you get infected or what. I didn't like sharing anything or whatever, even my kids to touch people who are HIV, because I had that hatred, I don't want to lie. But now at least I've learned and I can understand that you can live with those people…
- F: That's also something huge to be able to say. What does it feel like now for you to have information?
- P: Now it has changed me a lot because I can understand and I can feel that pain that person is going through, and that HIV as such, it's just a normal virus, it doesn't kill or what, like flu or anything.

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Qualitative study

- P: Actually I'm HIV+, I'm living with it, and the way people used to treat us, those who were in the course, they changed, their behaviour towards us has changed a lot.
- F: Tell me a bit about that, like in which way has it changed? What was it like before and how is it now?
- P: Like sometimes, we do use the same toilet and the same shower, if you go to the toilet and they know that you are positive some people would go to the toilet with Dettol, stuff like that, you know, not knowing that the toilet cannot make you to get HIV infected. So from there, when they attended the course they did understand better what's going on with this HIV virus.

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Qualitative study

- Participants and facilitators took ownership and responsibility for the project e.g. almost 100% attendance; letters of apology written if unable to attend; facilitators had one-on-one sessions to make up missed sessions
- Facilitators showed commitment and belief in the project e.g. organised venue, TV and VCR with little or no support; managed large groups & improvised methodology; supported each other & participants where necessary; kept records of attendance & diligent notes about the groups
- Started new groups on own initiative after pilot was finished
- There is evidence of positive change in attitude towards people living with HIV and examples of concrete changes as a result of the intervention e.g. mothers have spoken to their teenage children for the first time about sex; behaviours based on fear have stopped (e.g. isolating people living with HIV, using detergents in baths & toilets after PLHAs have used these facilities)

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Overall impact

- Apart from expected outcomes, many unintended but positive outcomes. These included:
- Many stories that illustrate that participants used Tsha Tsha as a tool for self-reflection (e.g. about prior high risk sexual behaviour and subsequently personalising HIV risk)
- Reflection on pathways into crime and how for some, this was linked to HIV/AIDS (e.g. one participant spoke about growing up with 2 uncles, with whom he felt secure & loved. However, both uncles were HIV positive and died from AIDS a few months apart. Participant stopped going to school in order to take care of his uncles. After their death, he described feeling 'lost' and in emotional pain. His need to 'belong' led him to join a gang and together with his inability to cope with the major losses in his life, he began drinking, having casual unprotected sex, taking drugs and engaging in crime.

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Overall impact

- Communication, life skills and problem-solving skills. Participants described that through the intervention, they had learned: to think before acting; that every action has a consequence; that there are alternatives to violence and crime; tolerance of difference and respect for others' opinions; healthy coping strategies; to take responsibility for choices and their consequences
- Many described experiences of developing self-confidence or of discovering skills and talent that they were not previously aware of e.g. facilitation skills; being a good listener; desire to continue working in HIV/AIDS field
- Tsha Tsha is about young people's lives – relationships, family, work, fun and play. In the midst of this, HIV exists and is related to in a particular way. Project participants used Tsha Tsha as a platform to talk and think about their own lives and how these intersect with HIV/AIDS

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Challenges

- Allocation of responsibilities from a DCS management level for the smooth roll-out of the pilot groups were either not made or not communicated clearly. Resulted in:
- Disruption of group meetings (e.g. if coordinator / nurse was out of the office, group would not be able to meet as there was no one who was willing to open a ‘gate’ to allow offenders to get to the meeting venue)
- Technical resources: venue, TV, VCR were not always available; women’s correctional centre does not have a TV. Much time spent by facilitators organising to borrow a TV from other sections and looking for a venue; lack of meeting space resulted in having large groups (e.g. 50 people) in a very small room; no refreshments were provided
- Challenging stigma and discrimination of people living with HIV/AIDS at correctional centres – DCS personnel need to lead through example

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Challenges & recommendations

- Acknowledging that HIV/AIDS coordinator posts were created in 2006 (and not at all management areas), there is a need to integrate the Tsha Tsha project within existing HIV/AIDS programmes at each correctional centre. In this way Tsha Tsha would be one of many components that work in unison – building on each other
- There is a need to acknowledge the impact that facilitating groups can have – and mechanisms put in place to provide debriefing and support for facilitators (e.g. to deal with personal experiences triggered by a discussion; to deal with difficult group members; to deal with feelings of anger etc).
- The concept of self-care (which includes debriefing, support etc) needs to extend to all who work with HIV/AIDS i.e. to include DCS personnel

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Recommendations

- National rollout of Tsha Tsha: It is proposed that working within DCS management structures, persons are identified that can be trained as trainers, and given the responsibility of ensuring rollout takes place in a particular province or management area
- Re national rollout, a 2-prong approach is recommended:
  - Trainer to provide the training / programme to DCS staff
  - Trainer to train existing peer educators in the methodology
- The pilot study indicates that Tsha Tsha is a useful and powerful way of engaging people to reflect, think, talk about and change behaviours that contribute towards an increased risk of HIV infection. It has also been shown to reduce stigma and discrimination of PLHAs; and to increase individual and collective capacity for the care and support of PLHAs

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