Oxford Policy Management

Bumb'INGOMSO HIV Prevention Project – Secondary Research Baseline Study

Final Report

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The DG Murray Trust (DGMT) contracted Oxford Policy Management (OPM) to conduct and secondary research and baseline household survey for an HIV prevention project in Buffalo City Metropolitan Municipality in the Eastern Cape Province of South Africa, Bumb'INGOMSO.

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Executive Summary

This secondary source baseline study was conducted to assist the planning of the bumb'INGOMSO HIV prevention project, an intervention implemented in Buffalo City Metropolitan Municipality (BCMM) by the DGMT and co-funded by KfW. This report presents results of an extensive desk-based study to identify what is known about the HIV epidemic in BCMM and, in particular, the drivers of HIV infection amongst adolescent girls and young women. The study found limited information on the specific dynamics and characteristics of the BCMM HIV epidemic. However, there are indications in the available information that the dynamics and characteristics are similar to those of the national epidemic and that adolescent girls and young women are a particularly vulnerable sub-population in the municipality.

BCMM's demography

BCMM has a predominantly young population; 20-29 year old adults are the largest age group followed by 15-19 year old adolescents. Overall, the bulk of the municipality's population lives in urban areas with over 50% of inhabitants residing in East London and Mdantsane. There are some indications that Mdantsane, Dimbaza and settlements adjacent to East London, such as Duncan Village, have relatively large sub-populations of 15-29 year old individuals.

In 2011, 34% of pregnant women attending antenatal clinics in the municipality tested HIV positive. In 2012, the highest HIV incidence rate was amongst 15-24 year old women and among informal settlement residents. Between 2008 and 2013, HIV/AIDS and TB were the main cause of death for 15-24 year old women (48%). For similarly aged men, physical injury was the main cause (71%); 11% of mortalities were due to HIV/AIDS and TB-related conditions.

Drivers of HIV in BCMM

There are clear indications that poor physical, social and economic conditions (structural HIV drivers) contribute indirectly to the high HIV transmission rates amongst adolescent girls and young women. There are 154 informal settlements in BCMM and 12% of the population (90,000 people) live in these settlements. Living conditions are difficult in predominantly informal areas: only 24% of the population has piped water in their homes; 17% have piped water in their yards. Nearly 70% have access to flush toilets but it is likely that many people share access to communal toilets. Approximately a third (31%) of the population do not have formal employment, of whom 65% are individuals younger than 29 years. Twenty nine percent (29%) of the population, 14 years and older, are illiterate and only 20% of the population, 20 year and older, have completed their secondary education.

The study found little information on the behavioural and biomedical drivers of BCMM HIV epidemic, to account for the high HIV incidence rate amongst young women. There is some BCMM-specific information for three common drivers: early age sexual debut (before age of 15 years), age disparate sexual relationships (relationships with person 5 years older or younger than oneself), and inconsistent condom use. Results of the 2012 national HIV prevalence, incidence and behaviour survey idenifftied BCMM as the metropolitan area with the highest proportion of individuals who reported early age sexual debut (27%). Likewise 27% of BCMM informants reported having been involved in age disparate relationships. Another 2012 study, presenting results for the Eastern Cape province, records that 31% of girls and young women, 16-24 years old, reported having a sexual relationship with a man five or more years older than themselves. Results from the same study suggest that condom use is not common practice amongst adolescent girls and young women in the province. 58% and 48% of 16-19 year old boys and girls, respectively, and 57% of 20-24 year old women, reported using a condom during their last sexual intercourse.

Bumb'INGOMSO has a particular interest in curbing violence against women. The study found no precise information of the scale of this problem in BCMM. However, the reports of several CSOs and the extensiveness of available interventions indicate the severity of the problem in BCMM. The study's analysis of literature on violence against women shows that it is a particularly difficult issue to address, as it is rooted in culturally and socially normative behaviours that reinforce gender inequality. It is likely that difficult social and economic conditions, such as poverty, lack of education and unemployment, contribute to creating environments in which these behaviours are maintained. The challenge for the interventions is therefore to attempt to change the environments which foster or reinforce violence against women.

Approaches to HIV prevention

Bumb'INGOMSO is envisioned as a multi-faceted project that combines and coordinates several intervention streams. The UNAIDS-formulated Combination Prevention model has been developed with the aim of incorporating interventions to change individuals' behaviour within a broader perspective of confronting the conditions in which people live as the underlying drivers of vulnerability that affect the extent to which individuals can change their behaviour to protect themselves from HIV infection. Specific guiding principles of this approach include:

- An evidence-based, participative planning process that ensures collaboration from all relevant stakeholders particularly individuals and communities affected by HIV
- Clear identification of transmission pathways in the most affected populations
- Nuanced understanding of the scale and intensity of the epidemic – geographical distribution and variation of the HIV local epidemic
- Identification of the structural factors that may be propagating or sustaining the local epidemic

The combination prevention model has been adopted in BCMM via the national and provincial governments' HIV/AIDS, STI and TB strategy for 2012-2016, and some programmes of the Departments of Health (DOH), Basic Education (DBE) and Social Development (DSD). These include the DOH 'r-PHC' agenda to revitalise primary health care services, the DSD's Integrated Programme of Action within which is the Victim Empowerment Programme (VEP), and the joint DOH/DBE Integrated School Health Programme (ISHP). With regard to female sex workers, the new national plan seeks to foster an 'enabling environment' through the co-ordinated interventions of health workers, justice department officials, police, lawyers, NGOs and communities. These frameworks can serve as reference points for bumb'INGOMSO to guide the planning of the interventions.

What we do not know about HIV and its transmission in BCMM

In light of this, a pertinent consideration for the project is the limited context-specific information on the drivers of HIV transmission amongst adolescent girls and young women. It means that there has yet to be clear identification of transmission pathways in this population and development of a nuanced understanding of intensity vulnerability across different settlements in BCMM. There are, therefore, information gaps which need to be addressed. Other gaps in the information include:

- The lack of adequate data to identify variations in HIV prevalence by location, age and gender. Health facility data is only captured for 15-49 year olds without further disaggregation.

- The lack of clear reporting on cases of violence against women. The current categorisation of sexual offences (which is broad and encompasses sex work, for example) is inadequate for monitoring VAW.

- Lacking information on fertility rates of adolescent girls and young women between the ages of 15 and 29 years old - recent research suggests that improving availability and access to contraception to reduce the incidence of unintended pregnancies can be a significant intervention to reduce HIV transmission;

- The virtual non-existence of pertinent information on female sex workers and incarcerated offenders in BCMM

What we do not know about services addressing HIV and VAW in BCMM

In the case of interventions to create economic opportunities for young women, the secondary research found little information to suggest that current institutional arrangements (e.g. the Youth Advisory Centres; TVET college initiatives; work link programmes with the private sector) are aligned to the framework for interventions and operations of the agencies discussed in this report. There is also very little information on whether incarcerated offenders are a particularly high-risk group within BCMM, and what type of HIV-related interventions are available for this population.

Other significant information gaps for the planning of bumb'INGOMSO are:

- The actual reach and catchment areas of the NGOs providing various services in different settlements;

- The actual reach of the ISHP; that is the number of schools served in the BCMM and number of children reached each year (reportedly, they were reaching only 29% of schools in the province);

- The location and current operations of the 'Ward Based Outreach Teams' (WBOT) in the BCMM, established via the r-PHC agenda. There are many of these teams in the province (400 in 2014 involving 1,507 CHWs) but at the time, it was reported that they were operational in only 206 of the province's 715 municipal wards and there was no information on the number and location of teams in the BCMM;

- How many clinics are youth friendly in practice and their locations;

- Details of the mechanisms (and their effectiveness) for co-ordination of the different government and non-government agencies' interventions in the BCMM.

Finally, while there is a framework for the project's interventions and many interventions are underway in BCMM, there is a question mark as to whether they are changing the environments in which HIV and VAW flourish. The main body of the report outlines operational challenges within government agencies, the seemingly dispersed and fragmented NGO interventions across the BCMM, and the limited reach of all interventions. This is not to deny that the initiatives incorporate an agenda to change those environments, nor to fail to recognise that this agenda is a process that takes time. The point here is that bumb'INGOMSO, as a new addition to existing initiatives, is in a position to consider how it can invigorate that process.

Recommendations for bumb'INGOMSO

1. Allow review of intervention proposals to ensure that they are aligned with the framework for HIV interventions in BCMM.

Bumb'INGOMSO does not have to do everything and try be the comprehensive response. Instead, the intervention must look for the strategic opportunities that could enhance the collective effort, or create a tipping point by saturating multi-faceted interventions in specific communities. The imperative here, therefore is that, individually, each intervention needs to add value to existing interventions of their kind and, collectively, they should be mutually supportive if they are to adhere to the logic of combination prevention.
This presumes collaborative planning between the contracted NGOs and consultation with organisations currently implementing interventions in BCMM. For example, it is likely that large organisations such as the DBE, loveLife and Soul City already have plans for expansion of their behaviour change communication programmes into areas they have identified as lacking interventions.

2. A necessary consideration is where the project's resources should be directed in BCMM. The question is whether the interventions should focus on one area/settlement or in two or more areas/settlements and on what grounds, to have the greatest 'impact'. The mapping exercise draws attention to different options in terms of the variations in the health facility positive test rate and other indicators of risk and vulnerability.

Furthermore, one impression from the secondary research is that the many interventions in BCMM are fragmented and have limited reach into the populations they target. While these interventions may be having beneficial effects, the beneficial effects may potentially be greater and achieved more quickly if different organisations concentrated their resources in particular areas/settlements.

Bumb'INGOMSO should consider the option of concentrating resources of the different interventions in one area/settlement with a view to 'saturating' it with co-ordinated interventions. While this would be the overall focus of the proposed interventions, there would need to be particular sub-initiatives which have particular agendas; for example, specific VAW-oriented services in particular health and community facilities within a settlement and/or a number of BCC initiatives which target different age groups (and needs and interests) of adolescent girls and young women.

3. Whatever option is chosen with regard to where the interventions will be conducted, engagement with the relevant residents in the affected community/ies is vital if the interventions are to be effective in changing the environments which foster the problems they seek to resolve. This would be about creating 'enabling environments' for the behaviour change, health, VAW and economic empowerment interventions to take root.

The nature of the interventions will have implications for the design of the primary study. It is not possible at this stage to define the implications in detail. However, it can be said that some of the information required will need to come from qualitative research, as this will likely be appropriate for providing a 'baseline' for interventions that may be focused on particular populations of young women in particular settlements/localities and on changing particular environmental conditions. In sum, the design of the primary study will need further discussion and will depend on the intervention plans that are proposed and approved for the bumb'INGOMSO project.

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List of Abbreviations

ABET	Adult basic education and training
ANC	Antenatal clinic
BCC	Behaviour change communication
BCMM	Buffalo City Metropolitan Municipality
CSTL	Care and Support for Teaching and Learning
DGMT	DG Murray Trust
DHIS	District Health Information System
DBE	Department of Basic Education
DHET	Department of Higher Education and Training
DOH	Department of Health
DOJ	Department of Justice
DSD	Department of Social Development
DQAF	Data Quality Assessment Framework
EMIS	Education Management Information System
FCS	Family Violence, Child Protection and Sexual Offences Unit
FSW	Female sex workers
GBV	Gender-based violence
GIS	Geographic Information System
ISHP	Integrated School Health Programme
KAP	Knowledge, Attitude and Practice
MSM	Men who have sex with men
NGO	Non-governmental organisation
NPA	National prosecuting authority
OPM	Oxford Policy Management
SAPS	South African Police Service
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
TCC	Thuthuzela Care Centre

TOR	Terms of reference
TOC	Theory of change
TVET	Technical and vocational education and training
VAW	Violence against women
VEP	Victim empowerment programme

Glossary of Terms

Econometrics	The use of mathematical methods, especially statistics, to describe social and economic principles. Typically, it involves creating a hypothesis, e.g. HIV prevalence is higher among young women who are out of school; and then using real life data to test whether this hypothesis is actually true.
Seropositivity	The number of people that have tested positive for a disease (in this case HIV). This is used to distinguish between true prevalence – the proportion of population with a specific condition and the proportion of tests that have an HIV positive outcome in a given sample of tests.

1 Introduction

The DGMT has commissioned two baseline assessments to guide the targeting, delivery and evaluation of the bumb'INGOMSO HIV Prevention Project[1] in Buffalo City Metropolitan Municipality (BCMM). This report presents the findings of the secondary source baseline assessment. It provides a context-specific overview of HIV risk and vulnerability within BCMM to assist in the planning, design and targeting of bumb'INGOMSO. In addition, these findings will provide information to guide the content of the subsequent primary baseline study.

The main purpose of this study is to:

a) Guide the practical planning of bumb'INGOMSO's five sets of interventions to reduce HIV infection amongst young women (15-29 years old) who live in BCMM. These interventions are:

   1. A behaviour change communication intervention aimed at in-school, out-of-school and post-school youth to achieve a positive change in risk behaviour;

   2. A health services intervention to support existing health services, to improve 'youth friendly' services with a focus on HCT, contraception and STI treatment in public clinics and in GP practices;

   3. An intervention that acts as a systemic response to gender-based violence, involving community mobilisation and improving the co-ordination, accessibility and use of GBV-oriented services[2];

   4. A programme to increase economic opportunities for vulnerable young women, involving communication of educational, training and links to jobs;

   5. An intervention to incorporate female sex workers and incarcerated offenders as beneficiaries of the project.

A secondary objective is to:

b) Assist the planning of the primary research which will provide a 'baseline' of the current conditions which create the high risk of HIV infection for BCMM's young women by drawing out any implications or recommendations for the primary study. That 'baseline' will provide a basis on which to evaluate bumb'INGOMSO's interventions in three years' time.

There are two core reasons for bumb'INGOMSO's focus on young women:

1. The high HIV infection rates among young women. The 2012 national HIV prevalence, incidence and behaviour survey recorded that HIV incidence rates were 1.4% (300,000 new infections) amongst adults but the rates were higher, 1.5% (139,000 new infections) amongst 15-25 year old youth and as alarmingly, 2.5% amongst 15-24 year old girls and young women (113,000 new infections) during the year (Shisana et al., 2014). Notably, 80% of the infections amongst 15-24 year old youth were amongst girls and young women (113,000 compared to 26,000 amongst boys and young men);

[1] Referred to as bumb'INGOMSO for the remainder of the report
[2] Given the project's focus on young women in particular, we have chosen to use the term 'Violence against women (VAW)' in the remainder of the report (as opposed to 'Gender-based violence (GBV)'

2. The high levels of violence against women in South Africa, which is a factor that increases the risk of HIV infection amongst women generally in this country and amongst young women in particular (Gibbs, 2016; Kamndaya et al, 2014).

Accordingly, the secondary study sought to synthesize available information on the HIV epidemic in BCMM and the factors which make young women a particularly vulnerable population. In short, it was a 'know your epidemic' study. It involved an extensive review of literature, covering:

- The general dynamics of South Africa's HIV epidemic with a particular focus on what is known about the epidemic in the Eastern Cape and, specifically, in BCMM;
- Current intervention strategies and programmes of government departments and CSOs, in the Eastern Cape and in BCMM, and the logic behind the design of these strategies and programmes;
- The institutional arrangement of interventions in BCMM; that is, the type, location and reach of interventions which already exist in BCMM.

A particular feature of this study is the mapping exercise which involved spatially representing available information on demographic, social and economic conditions, HIV risk, and the location and reach of HIV services across BCMM. The purpose was to see if there are evident relationships between different conditions.

The review of current intervention strategies, programmes and institutional arrangements provides the context for planning bumb'INGOMSO's interventions; in particular, the logic underpinning existing interventions. In other words, there are already a range of interventions similar to those proposed by the project and they subscribe, in principle if not always in practice, to the UNAIDS-formulated HIV combination prevention model which incorporates the principles of integration and co-ordination of different interventions. Bumb'INGOMSO's design suggests that it will be underpinned by this model; hence, this secondary study's inclusion of existing interventions as reference points for the detailed planning of the project's interventions.

2 Methodology

This study was conducted between May and August 2016 as a desk-based research study complemented by some informal interviews with representatives of government departments and civil society organisations.

2.1 Description and micro-epidemic mapping of the HIV epidemic in BCMM

The mapping of the HIV epidemic in BCMM followed a two-pronged approach. First, a broad range of local and international literature was reviewed to describe HIV risk factors and attempt to identify the transmission pathways, in expectation that there would be similarities between conditions in BCMM and other metropoles in South Africa. Second, spatial data was used to show the distribution of HIV in relation to risk factors in BCMM.

2.1.1 Literature review of structural and behavioural drivers of HIV

The aim of the literature review was to summarise the structural and behavioural drivers of HIV in generalised epidemics with a particular emphasis on young women and high-risk groups. An additional chapter was dedicated to exploring the prevalence of and risk factors for violence against women in more detail, because of its high prevalence in BCMM and complex interactions with HIV vulnerability.

The literature was synthesised using a funnel approach. Broad international and South African literature served to identify the important structural and behavioural risk factors for HIV for young women, and to describe general transmission pathways and interactions between these risk factors. Nationally representative surveys were summarised to obtain an understanding of the general prevalence of certain risk factors in BCMM in relation to other metros in South Africa. Finally, where local-level data was available, this was used to contextualise HIV risk and vulnerability specifically within BCMM. It quickly became evident that local-level data was scarce, and this revealed several evidence gaps that were discussed in the literature review.

2.1.2 Spatial mapping of the HIV epidemic in BCMM

The aim of the spatial mapping was to illustrate the distribution of HIV and HIV risk across BCMM. The spatial mapping was based on the methodologies described in the UNAIDS Local Epidemics Issues Brief (2014), which suggests a location-based approach to understanding variations in HIV prevalence and identifying HIV service delivery gaps. Spatial data provides planners with textured information on the key variables that shape localised epidemics so that intervention strategies can be aligned with varying patterns of HIV distribution (UNAIDS, 2014).

Spatial mapping was performed using the QGIS software (version 2.14.3). Where necessary, data were prepared for mapping using STATA (version 14) and Excel. The sources of data for the mapping are presented in Annex A.

Calculation of the health facility HIV positive test rate

The health facility HIV positive test rate per ward was calculated by aggregating facility-level DHIS data. DHIS data were obtained from the provincial health department and contain facility level health usage statistics from across BCMM. DHIS data have several indicators related to HIV prevalence:

1. Proportion of clients at ANC facilities testing positive for HIV on their first test

2. Proportion of clients at ANC facilities testing positive for HIV on their second test (if the first test was negative)

3. Proportion of clients aged 15 – 49 at facilities (excluding ANC) testing positive for HIV

We considered using only ANC data because this would best approximate the HIV prevalence rate of the DGMT's target population (young women aged 15 – 29) – as most women of childbearing age would fall into this category. However, ANC testing rates in several wards were too low to yield reliable estimates (some wards recorded less than 10 tests per year). As a result, we used HIV test results for all the respondents that tested for HIV (ANC and the general population). HIV testing data is only available for 15 – 49 year olds, but with no further disaggregation (e.g. by age or gender).

Data limitations

The methodologies described in the UNAIDS Local Epidemics Issues Brief (2014) refer to analyses performed at national, provincial or district level. Current publically available data in South Africa is not always adequate to map distributions at a sub-district level. Our analysis is framed by these data limitations, and the results we present should be interpreted with an understanding of these.

Often, relevant data simply does not exist. For example, publicly available data on high-risk groups such as sex workers, e.g. numbers and HIV prevalence, is not systematically available at the local level in South Africa. Routinely collected health facility data is not disaggregated by age and gender to a level that enables analysis in relation to 15 – 29 year old girls and women.

To depict the distribution of HIV across BCMM, we relied on DHIS data that is collected at the health facility level. The relevant DHIS indicator refers to the proportion of clients aged 15-49 at facilities testing positive for HIV. Therefore, this is a proxy for the true HIV prevalence as it is based on the number of people who test at the health facility. People who choose to conduct an HIV test may be unrepresentative of the general population in some ways (e.g. they may be more educated or have better access to a health facility than the general population).

A further concern is that people may not attend a health facility close to where they live, and the proportion of people who test positive at a facility may therefore not represent HIV prevalence in the immediate community. To mitigate some of the misrepresentation that may arise at a local (ward) level, hospitals are excluded in the aggregation of facility level data because hospitals are more likely to attend patients from larger geographic areas. Second, we also considered the distribution of health facilities, and noted that in many cases, especially outside of the central areas of East London, Mdantsane and King Williams Town, health facilities were distinctly located to service specific populations i.e. there was some degree of isolation. In these cases, it would be reasonable to assume that people would attend the facility closest to them.

In general, therefore, the data should be interpreted with caution and should not on its own form the basis of targeting decisions. The maps should facilitate a broad overview of the distribution of HIV across BCMM, but are not suitable for considering variations at a localised level e.g. for comparing HIV risk between wards.

To assess the distribution of VAW across BCMM, we relied on police data of the number of sexual offences reported at each police station in BCMM. Again, there are some concerns about the reliability of this data. First, the definition of sexual offences is broad, ranging from sex work to domestic violence and rape. Second, sexual offences very often go unreported. There may be particular interactions between service availability and reporting of sexual offences: for example,

awareness raising on VAW or the provision of victim-friendly services may in fact *increase* the reporting of sexual offences because communities are more aware of the phenomenon and individuals feel safer to take action. Therefore, the interpretation of analysis should be mindful of these issues.

2.2 Services mapping

In this section, we mapped the availability of services that are instrumental for HIV prevention. The availability of secondary research data on services availability and effectiveness was limited, despite contacting various organisations directly to enquire about documents and sources. As an example, while there is an NGO directory with a list of NGOs in BCMM that broadly outlines what each does and the physical location of the head office, most NGO websites do not provide access/usage statistics by area by year. Due to the study design and timeframes, it was not possible to map every NGO offering or health service. As a result, we complemented the service mapping in BCMM with a literature review of international and national best practices in HIV prevention.

2.2.1 Literature review of international and national best practices in HIV prevention

A rapid literature review of international and national best practices in HIV prevention provides background on which interventions have been shown to be effective and under which circumstances. Results of the HIV epidemics mapping were used to focus the literature review on prevention approaches that are likely to be effective in HIV epidemics such as the one in BCMM. The key lines of inquiry were a) what approaches have been used to target similar HIV epidemics as the one we anticipate is within BCMM municipality; b) of these approaches, which ones have worked and c) why have they worked.

2.2.2 Services mapping within BCMM

This section focused on the services that are currently available in BCMM. The services mapping was structured around to the five intervention areas that the DGMT is focusing on. For each area, we initially identified prominent service providers through internet searches and service directories. These were contacted by email or phone and requested to provide any available documentation on relating to their service offering such as annual reports, monitoring reports, strategy papers and research studies. The websites of these organisations were also searched for relevant documents. This process produced somewhat limited useable information because a) many of the organisations are active nationally or provincially and their reports provided limited information on their specific activities within BCMM, and b) there is a general lack of available data as many of the NGOs do not have up to date websites.

As a result, an information-gathering mission to BCMM was organised, and meetings with the key organisations conducted. Brief information-gathering sessions were conducted with each organisation on the scope of their services in BCMM specifically. The organisations were also asked which other organisations they know of which are active in BCMM. Any additional organisations identified through this approach were asked to respond in writing to an email with basic questions on the scope of their services in BCMM. Annex B provides details of all organisations contacted.

Within each intervention area, health facilities, educational institutions, judiciary institutions, policing institutions, social services and sector-specific NGOs were included as appropriate. Given the limited availability of secondary source information, it was not possible to create indicators of service availability, standards and effectiveness under the different intervention groups. Instead, the scope

of service delivery was described qualitatively with a focus on differentiating between government and NGO response when applicable. Where information on the location of different services was available, the data were mapped spatially. These maps were used to consider how appropriately distributed services are within BCMM by, for example, considering how clustered services are in certain areas; how availability of services compares between rural and urban areas; and how availability of services compares with distribution of HIV risk factors.

For the health services interventions, because DHIS data were available, it was possible to look at three different indicators of health service provision: the number of male and female condoms distributed and the coverage of HIV counselling and testing (HCT).

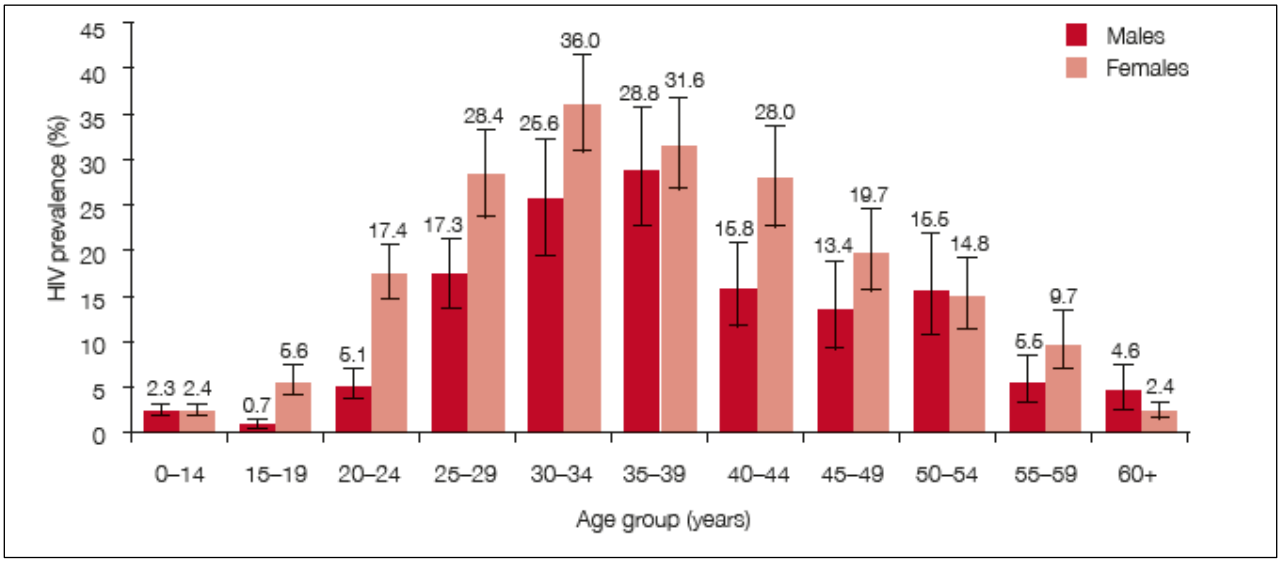
2.3 Institutional Assessment

The requirements of the assessment included reviewing policy and programme design and management documents to understand the interaction of different agencies (police service, judiciary, health services), particularly the co-ordination mechanisms and their effectiveness. It was recognised upfront that the value of this specific component would hinge upon access to internal policy and procedural documents and that the researchers could interview some key officials. However, access to some of the key information and informants was limited. Consequently, the institutional assessment was limited to analysis of published documents supported by discussions with some officials and representatives of NGOs.

3 BCMM's demography: A predominantly young, vulnerable population

The 2012 HIV Prevalence, Incidence and Behaviour survey (Shisana et al., 2014) identified several high-risk groups who have higher levels of HIV prevalence compared to the general population: young women, co-habiting (unmarried) couples, informal settlement residents, people who consume alcohol regularly, recreational drug users, and disabled people.[3] Figure 1 shows the marked and higher prevalence rates amongst different age bands of adolescent girls and young women, compared to adolescent boys and young men.

Figure 1: South African national HIV prevalence rates by age and sex



Source: 2012 HIV Prevalence, Incidence and Behaviour Survey (Shisana et al., 2014)

Table 1 shows the HIV prevalence rates among key populations that were identified in the survey as being at heightened risk for HIV infection. HIV prevalence rates in these populations are compared to the provincial and national averages.

Table 1. HIV prevalence rates among key populations at higher risk of HIV exposure compared to provincial and national averages

Population	%	95% CI
Black African women (20-34 years)	31.6	28.5 – 34.9
People living together, not married (15-49 years)	30.9	26.5 – 35.7
Black African men (25-49 years)	25.7	22.8 – 28.8
Disabled (15 years and older)	16.7	12.9 – 21.4
Urban informal locality (all ages)	19.9	17.4 – 22.7
High-risk drinkers (15 years and older)	14.3	11.8 – 17.3
Rural informal locality (all ages)	13.4	12.2 – 14.7
Recreational drug users (15 years and older)	12.7	9.7 – 16.5
Provincial (Eastern Cape) (2 years and older)	12.2	10.5 – 14.1
National (2 years and older)	12.6	11.7 – 13.5

Source: 2012 HIV Prevalence, Incidence and Behaviour Survey (Shisana et al., 2014)

[3] Odds ratios are not presented in the report, and significance tests are not consistently presented for all groups that the report identifies as high-risk.

This demographic summary of South Africa's HIV epidemic is relevant for bumb'INGOMSO because the municipality's demographic profile indicates that the population is predominantly young and a substantial proportion live in informal settlements.

With regard to age and sex, notable characteristics of the population in BCMM are (BCMM, 2015):

a) Young adults (20-29 years old) constitute the largest proportion of the population, followed by children and adolescents (0-19 years old) whilst the proportion of older adults narrows substantively with each age group 30 years and older.

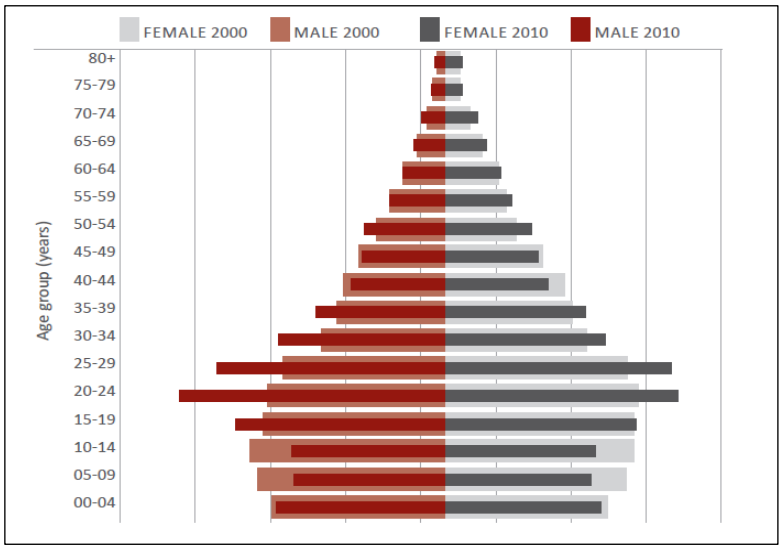
b) 0-4 year old boys and girls constitute a relatively large proportion (after 20-29 year old adults) and, according to the 2011 census there has been a substantial increase in the number of boys and girls in this group since 2001, but there has been a decrease in the proportion of boys and girls in all age groups from 5- 19 years old (i.e. 5-9, 10-14yrs, 15-19 years old).

c) There has been an increase in the proportion of young adults in the 20-24 and 25-29 year old groups but minor increases amongst women as opposed to a substantial increase in the proportion of young men.

d) The ratio of men to women, 30 years and older decreases proportionately with age: the proportion of men increases slightly or remains static up to the age of 50 years old but the proportion of women decreases between the ages of 30 and 44 years old and then increases substantially between the ages of 45 and 59 years old (ECSECC, 2014).

Figure 2 illustrates this pattern in BCMM's population pyramid (ECSECC, 2014).

Figure 2: Age and gender distribution in BCMM



Source: ECSECC Socio-economic Profile of Buffalo City Metro, Eastern Cape 2014

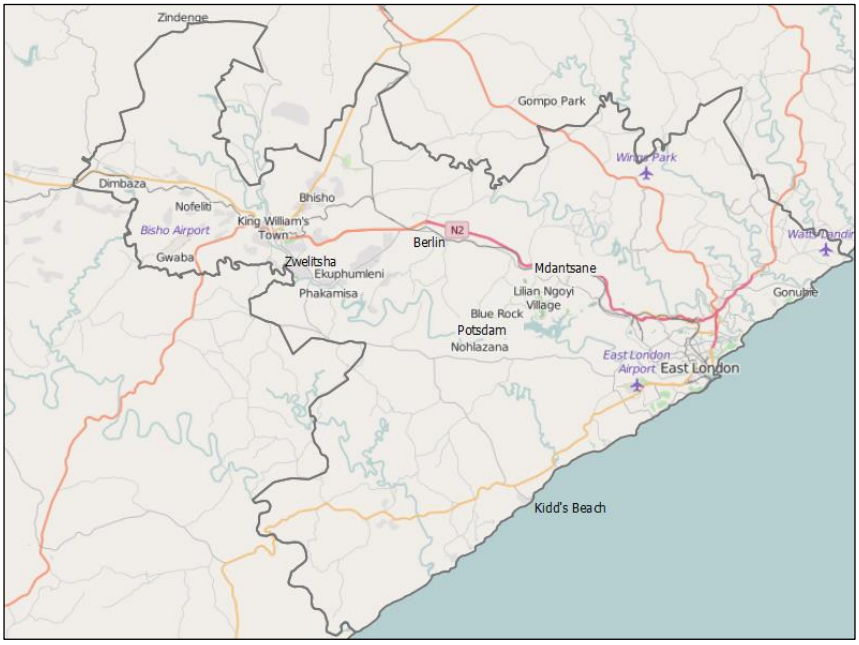
Three quarters of a million people live in BCMM, mainly in the urban areas (in 2011, 755,200 people in 223,468 households) (StatsSA, 2011). Figure 3 below illustrates the general distribution of BCMM's population. Over 50% of the population is located in East London and Mdantsane. A minority, about 20% of the population, live in rural and peri-urban settlements. The remaining 30% are located in, Berlin, Bisho, Dimbaza. Ginsberg, Gonubie, King Williams Town, Phakamisa, Potsdam and Zwelitsha. King William's Town and Zwelitsha are the largest towns after East London and Mdantsane. A significant characteristic for the purposes of bumb'INGOMSO is that BCMM has 154 informal settlements which house approximately 12% of the population (95,114 people) (BCMM, 2015).

In 2011, there were 104,972 women aged between 15-29 living in BCMM, compared to 110,259 men in that age group (StatsSA, 2011). Based on the estimate that 12% of the population live in informal settlements, one would expect approximately 12,600 of these young women and 13,230 of these young men to be living in informal settlements. The proportion of young people living in an informal *dwelling* (defined as a shack, whether or not located in a backyard) is likely to be higher. According to the 2011 census, 22.7% of dwellings in BCMM are informal (StatsSA, 2011). If we assume that this implies that 22.7% of young people live in an informal dwelling, we estimate that 23,830 young women and 25,030 young men aged 15-29 lived in an informal dwelling in 2011.

With regard to the distribution of 15 – 29 year old population category, analysis of available information suggests that it is spread across the municipality but the highest densities (i.e. number per km^2) are in the urban areas: in Mdantsane, Dimbaza and in East London including informal settlements such as Duncan Village, followed by Zwelitsha and Ndevana. There seem to be fewer 15-29 year old residents in King William's Town (Figure 4).

Some rural areas appear to have large 15 – 29 year old populations (darker coloured areas on the right hand map) but the density in these areas is low (the same areas are lighter on the left hand map); suggesting that this population is spread across large areas.

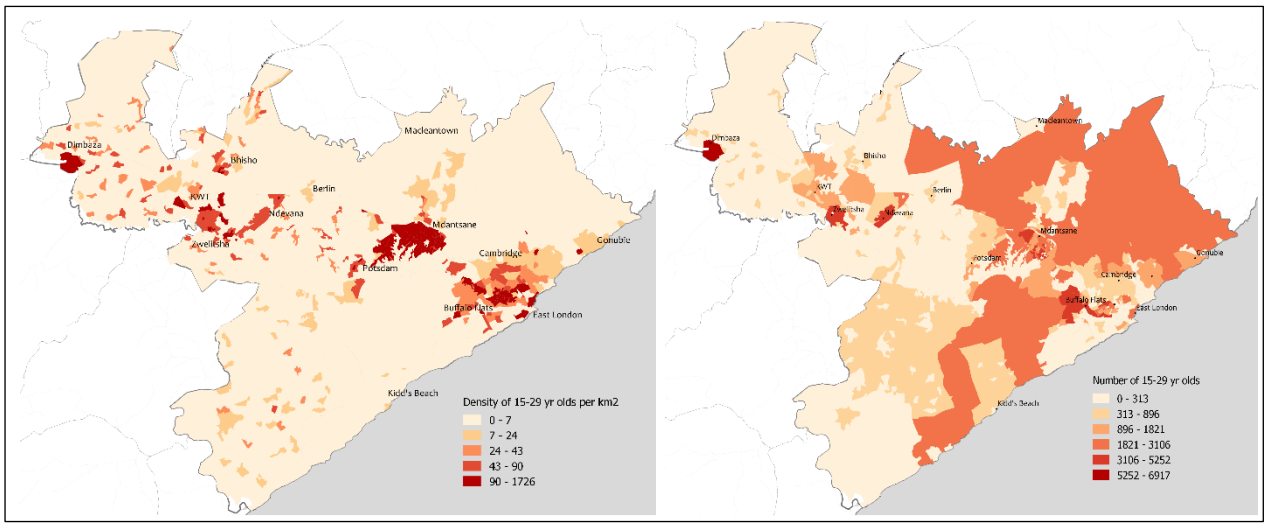
Figure 3: Outline of BCMM and population numbers in key areas



Settlement type	Population
Towns	**270 308**
East London	225 101
King Williams Town	34 015
Bisho	9 192
Townships	**219 077**
Mdantsane	156 834
Dimbaza	21 294
Zwelitsha	18 186
Ginsberg	10 766
Phakamisa	6 602
Sweetwater	5 395
Rural settlements	**170 701**
Informal settlements	**95 114**
TOTAL	**755 200**

Source: BCMM Annual Report 2014-2015, Open Street Maps

Figure 4: Density and number of 15-29 year old population in BCMM



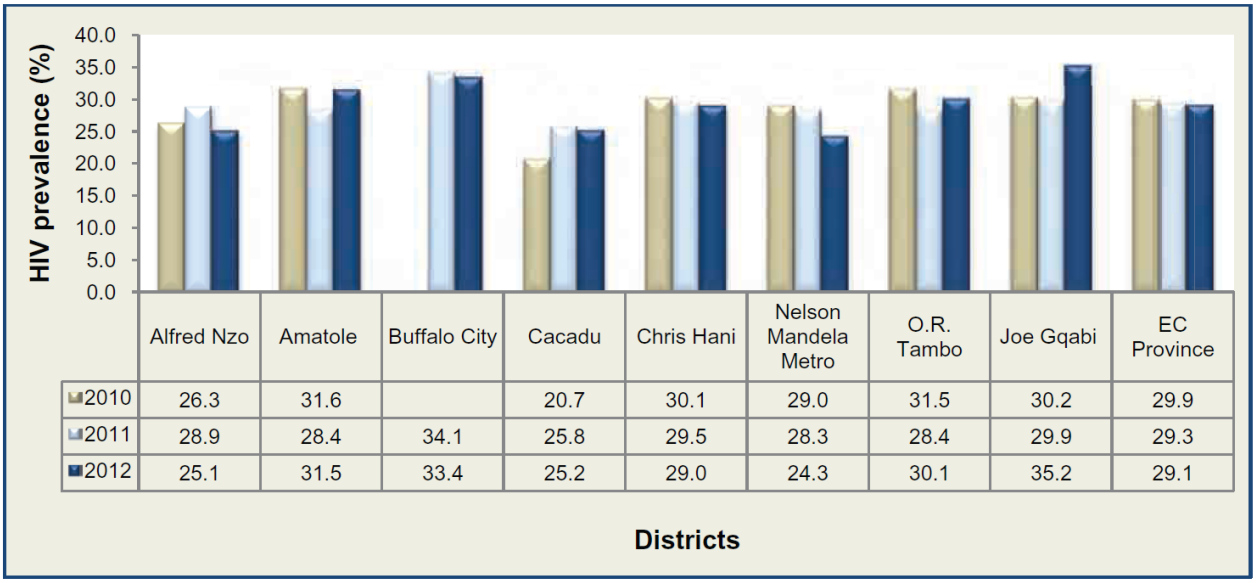
Source: BCMM GIS Unit.

The demographic characteristics of the municipality therefore reflect the demographic characteristics of South Africa's HIV epidemic described by national surveys. In BCMM, and in South Africa in general, the predominantly young population (particularly adolescent girls and young women) is a very vulnerable population. BCMM-specific HIV statistics support these inferences.

3.1 BCMM's HIV epidemic

The HIV prevalence rate (all ages) is 13.6% in BCMM population, which is higher than the provincial (11.6%) and the national rates (12.2%) (Shisana et al., 2014). In 2011, the HIV prevalence rate amongst pregnant women attending ante-natal clinics in the municipality was the highest out of all districts in the Eastern Cape at 34% (Figure 5).

Figure 5: HIV prevalence rate per district in the Eastern Cape



	Alfred Nzo	Amatole	Buffalo City	Cacadu	Chris Hani	Nelson Mandela Metro	O.R. Tambo	Joe Gqabi	EC Province
2010	26.3	31.6		20.7	30.1	29.0	31.5	30.2	29.9
2011	28.9	28.4	34.1	25.8	29.5	28.3	28.4	29.9	29.3
2012	25.1	31.5	33.4	25.2	29.0	24.3	30.1	35.2	29.1

Source: National Department of Health (2013) as cited in the 2012 National Antenatal Sentinel HIV & Herpes Simplex Type-2 Prevalence Survey in South Africa

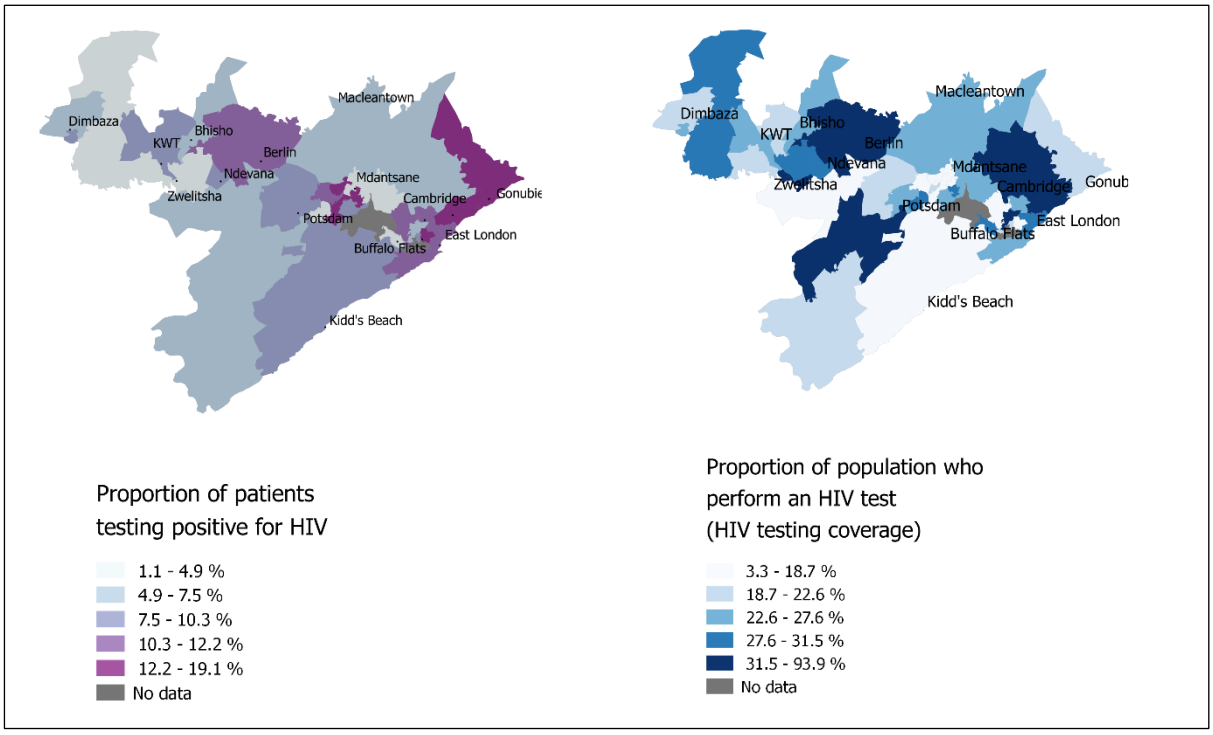
The research team reviewed available information to see if there was any clear relationship between the variations in HIV prevalence rates across different BCMM settlements and areas where there

are concentrations of the 15-29 year old population. However, the available information allows only a limited finding; in short, that there are concentrations of this population in some high HIV prevalence areas. The findings are described below.

Analysis of available information suggests that HIV prevalence in BCMM is higher in some areas than in others. Figure 6 shows the proportion of health facility patients who tested positive in an HIV test in different areas of BCMM between April 2015 and March 2016, and the proportion of the population in those areas who were tested at the facilities. Data was obtained from the Department of Health Information System (DHIS) which captures the number of HIV tests performed at public health facilities and the result of the tests. The data is for all patients aged 15 – 49 because the DHIS data is not disaggregated. The data, therefore, represents only those people who chose to perform an HIV test at a health facility. The analysis involved comparing the proportion of area populations who were tested with the HIV prevalence amongst those were tested. The 'hypothesis' is that test results in areas where a relatively high proportion of the area population had HIV tests are representative of HIV prevalence rates in those area populations.

On this basis, the analysis suggests relatively high HIV prevalence rates in some areas of East London (particularly Cambridge and Duncan Village) where 27-30% of the area populations were tested. In contrast, the findings suggests lower HIV prevalence rates in Zwelitsha, Dimbaza, Potsdam and King Williams Town in view of the relatively high proportion of the population in these areas who were tested. The DHIS recorded relatively high positive test rates amongst health facility patients in Mdantsane and Gonubie but also a low proportion of the population in those areas who were tested. Therefore, it is possible that the positive test records do not reflect the HIV prevalence rates in those areas.

Figure 6: The distribution of HIV across BCMM (Apr 2015 - March 2016)

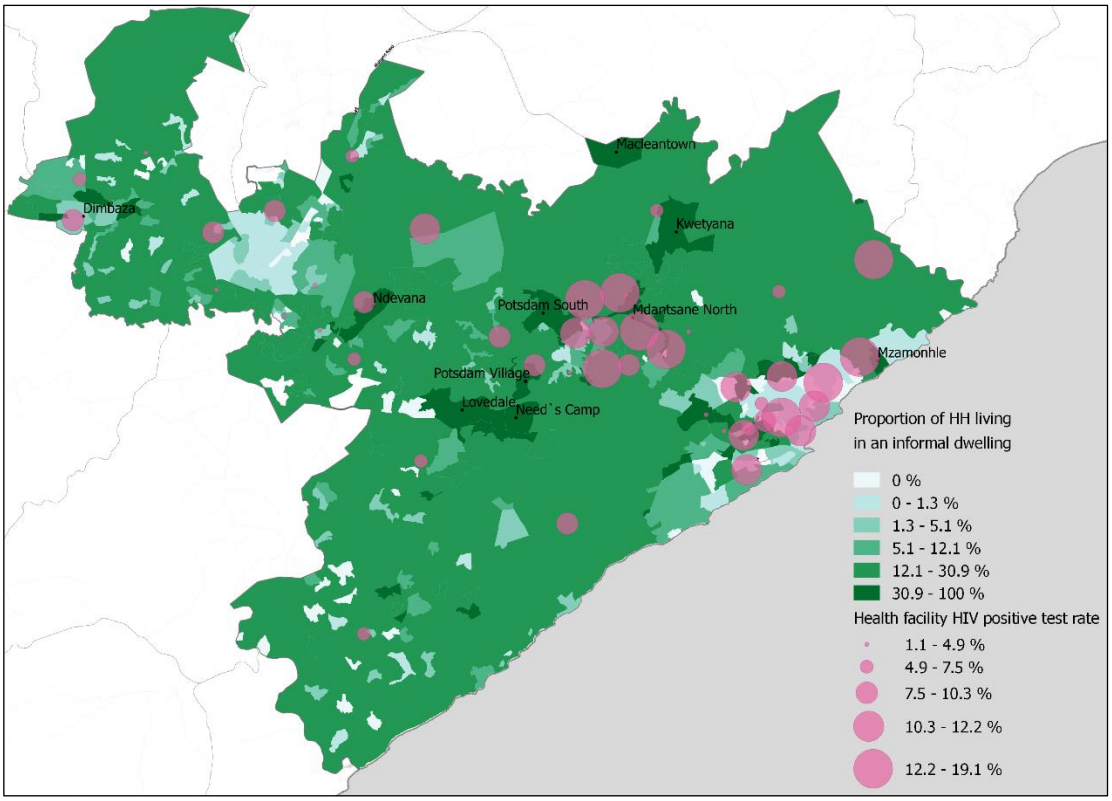


Note: Data combines HCT and ANC testing among 15-49 year olds in all clinics, community health centres and mobile services in BCMM, and is aggregated at a ward level. Data is aggregated over the past 12 months (Apr 2015 – March 2016). Hospitals are excluded because they draw patients not only from the immediate catchment area surrounding the facility. Source: DHIS.

Figure 7 shows the distribution of health facility HIV positive test rate in relation to the locations of informal settlements (measured as the proportion of households that are of an informal nature).

There is no clear-cut correlation between HIV positive test rate and a high proportion of households living in informal dwellings. Scenery Park and Need's Camp, for example, are large informal settlements with comparatively low HIV positive testing rates. However, the maps also show that Mdantsane, Duncan Village and Cambridge are all areas with high proportions of informal dwellings. Mdantsane and Duncan Village are also two of the areas with the poorest access to electricity, water and sanitation. Mza'Momhle township is another area with high proportion of informal dwellings, poor service delivery and a high HIV positive testing rate. However, the potentially poor representative of the HIV testing data implies that this information should be interpreted with caution and assessed in relation to other drivers of HIV described in the next sections of the report.

Figure 7: Health facility positive testing rate and distribution of households living in informal dwellings



Note: Health facility positive testing rate based on HIV + ANC DHIS data for Apr 2015 to March 2016 aggregated at ward level. Source: DHIS, 2011 Census, BCMM GIS unit.

In summary, comparison of the areas where there are concentrations of the 15-29 year old population and the information on HIV prevalence rates across BCMM, suggest that Mdantsane, Mza'Momhle and areas around East London are locations where there could be high HIV prevalence. Otherwise, the best that can be inferred from demographic factors is that young women who live in any of the townships and informal settlements, constitute a vulnerable population. Available demographic information on BCMM's HIV epidemic is not detailed enough to identify areas which should or could be the priority focus of bumb'INGOMSO's interventions. However, they do allude to structural drivers of the municipality's HIV epidemic, which are discussed in the following chapter.

4 Drivers of HIV in BCMM

Individual HIV infection can be seen as the outcome of a complex interplay between a number of factors, some which may be in the control of the individual (e.g. using a condom or not) and others that are not in his/her control (e.g. underlying HIV prevalence rate in the population). These two groups of factors affect the chances that an individual will be exposed to HIV, whilst the individual's existing health state will influence whether HIV transmission occurs or not. The distinction between factors that are under an individual's control and those that are not, provides the basis for a classification of drivers of the HIV epidemic as structural, behavioural, or biomedical.

Structural drivers are environmental conditions and life circumstances which predispose individuals to behaviour that directly increases the risk of HIV infection. For example, conditions which can negatively influence individuals' behaviour include the cultural context, the home and neighbourhood environments, violence (e.g. racial, physical, sexual, emotional [e.g. stigma and discrimination]), government policies (e.g. economic policies which influence work availability; health policies which influence access to health care and public health conditions), and demographic factors (e.g. population migration and mobility; urbanisation). Poverty is also sometimes identified as a structural driver in the sense that it is a proxy for individuals' circumstances such as unemployment, low socio-economic status, and low or inadequate education. Behavioural drivers refer to sexual practices (e.g. using protection or not; sex with many partners or one; age of sexual debut) which, in principle, are under an individual's control and which, in the context of an HIV epidemic and circumstances of sexual behaviour, indicate an individual's susceptibility to HIV infection. Biomedical factors relate to the health status of individuals or populations that influence the probability of infection (e.g. whether a man is circumcised; whether an individual's internal health is compromised by another illness such as an STI or by his/her diet).

In reality, the distinction between these drivers is not discrete (e.g. women often do not have control over decisions about condom use) but the concept of different types of drivers assists analysis of the challenges to curtail HIV epidemics. In the case of BCMM, there are some indicators of why the municipality has a rampant HIV epidemic and why young women face a high risk of HIV infection.

4.1 Structural Drivers

BCMM contributes 23% of GDP of the Eastern Cape and 19% of employment opportunities, primarily focused in the industrial and service sectors (BCMM, 2014). However, there is a relatively high unemployment rate (21% in 2013; narrow definition), and 65% of the unemployed are less than 29 years old (BCMM, 2015; ECSECC, 2014). An estimated 47% of BCMM population live in poverty (ECSECC, 2014). Education levels are low: 39.1% of the population has primary schooling only; 29% of people 14 years old and above are illiterate (StatsSA, 2011). These statistics indicate the range of structural drivers of BCMM HIV epidemic. The sub-sections below outline the study findings from available information that lies behind these statistics.

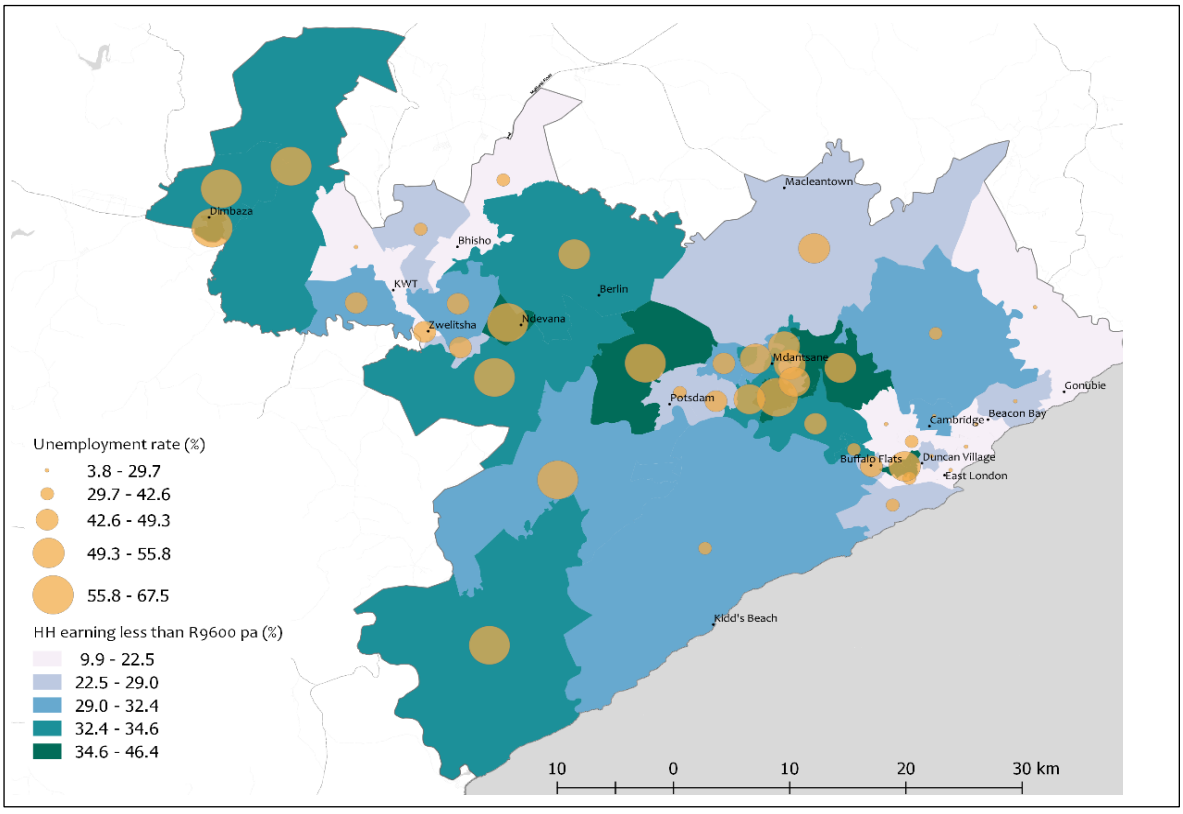
4.1.1 Poverty

Poverty is linked to HIV infection but the pathways through which it modifies individual behaviour vary from place to place and are complex. Furthermore, HIV/AIDS is not simply a disease of poverty. Poverty is a pertinent consideration in contexts of marked economic inequality. Generally, poverty influences HIV infection in two ways: by affecting individuals' biophysical health and by influencing their survival strategies.

On the one hand, malnutrition and undernutrition, repeated infection with disease and limited access to health services are common conditions facing poor individuals. Such conditions compromise the integrity of individuals' immune systems such that when an individual is exposed to HIV, there is a greater probability of infection compared to healthy individuals. In South Africa, TB is the disease frequently associated with these conditions and HIV infection. The research literature also suggests that untreated STIs, especially those that produce ulceration or inflammation of reproductive organs, cofactor infections (urinary schistosomiasis, malaria & trachoma) and undernutrition increase the transmission of HIV (Sawers & Stillwaggon, 2008). On the other hand, poverty can drive individuals to adopt survival strategies that reduce financial hardship but which threaten their health. These strategies may include transactional sex and having multiple partners, which are discussed further in the section on behavioural drivers (Gupta, 2008; Jewkes et al., 2007; Madlala, 2008).

Poverty is a reality for a large proportion of BCMM population. Figure 8 shows how unemployment rates and the proportion of households per ward that earn less than R9600 per annum vary across BCMM. Dimbaza, Ndevana, Duncan Village, parts of Mdantsane and the area between Potsdam and Berlin appear to be key areas where unemployment rates are high and many households earn a low income.

Figure 8: Unemployment rate and annual household income in BCMM



Note: Broad definition of unemployment (including discouraged work seekers) was used. Source: BCMM GIS Unit, 2011 Census

4.1.2 Education

Completion of higher secondary education is known to be a protective factor against HIV infection amongst adolescents. However, there is no certainty that education reduces risk over time, as adolescents become young adults. On the one hand, researchers have suggested that secondary education affects HIV risk in three ways. First, educational attainment improves individuals' understanding of the link between sexual behaviour and HIV transmission, thereby improving their perceptions of the risk of infection and actions to reduce that risk. Second, higher secondary

education is associated with improved socio-economic status and, therefore, reduction in the risks associated with poverty. Third, being in school itself has a protective effect due, perhaps, to a better social life, through being among peers and opportunities to associate with different peer groups compared to being out of school (Jewkes et al., 2009). On the other hand, completion of higher secondary education predicts both risk-reducing and risk-enhancing behaviours. De Walque (2009), for example records that the higher the level of school education the greater the frequency of reported condom use, HIV testing, and level of HIV knowledge but also increased incidence of infidelity and lower incidence of abstinence, and that the strength of these correlations varied from country to country.

According to the 2011 Census, only 27% of people aged 20 and above in BCMM have completed secondary schooling. The Department of Basic Education records show why this is the case. A review of the progress of the cohort of 281,073 students who started schooling in Grade 1 in 2004, revealed that only 85,254 (30%) reached Matric or Grade 12 in 2015. The largest single drop in numbers (40,171) occurred in 2014 when 85,254 out of the 125,425 students in Grade 11 progressed to Grade 12. This drop does not necessarily mean that 40,171 BCMM adolescents (17-18 years old) dropped out of school in 2014 since the school system allows students to repeat grades. However, the indications are that BCMM has a large population of adolescents who do not have adequate basic education and who have dropped out of school.

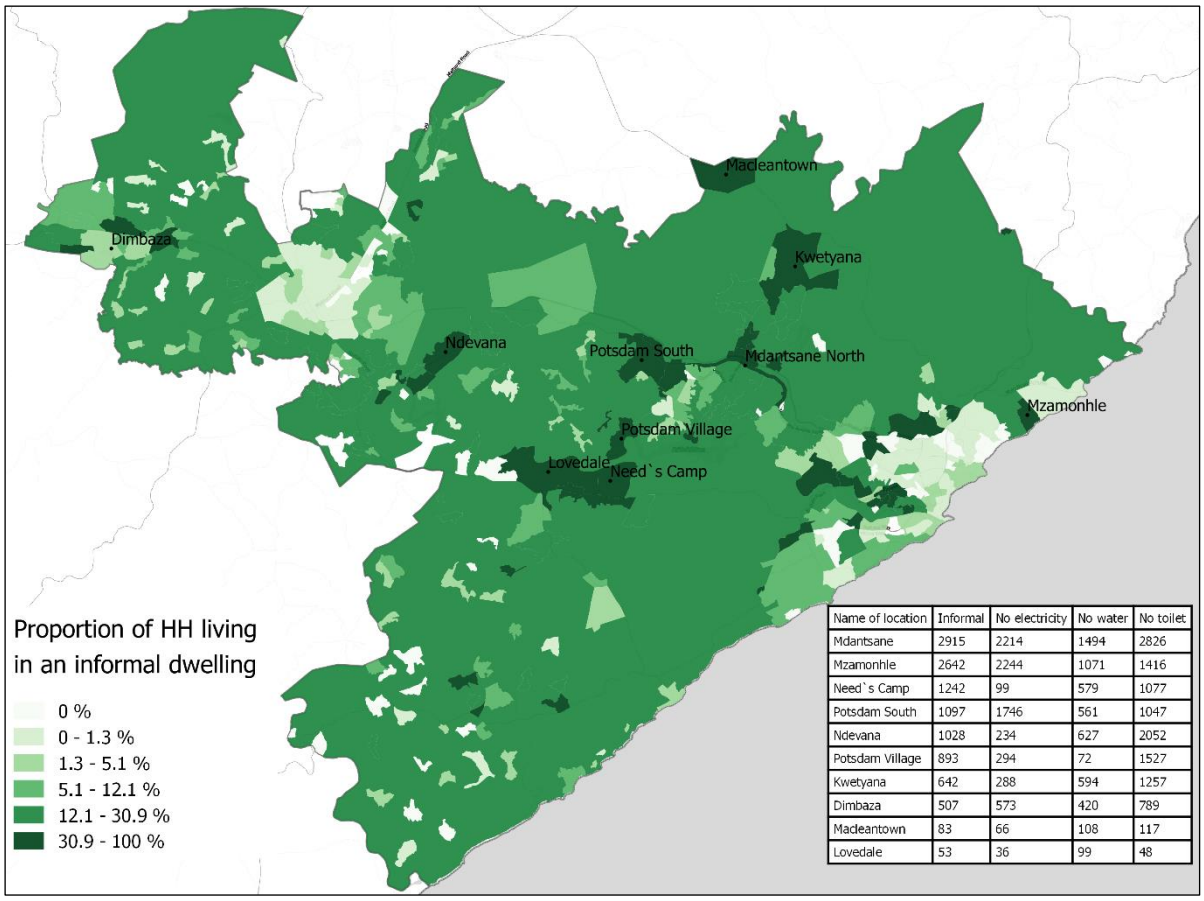
4.1.3 Socio-economic status

Socio-economic status is a composite indicator of an individual's social standing which is linked to their vulnerability. An individual's social standing is usually defined in terms of their level of education, income, social networks, employment, social connectedness and gender (Barnighausen et al., 2007). The lower the socio-economic status, the higher the vulnerability of an individual in terms of limited access to information and to services, lack of income and likelihood of experiencing discrimination. These circumstances, in turn, constrain individuals' opportunities and can negatively affect their behaviour. Living in informal settlements is a common indicator of this vulnerability.

As was noted earlier, BCMM has approximately 154 informal settlements that house over 90,000 people 12% of the population. In addition, the number of informal dwellings in BCMM is even greater. According to the 2011 census, 49,698 of dwellings in BCMM are informal (10,854 shacks located in backyards and 38,844 shacks not located in backyards). This constitutes 22.7% of dwellings in BCMM (StatsSA, 2011). One reason that the proportion of informal dwellings may be higher than the proportion of residents in informal settlements is that informal dwellings may also be located in otherwise more formal townships, such as Mdantsane.

Two factors indicate that low socio-economic status is a significant structural driver of BCMM's HIV epidemic. Firstly, in South Africa, generally, HIV prevalence rates are nearly twice as high in formal settlements and nearly a third of all new infections occur in the populations of informal settlements (SANAC, 2011; Shisana et al., 2014). Secondly, a larger proportion of BCMM's residents live in 'slum-like' conditions than is suggested by the number who live in informal settlements. In this instance, the indicators are the number of dwellings/houses which lack water, electricity and toilets. These are officially defined as 'informal dwellings' (HSRC, 2010; HDA, 2013; SACN, nd.). While the vast majority of dwellings are 'informal' in informal settlements, the 2011 national census survey revealed that there are large numbers of these dwellings in formal settlements; for example, 2,915 such dwellings in Mdantsane and 2,642 in Mza'Momhle. Figure 9 and Figure 10 illustrate the census findings.

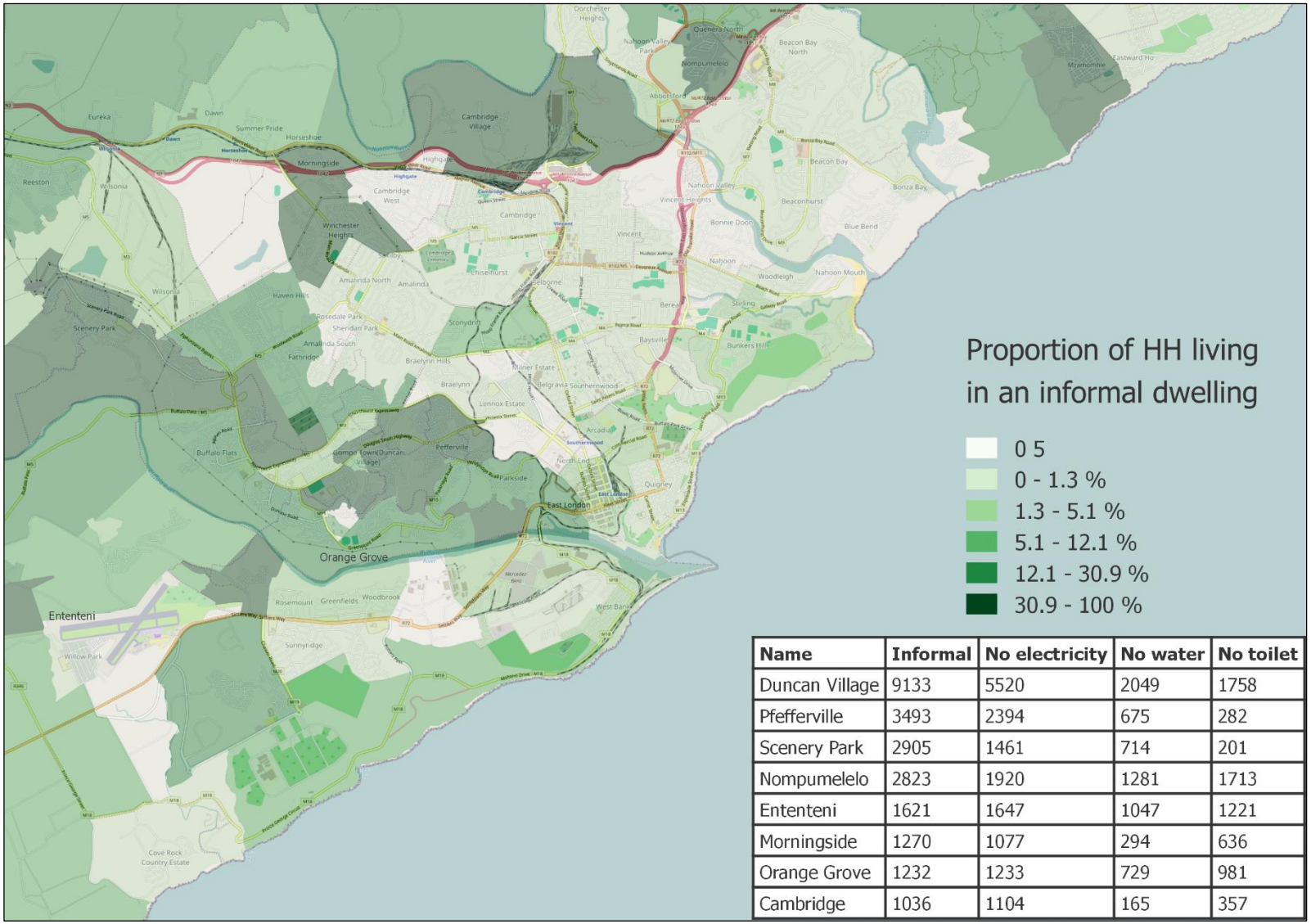
Figure 9: Proportion of households living in an informal dwelling in BCMM (excl. East London)



Name of location	Informal	No electricity	No water	No toilet
Mdantsane	2915	2214	1494	2826
Mzamonhle	2642	2244	1071	1416
Need`s Camp	1242	99	579	1077
Potsdam South	1097	1746	561	1047
Ndevana	1028	234	627	2052
Potsdam Village	893	294	72	1527
Kwetyana	642	288	594	1257
Dimbaza	507	573	420	789
Macleantown	83	66	108	117
Lovedale	53	36	99	48

Notes: 'Informal' – number of households within the area that live in an informal dwelling. 'No electricity' – no access to electricity as a source of lighting. 'No water' – no access to piped water within the dwelling or within 200m of the dwelling. 'No toilet' – no access to a flush toilet or to a pit latrine with ventilation. Source: 2011 Census.

Figure 10: Proportion of households living in an informal dwelling in East London only



Name	Informal	No electricity	No water	No toilet
Duncan Village	9133	5520	2049	1758
Pfefferville	3493	2394	675	282
Scenery Park	2905	1461	714	201
Nompumelelo	2823	1920	1281	1713
Ententeni	1621	1647	1047	1221
Morningside	1270	1077	294	636
Orange Grove	1232	1233	729	981
Cambridge	1036	1104	165	357

Notes: 'Informal' – number of households within the area that live in an informal dwelling. 'No electricity' – no access to electricity as a source of lighting. 'No water' – no access to piped water within the dwelling or within 200m of the dwelling. 'No toilet' – no access to a flush toilet or to a pit latrine with ventilation. Source: 2011 Census.

BCMM's own records show that the availability of formal housing has increased in the last decade and now constitutes approximately 60% of all housing types whilst informal dwellings now constitute 22% of all housing types as opposed to 29% in 2001. However, only 24% of BCMM's residents have piped water in their homes, only 17% have piped water in their yards and, while the nearly 70% of the population now has access to flush toilets, the statistics do not indicate what percentage of the population shares access (i.e. how many use communal flush toilets – a feature of some townships).

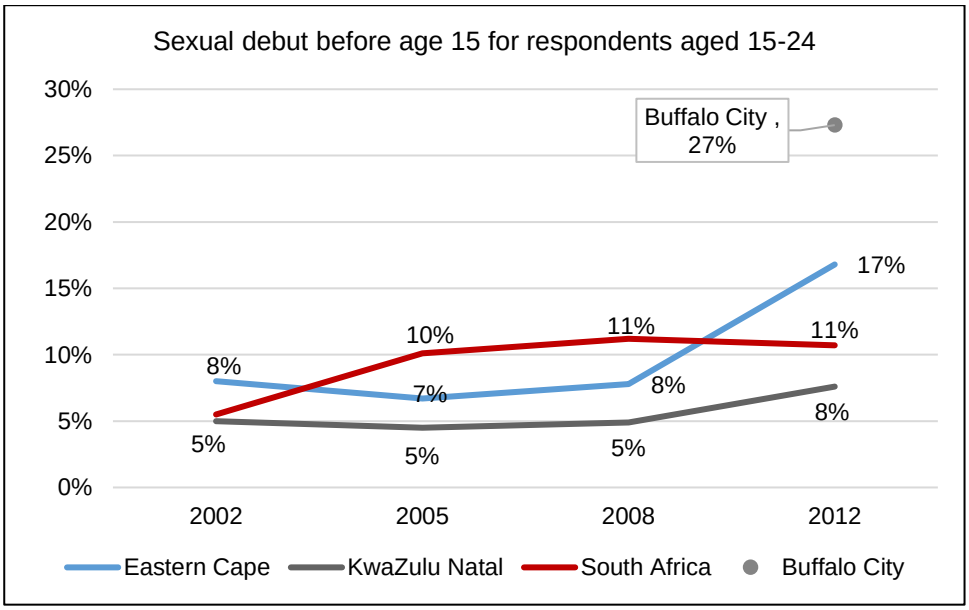
4.2 Behavioural Drivers

Commonly cited behavioural drivers of HIV are inconsistent condom use, early age sexual debut, multiple and concurrent sexual partnerships, age disparate sexual relationships, transactional sex, high alcohol consumption, recreational drug use and abuse, and individuals' perception of their risk of getting infected. This study found very little information on HIV behavioural drivers in BCMM. There is some BCMM specific data on early age sexual debut and age disparate relationships. There is some fragmentary information on inconsistent condom use from surveys in the Eastern Cape which probably included informants in BCMM.

4.2.1 Early age sexual debut

The 2012 national HIV Prevalence, Incidence and Behaviour Survey records that early age sexual debut could be a potential driver of HIV in the Eastern Cape (Shisana et al., 2014). The study shows that the proportion of respondents who reported that they had had sex before the age of 15 years, is highest among 'black African' women and among respondents in informal settlements, whether these were urban or rural. Notably, the Eastern Cape as a whole had the largest proportion of respondents (16.8%) reporting that they engaged in sex before the age of 15 years (Gauteng, 9.5%; Mpumalanga: 7.7%; KZN: 7.6%), and the figure for BCMM is substantially higher than the provincial average (27%; see Figure 11). Furthermore, in the Eastern Cape, there has been a large increase in the proportion individuals reporting early age sexual debut; in 2002, 7% of the sampled population reported early age sexual debut compared to 17% in 2012 (ibid).

Figure 11: Trends in self-reported age of sexual debut in South Africa



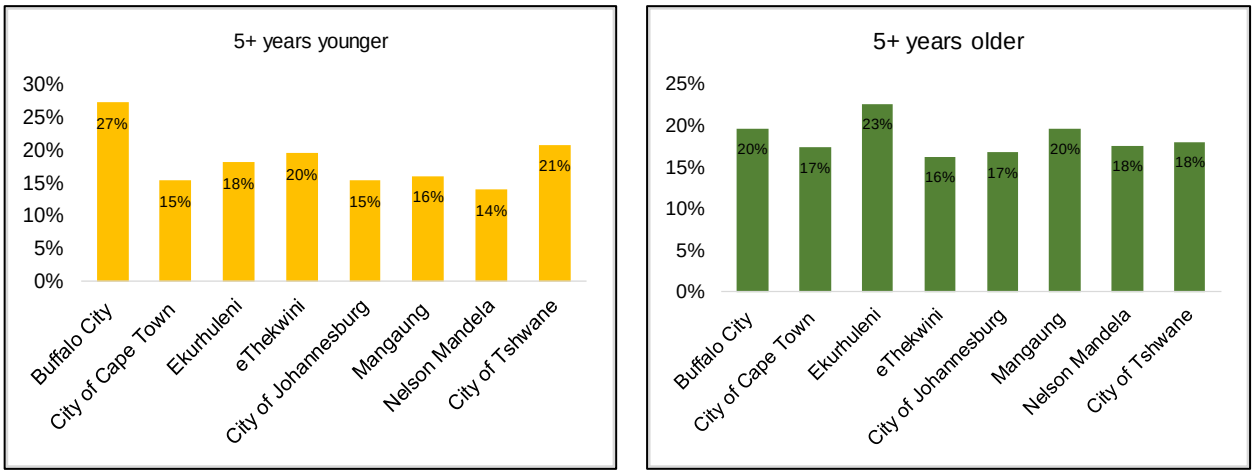
Source: Shisana et al, 2014:67

4.2.2 Age disparate sexual relationships

Questions on age disparate sexual partnerships (sex with a person 5 or 10 years older or younger than oneself) are often asked in behavioural surveys on the premise that older men are infecting adolescent girls and young women. Such questions are also asked as an indication of unequal power dynamics within these relationships. For example, they may provide an indication of transactional sexual relationships in terms of young women exchanging sex for material security from older men (e.g. 'blessers' in popular discourse in SA).

Of the nine metropolitan areas in South Africa, BCMM has one of the highest rates of age disparate sexual relationships, as reported in the 2012 HIV Prevalence Survey (op cit.). Approximately 20% of respondents in BCMM reported having a sexual partner who is five or more years older than themselves, while 27% reported having a partner five or more years younger (Figure 12). These findings refer to respondents aged 15 years and older (i.e. not only to young people) and are for males and females collectively. Results from the Eastern Cape component of the third national HIV Communications survey in 2012 (Johnson et al., 2012) recorded that 31% of women aged between 16 and 24 years in the province reported having a sexual relationship with a man 5 or more years older than themselves (Johnson et al., 2012).

Figure 12: Trends in age disparate relationships in South Africa and BCMM



Note: The data represent age-disparate relationships among respondents aged 15 years and older who have had sex in the past 12 months. Source: Shisana et al., 2014:81.

4.2.3 Inconsistent condom use

Condoms are the most effective device for preventing HIV infection from sexual intercourse. There is some indication that sexually active, young adolescents (13/14 -18 years old) in BCMM do not use condoms consistently. The 2011 National Youth Risk Behaviour Survey reported that 28.7% of teenagers at school in grades 8 to 11 in the Eastern Cape reported consistently using condoms. Reported consistent use increased by school grade (Reddy et al., 2013).[4] Results from the national 2012 HIV Communications Survey cited above (Johnson et al., 2012), record that in the Eastern Cape, 58% and 48% of 16-19 year old boys and girls respectively, reported using a condom during their last sexual intercourse. The highest reported condom use (across age bands covering 16-55 year old informants) was amongst 20-24 year old adults (men: 71 %; women: 57%). In other words,

[4] Condom availability seems not to be a problem. An average of 42 condoms were distributed for every male aged 15 and older in BCMM during 2015; the national average was 38 condoms/man/district (Massyn et al., 2015).

the intimation is that condom use is not common practice amongst adolescent girls and young women in BCMM.

4.2.4 Other HIV behavioural drivers

This study did not find BCMM-specific information on transactional sex and only fragmentary information on multiple and concurrent sexual partnerships and perceptions of HIV risk. Johnson et al (2012) find that 7% of respondents in the Eastern Cape reported having multiple and concurrent sexual partnerships. Approximately 2% of women reported these partnerships, and 20-24 year old men reported having these relationships more frequently than men and women in other age groups.[5]

With regard to transactional sex, surveys in rural locations in the Eastern Cape have recorded that one in six men reported the transfer of material resources or money to both casual and their main partners (Dunkle et al., 2007). In addition, 25% of women and almost 30% of men said they had had transactional sex (Jewkes et al., 2008).[6]

With regard to perceptions of HIV risk, we did not identify BCMM-specific research. One factor associated with low perceptions of HIV risk is inadequate knowledge of HIV or of protective behaviours. A national survey on HIV-related knowledge, attitudes and behaviours amongst TVET students and staff, revealed very low levels of awareness of services on their campuses. Just under a tenth (9.5%) of respondents were aware of the HCT services, 20% were aware of condom distribution, and 22.1% were aware of HIV and AIDS related information that was available (Mbelle et al., 2014).[7]

4.3 Biomedical drivers

Again, the study did not find BCMM-specific information on biomedical drivers. There is some information on STIs in relation to male circumcision from research conducted elsewhere in the Eastern Cape and on HSV-2 (Herpes) infection from a national pilot study. A 2008 study (Pelzer et al., 2008) reported that 9% of young men in the survey had been diagnosed with an STI in the 12 months leading to circumcision, 15% reported at least 3 lifetime partners, and 38% were not using

[5] Concurrent multiple sexual partnerships are linked strongly to HIV infection in South Africa and elsewhere. Concurrent partnerships infer a potentially large sexual network of individuals (e.g. if one individual has two or more partners and the latter also have two or more partners). This allows transmission of the HI-virus to many people once one person in that network is infected. Furthermore, transmission can be rapid through the network because of the probability that the infected individual will infect another during the period that the viral load is at its highest (for 2-3 months after moment of infection). Mathematical modelling has shown that HIV prevalence rates grow exponentially in these networks (Morris and Kretzschmar, 2000).

[6] Transactional sex is the exchange of favours, gifts or money in exchange for sex. In this context, it refers to sexual relationships in which women obtain money or gifts to meet basic needs such as food or consumer goods such as cellphones and clothing, and often through relationships with two or more men. Likewise, men, sometimes considerably older men, use their relative wealth to have relationships with several women. There are inherent high risks of HIV transmission in these relationships due to their concurrency and, frequently, inconsistent condom use (Choudry et al, 2015; Dunkle et al, 2004; Nancy, 2005; Wojcicki, 2002; Phaswana-Mafuya et al. 2014).

[7] Various studies in southern and sub-Saharan Africa have revealed that young people frequently perceive that they are unlikely to be infected (Barden-O'Fallon et al., 2004; Macintyre et al, 2004; MacPhail & Campbell 2001). One identified reason for these perceptions is that individuals deny or downplay the risk of infection in view of the social stigma arising from admitting they are at risk. Admission of risk implies being sexually active which itself carries the threat of social stigma, as does the possibility of being perceived to have been infected (Kalichman et al., 2005; Macintyre et al, 2004; Maughan-Brown 2006). Another reason is inadequate knowledge of HIV/AIDS. For example, one study conducted in the Eastern Cape reported that 200 (65%) respondents in a sample of 308 individuals which did not believe they would be infected because they didn't have sex with prostitutes and/or did not share needles (Johnson, Kincaid, Laurence et. al., 2010). A third possible reason, highlighted in research amongst South African miners, is that individuals view other life risks as more significant, such as work dangers in the case of miners (Jewkes et al. 2010).

condoms consistently. With regard to HSV-2 infection, a pilot study in Gauteng, KwaZulu-Natal, Northern Cape and Western Cape in 2012, the prevalence of HSV-2 was estimated at 55.8%, albeit with significant differences among the provinces (e.g. 60% in KwaZulu-Natal and 46% in the Western Cape (HSRC, 2012). The same pilot showed that among women attending antenatal sites, 89% of those that were HIV positive, also tested positive for HSV-2, compared to 43% who tested positive for HSV-2 but negative for HIV.[8]

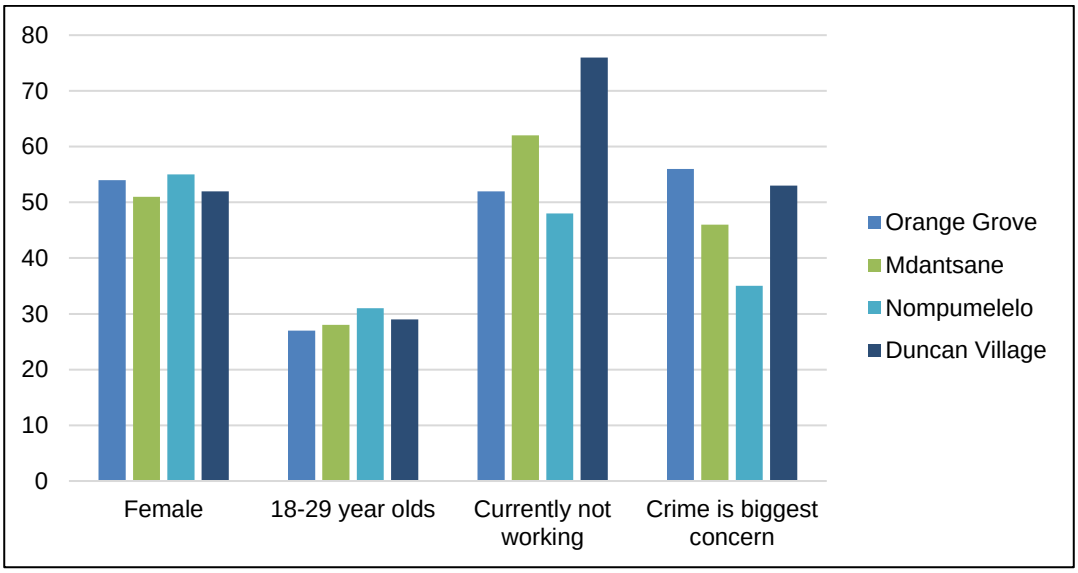
4.4 Summary

Although there is limited information on the drivers of BCMM's HIV epidemic, there is enough evidence to support the assessment in Chapter 3 that young people, and adolescent girls and young women in particular, are a very vulnerable population. Two out of three unemployed persons are under 29 years old. Nearly a third of the municipality's population are illiterate and there are indications that there is a large number of adolescents who have either dropped out of school or who do not complete their secondary education. There is a large population of adolescents and young adults who live in slum environments; an intimation being that they live in difficult circumstances which has a negative influence on their behaviour and life strategies. Indications of that influence amongst adolescent girls and young women, include one in three, between 16 and 24 years old (in the province, in 2012) reporting sexual relationships with a man 5 or more years older than themselves and that condom use is not common practice. In other words, the intimation is that many adolescent girls and young women engage in transactional sexual relationships with the attendant high risk of HIV infection and that these are fundamentally unequal relationships which, as is discussed in the following chapter, contribute to the high levels of violence against women in the municipality.

This summary infers a lot from the limited information on the living conditions and HIV drivers of adolescent girls and young women in BCMM. This reflects the inherent difficulty for scientific research to quantify behavioural risk and vulnerability in any setting because of the complexity of the factors that need to be taken into account. HIV 'drivers' are a case in point: 'drivers' is an imprecise concept but it directs attention to, and distinguishes, the multitude of factors to be considered in planning HIV interventions. This is illustrated by a 2010 Human Sciences Research Council (HSRC) study of informal settlements in the Eastern Cape, four of which were located in BCMM (HSRC, 2010). The significant findings, for purposes of bumb'INGOMSO and as is illustrated in Figure 13, were that approximately 50% of the residents were women, 30% of residents being between 18 and 29 years old, the very high unemployment rates amongst women, and crime (including domestic violence) being highlighted as a significant problem by many residents (and by a majority in Orange Grove and Duncan Village). In other words, the findings indicate particular life challenges faced by young women living in BCMM's informal settlements and, in turn, allude to why young women are a 'high HIV risk' population.

[8] Herpes Simplex Virus – 2 infection is strongly correlated with HIV infection in South Africa

Figure 13: Illustration of Structural and Behavioural HIV Drivers in four BCMM informal settlements



Source: HSRC, 2010.

5 Highly vulnerable groups – women who experience gender-based violence, female sex workers and incarcerated offenders

5.1 Violence against women (VAW)

VAW refers to violence on the basis of their sex and/or sexual disposition, ranging from physical beatings to rape, to emotional abuse which minimises victims' capacity to make sound personal decisions about their lives and health. VAW is a known, significant problem in South Africa. Confronting and curbing VAW requires recognition of the complex nature of the problem and interventions to change people's social environments alongside interventions to change the behaviour of individual men and women.

Bumb'INGOMSO involves interventions to curb VAW as the latter is an indicator of risk of HIV infection for both perpetrator and victim, as we explain later. VAW is also an indicator of women's vulnerability in terms of limiting individual autonomy, or their freedom to determine one's own physical, mental, reproductive and sexual health. This lack of autonomy, in reality, for young women, is reflected in experiences of coercive sex, unintended pregnancies and, consequently, heightened potential for negative social and economic repercussions such as inability to complete their education and to obtain formal employment (Wood et al, 1997; 2008). Furthermore, VAW is a significant feature of the burden of care on South Africa's public health system (Smythe et al, 2004). Smythe et al.'s (2004) report cites a 2002 study which showed that 53% of women who suffered 'physical domestic abuse sought medical assistance after the incident' (*op cit*; 168).

Research has found extremely high levels of violence against women, particularly intimate partner violence (IPV). A study in Cape Town for example, found that 86% of young women had experienced IPV in the 12 months preceding the survey (Zembe et al, 2015). The same pattern was observed in Durban, where IPV in informal settlements was 3-5 times higher than the national averages (Jewkes, et al, 2011; Jewkes et al., 2014). In view of the discussion in chapter 4, the evidence suggests that women bear the brunt of the HIV behavioural and structural drivers in South Africa, particularly women who live in informal settlements (Gibbs, 2016; Kamndaya et al, 2014).

However, there is a lack of data generally, and of recent data on VAW in BCMM. Much of the text for this chapter relies on the limited and relatively old data from research conducted in the Eastern Cape and not specifically in BCMM. With regard to general indication of the scale of the problem, an old study (circa 1999/2000), albeit a large random survey across South Africa, indicated that "26.8% of women aged between 18 and 49 in the Eastern Cape reported having been physically abused by a current or ex-partner, 10.9% within the last year, and a third of this latter group reported having been injured" (Wood et al., 2008).

Official reports do not provide a clear picture of the matter for several reasons. First, VAW is addressed, in principle, via the Domestic Violence Act by which domestic violence covers a wide range of abuse: physical, sexual, emotional, economic (depriving family members of resources they have a right to) and psychological (including repetition of acts which humiliate and cause mental distress and also acts inspired by jealousy and possessiveness which restrict individuals "privacy, liberty, integrity or security") (ISS, 2014). Furthermore, the South African Police Service is constitutionally committed to providing support and care for any person who makes a complaint about such abuse (SAPS, nd). However, 'domestic violence' is not a statutory crime category. Legal interventions are defined by the Criminal Offences Act whereby statutory crimes such as assault, grievous bodily harm (GBH), rape and homicide are the basis for investigating and reporting domestic violence cases. Consequently, official reports do not record domestic violence per se but

incidents of those crimes.[9] Justice department records provide some insight in terms of providing statistics of protection orders issued each year (between 200,000 and 220,000 in recent years) (ISS, 2014; Parliament RSA, 2013).

Secondly, police statistics suggest a marked decline in crimes that are associated with VAW; for example, common assault by nearly 50% between 2003 and 2015, grievous bodily harm (GBH) by 40% in the same period, and rape by 7% between 2008/9 and 2014/15 (ISS, 2015). The number of cases are still very large; for example, in 2014/14: 161,486 cases of common assault, 182,556 GBH cases, 43,195 rapes cases) (ISS,2015). Statistics from the Eastern Cape and BCMM showed a remarkable decrease in reported rapes in some areas between 2014 and 2015; for example, Grahamstown 188 reported rapes to 73; Duncan Village 140 to 81; Vulindlela 121 to 83; Mdantsane 157 to 124; King Williamstown 81 to 62; Gonubie Police station 60 to 33 cases; Inyibiba Police station 67 to 59; Buffalo Flats 49 to 47 (Masimanyane, 2015).10

Thirdly, research studies in different localities indicate that there is substantial under-reporting of domestic violence and VAW to the police (Gender links, 2014; ISS 2015; Tshwaranang Legal Advocacy Centre, 2015). Furthermore, the police lack resources (e.g. only 72 forensic social workers in the country; few stations have 'victim friendly rooms' for providing care and support from a complainant; Wakefield, 2014) and, potentially, SAPS performance targets to reduce crime levels leads to under-reporting and investigation of crimes associate with GBV (ISS,2015).

5.1.1 The scale of VAW in BCMM

In 2015, Masimanyane, which runs 14 women's support centres throughout the Eastern Cape and several in BCMM, reported that it had provided 14,350 psychological counselling sessions during the year. This amounts to an average of 39 sessions (2-3 in each centre) per day for every day of the year. Masimanyane is one amongst approximately 42 NGOs in the province and 7-10 in BCMM that provide care and support for violated women. This is possibly as accurate testimony of the scale of VAW in BCMM as is possible.

Other statistical records that attempt to distinguish the different forms of VAW confuse rather than clarify the situation. For example, the 2012 report on BCMM Human Development Indicators (ECSECC, 2012) reveals that incidents of 'sexual crimes' were increasing in the province though decreasing nationally and yet the rates in BCMM were lower than the national and provincial rates. However, the report's definition of sexual crime, presumably drawn from the South African Police Service (SAPS), is that it "includes rape (updated to the new definition of rape to provide for the inclusion of male rape), sex work, pornography, public indecency and human trafficking". Inevitably, these statistics include incidents which do not refer to VAW (e.g. reported cases of solicitation [sex work] and some forms of public indecency) whilst obscuring coercive sex compelled by physical and/or emotional abuse which is a sexual offences and which is one aspect of domestic violence. In 2014, the ECSECC reported that the rate of sexual offences in BCMM (207 per 100,000 people) was higher than the national rates (120 per 100,000 people) and provincial averages (193 per 100,000 people) (ECSECC, 2014).Furthermore, SAPS 2015 statistics compared to the 2014 statistics reveal substantive decreases in reported rape cases throughout the province and in BCMM.

This varied information presented challenges for this study's analysis of available information on sexual offences in BCMM. Figure 14 shows the reporting of sexual offences in BCMM, relative to

[9] SAPS stations are supposed to keep a register of reported cases of domestic violence and the SAPS is supposed to produce monthly reports on incidences. However, they are not available and the statistics are not presented in SAPS reports (Parliament RSA, 2013).

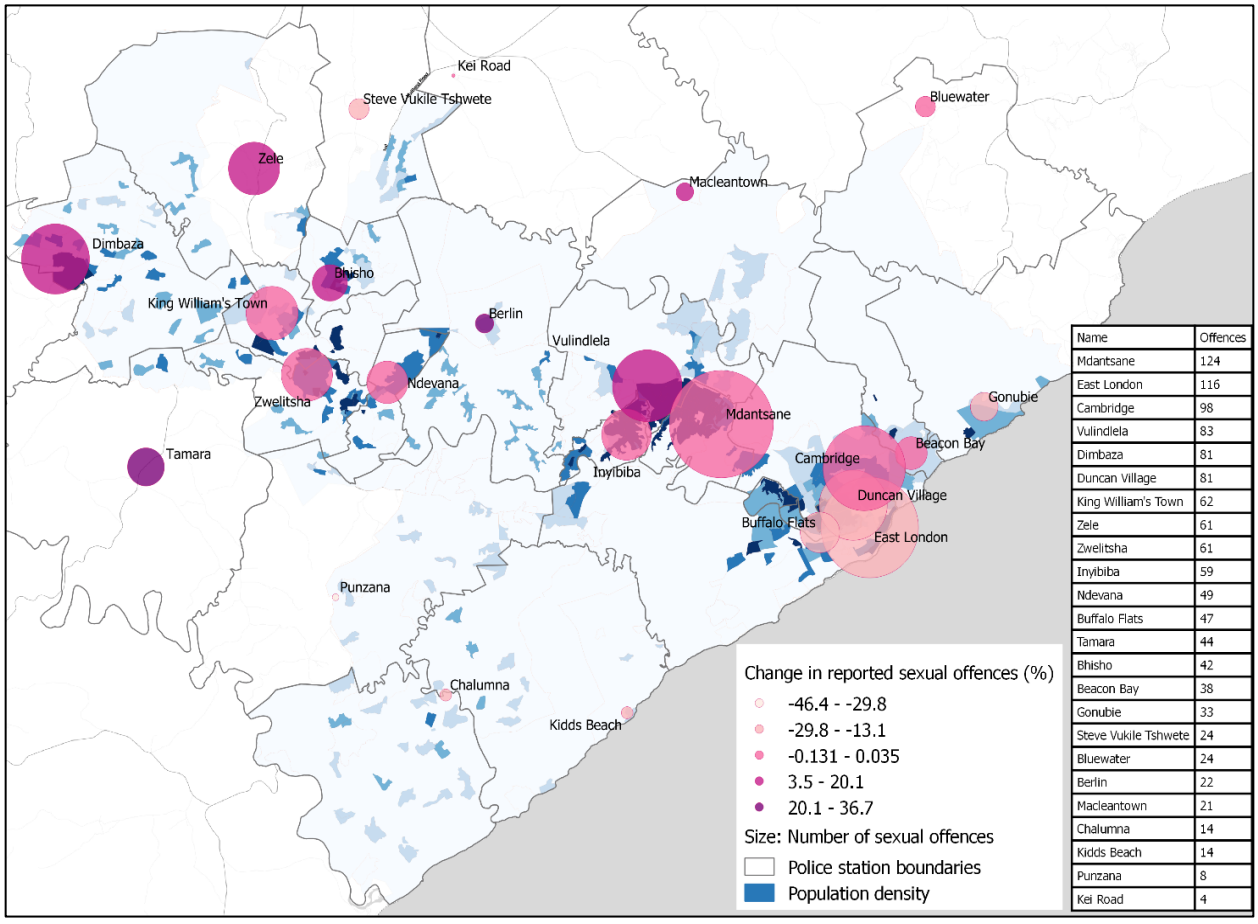
[10] The Masimanyane report is unclear on the statistics for East London. The relevant sentence reads: "Beacon Bay saw 7 less cases, East London reported 6 while Inyibiba Police station reported 59 rapes down by 8 on the previous year." The inference is six less cases but it could be six cases in total.

population density. The size of the circles is indicative of the number of sexual offences reported to that police station during 2014/2015 according to SAPS data, with larger circles representing higher numbers of sexual offences. The colour of the circle shows how the number of sexual offences reported has changed over the past two years, with darker colours indicating the largest increase in the number of sexual offences reported at the police station.

In 2015, the highest number of sexual offences were reported to the Mdantsane, East London and Cambridge police stations. In general, reporting of sexual offences is far higher in the urban areas of BCMM. This is to be expected due to the larger number of people living in these areas. For reasons described earlier in the discussion of VAW and HIV, these data are somewhat difficult to interpret as the definition of sexual offences is broad, ranging from sex work to domestic violence and rape. This is likely to be one of the reasons for higher reporting in urban areas where sex work is more prevalent.

While the reporting of sexual offences in the areas around East London appears to have decreased in the past two years, the number of sexual offences reported in the areas around Mdantsane has stayed the same or increased. Sexual offence reporting in Dimbaza, Bisho and Berlin has also increased over the past two years. This information should be interpreted with caution, as there is no suggestion for the causes for these trends. For example, a new police station has opened recently in Scenery Park and recorded 41 sexual offences in 2014/2015. Adding this figure to the number of offences reported to the East London police station, the number of sexual offences has remained about the same over the past two years, rather than showing a slight decrease.

Figure 14: Reporting of sexual violence across BCMM

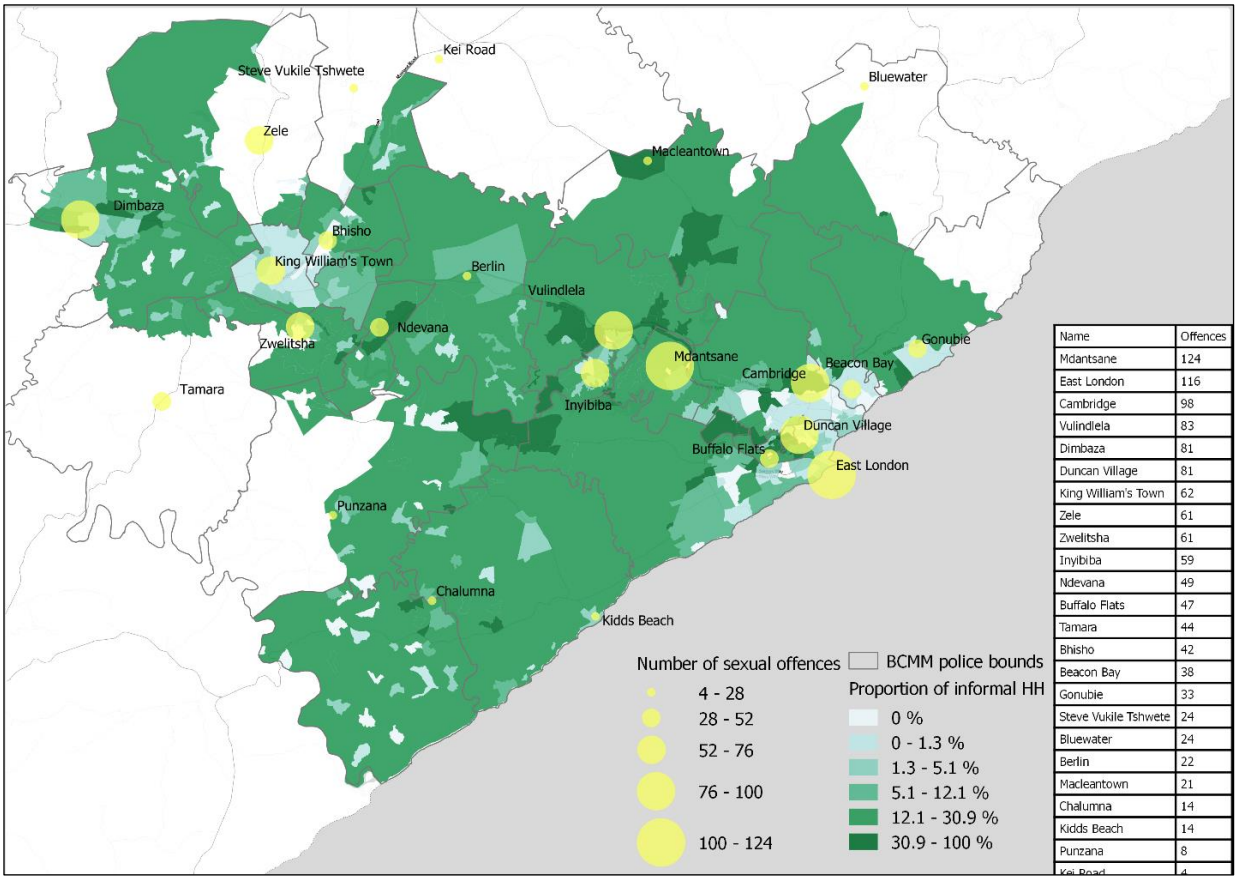


Name	Offences
Mdantsane	124
East London	116
Cambridge	98
Vulindlela	83
Dimbaza	81
Duncan Village	81
King William's Town	62
Zele	61
Zwelitsha	61
Inyibiba	59
Ndevana	49
Buffalo Flats	47
Tamara	44
Bhisho	42
Beacon Bay	38
Gonubie	33
Steve Vukile Tshwete	24
Bluewater	24
Berlin	22
Macleantown	21
Chalumna	14
Kidds Beach	14
Punzana	8
Kei Road	4

Note: 'Change in reported sexual offences (%)' – average change in the number of sexual offences reported to the police station between 2013 and 2015. 'Offences' – number of sexual offences reported to the police station in 2014/2015.
Source: BCMM GIS unit, SAPS.

Figure 15 shows the number of sexual offences reported in relation to the distribution of informal settlements. Mdantsane, Cambridge and Duncan Village have high reported numbers of sexual offences and also have high proportions of informal settlements and informal dwellings. These are the areas that have already been highlighted as pockets of HIV risk and, therefore, there is an intimation that sexual violence may be a further structural driver of HIV in these areas but not necessarily elsewhere. The high number of sexual offences reported in central East London is likely in part to be related to the presence of sex workers (i.e. the figures probably include solicitation as an offence).

Figure 15: Number of sexual offences in relation to location of informal settlements



Name	Offences
Mdantsane	124
East London	116
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Vulindlela	83
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Buffalo Flats	47
Tamara	44
Bhisho	42
Beacon Bay	38
Gonubie	33
Steve Vukile Tshwete	24
Bluewater	24
Berlin	22
Macleantown	21
Chalumna	14
Kidds Beach	14
Punzana	8
Kei Road	4

Note: 'Proportion of informal HH' – proportion of households in the area which are informal. 'Number of sexual offences' – number of sexual offences reported to the police station in 2014/2015. Source: 2011 Census, BCMM GIS unit, SAPS.

5.1.2 The nature and the socio-economic determinants of VAW in BCMM

This section extrapolates findings of research studies on VAW and evaluations of a prominent GBV intervention, the Stepping Stones program, which have been conducted at various sites across South Africa, including urban sites in the Eastern province but, to our knowledge, not in BCMM. Our assumption is that these studies have been conducted in settlements not dissimilar to those where VAW is rife in BCMM; that is, in poor rural villages and urban slums.

The challenge for interventions is that the phenomenon of VAW is not simply an expression of innate male masculinity (i.e. as a natural or primordial male characteristic) coupled with a breakdown in social norms of behaviour, nor of a breakdown of social norms alone, nor is it explainable in these terms. Such explanations are, at root, contradictory (VAW is not universally practised by all men; VAW, as a large-scale phenomenon, reflects particular social norms of behaviour in particular settings at particular moments/periods in time, and it occurs within socially ordered settings). The

consensus of research in South Africa and elsewhere (Bower and Abrahams, 2015; Dunkle et al, 2007; Higgins et al, 2010; Jewkes et al 2008; Jewkes et al, 2010; Jewkes and Morrell, 2011; MRC-UNISA, 2004) is that:

VAW is a manifestation of efforts by men living in circumstances where their own identities and sense of self are threatened (by poverty and/or living conditions such as densely populated settlements with poor housing and services) to exert control of their own existence and that of other men and women;

Some aspects of VAW, notably physical beatings of women by men, is perceived as 'normal' within the populations of young men and young women (and adolescents) in settlements where VAW is rife;

Interventions to curb VAW in particular, and GBV generally, notably Stepping Stone programs, have been successful to the extent of reducing the incidence of violent acts by men but not in changing the underlying gender norms and values amongst both perpetrators and victims about the dominance of men and the subordinate status of women.

To illustrate, Jewkes and Morrell (2011:1), in a paper based on an evaluation of the Stepping Stones program in South Africa, summarised their analysis in the following terms:

"Agency was most notable in particular stages of the dating 'game', especially relationship initiation. Constructions of desirable men differed but generally reflected a wish to avoid violence, and a search for mutual respect, sexual pleasure, romance, modernity, status and money. Agency was constrained once relationships were consented to, as men expected to control their partners, using violent and non-violent methods. Women knew this and many accepted this treatment, although often expressing ambivalence. Many of the women expressed highly acquiescent femininities, with power surrendered to men, as a 'choice' that made their lives in cultural terms more meaningful. In marked contrast to this was a 'modern' femininity, centred around a desire to be 'free'. A visible third position, notably emerging after the Stepping Stones intervention, rested not on a feminist challenge to patriarchy, but on an accommodation with men's power whilst seeking to negotiate greater respect and non-violence within relations with men."

The pertinence of the above for bumb'INGOMSO is that while VAW is a known HIV risk indicator interventions to curb VAW do not unequivocally reduce that risk:

"Participation in the Stepping Stones programme in South Africa did not reduce the incidence of HIV infection among young men and women aged 15/26 but was associated with a reduced incidence of herpes simplex type 2 (HSV-2). There was no evidence of any desired behaviour change in women. There was more transactional sex with a casual partner at 12 months (but not at 24 months) among women in the Stepping Stones arm, and there was a suggestion of more unwanted pregnancies at 24 months. Men in Stepping Stones reported less transactional sex at 12 months, less perpetration of intimate partner violence (significant at 24 months, suggested at 12 months), less problem drinking at 12 months, and less drug misuse at 24 months. There was a suggestion of change in several other outcomes in men, including fewer partners at 12 months, less likelihood of casual partners, less rape at 12 months, and less depression at 24 months" (Jewkes et al., 2008)

Research findings and the reports of NGOs reflect the fact that a variety of social and economic factors a) perpetuate VAW, b) sustain high risk of HIV infection amongst perpetrators and victims, and c) reduce effectiveness of interventions. These factors include lack of education – many perpetrators and victims include adolescents and young adults who dropped out of school, of employment, of knowledge about laws designed to protect people against violence and about public services to provide care and support (Wood et al, 2008; Nduna and Jewkes, 2012; Jewkes et al,

2012). Intertwined with these factors are others such as the living conditions in slums, high rates of depression amongst young people as a result of diverse causes; for example, being orphaned and brought up in urban homes by relatives or being brought up by those relatives due to poverty of parent(s) in rural homes; insecure lives due to frequent experience of lack of food, clothing, intermittent school attendance, and, for orphans, loss of inheritances of land and/or houses of parents or other parental investments to adult relatives, and experience of the social stigma of poverty (Nduna and Jewkes, 2012). In other words, VAW, risky sexual behaviour and the associated spread of HIV are, in part, a function of the social environments in which people are reared and live. To this, we add that these environments are recreated daily throughout South Africa through the proliferation of 'informal' urban and rural settlements', and at rates beyond the capacity of the government to provision with adequate services.

These environments foster daily activities and life strategies which include acquiescence to violence in social relationships and which encourage sexual behaviour that exacerbates the risks to individuals' physical, mental, sexual and reproductive health. The underlying issue here is the development of what is perhaps, predominantly an urban sub-culture which 'resists' the efforts of civil society organisations, the police, judiciary, health and welfare services to change that culture. Put differently, the wide array of legal and social mechanisms to protect and improve people's welfare and, more broadly, to entrench appreciation of people's human rights, of the ethos of equality, and of the variety of services available, are relatively ineffective in changing the environmental conditions and many individuals' life strategies in the settlements where VAW is rife. This helps to explain the disjunction between official statistics of crimes associated with VAW and research studies and NGO reports on the high levels of VAW in many settlements across the country. Wood et al (2008:59) provide an apt illustration:

"Despite attempts to implement legislation aimed at making the process of reporting domestic violence easier for women, local police often encouraged the woman merely to "report" the incident rather than formally "open a case"—a distinction that is not recognized in law or police codes of practice. Local township police, aware of the cultural pragmatics of male persuasion (whereby men reframed their actions to their partners), were far more likely to slap the accused around or force him to do push-ups as a warning than to arrest him, or else often advised the woman concerned to return the next day should her determination to open a case still be solid."

5.2 Female sex workers in BCMM

The vulnerability of women outlined above is exacerbated in the case of female sex workers. This is due to the marginal existence of sex workers (male and female) in South Africa. Scheibe et al (2016: 166) summarise the situation succinctly:

"The context of sex work in South Africa places sex workers – referred to here as adults who consent to the sale of sex – on the periphery: individuals involved in the sale of sex in South Africa are criminalised; are particularly vulnerable to illness, sexually transmitted infections (STIs), violence and abuse; and are underserved by the current health system. As a result, sex workers face increased exposure to health risks and are often unable to mitigate dangers. These risks are compounded by migration status, sexual orientation, gender non-conformity, working in unsafe spaces where clients are solicited, and through harmful substance use."

A key indicator of female sex workers' health vulnerability is the very high HIV prevalence rates in this sub-population in towns and cities across South Africa. For example, a 2014/15 study in Port Elizabeth with 410 female sex workers found that 258 (63.7%) women were living with HIV (Scheibe et al, 2016). This high percentage correlates with data on HIV prevalence amongst female sex workers in other towns and cities in South Africa (e.g. 39.7% in Cape Town; 53.5% in Durban; 71.8% in Johannesburg; 88.4% Harrismith and Pietermaritzburg (Scheibe et al, 2016). There is no data on

HIV prevalence amongst female sex workers in BCMM but there are relatively reliable estimates of the size of this sub-population in the metropole, from which one can infer that these women are a significant 'key population' for bumb'INGOMSO. The size of the sex worker population (which includes men and transgender individuals) in BCMM in 2012 is estimated to be between 915 and 1264 of which 200-500 are in East London (Konstant et al, 2015; SANAC, 2013).[11]

Notably, South African data highlights 'risky' behaviour such as frequent unprotected sex, binge drinking, and alcohol and drug dependency; police harassment and abuse from clients; and factors such as low levels of education, relatively high dependency of family members on the women (an average of four dependants), limited availability of accessible health services, and low government policy and programmatic priority (African Sex worker Alliance, 2011; Fick, 2006; Richter et al, 2013; Schiebe et al, 2016; Wakefield, 2014).

5.3 Incarcerated offenders

Incarcerated offenders are a group of interest for various reasons. Marginalised groups are often disproportionately represented in the prison population (but also among the general population living with HIV) (Goyer, Saloojee, Richter and Hardy, 2002). The underlying reason for this is that the various drivers for HIV infection, both structural and behavioural are more pronounced among this population subgroup. The second is that HIV transmission in prisons is higher than in among the general population and reasons include high-risk sexual activity, sexual assault, contaminated needles and other cutting instruments (*ibid*). Another is that patterns on incarceration show that on average, the majority of offenders are in the prison environment for less than 2 years (ibid). Given that the prison population in South Africa is generally increasing, this implies a high degree of turnover (or churn) of incarcerated offenders, where individuals enter and leave the high-risk prison environment and then interact with the general population.

Studies on the HIV prevalence of incarcerated offenders in South Africa are not common although some estimates available publicly suggest that HIV prevalence in this setting could be as high as 80% (e.g. Westville report 2002). However, this study and others that attempt to shed light on the matter have been disputed or results not widely disseminated. There is not enough information in the public domain to explore in detail some of the issues around incarcerated offenders to provide any concrete recommendations on the type of interventions that would be appropriate for bumb'INGOMSO to incorporate in the suite of interventions.

5.4 Summary

The evidence of VAW shows that bumb'INGOMSO faces a difficult challenge in addressing the vulnerability of young women in BCMM. The evidence draws attention to the importance of obtaining more information on the work, successes and failures of NGOs who have experience with confronting VAW in BCMM, and to promoting close co-ordination of project interventions with these NGOs and government agencies. The project will need to keep in mind that the interventions must contribute to changing the social environments that foster the high levels of violence against women.

[11] The East London estimate is based on a reportedly very sound empirical fieldwork; the figure of 200 as a minimum is an observed number (SANAC, 2013).

6 HIV prevention strategies in BCMM

This chapter presents the results of the services mapping and institutional assessment in BCMM. The purpose is to describe the nature of HIV-related services in BCMM, along the bumb'INGOMSO's five focus areas. We outline the key focus areas of government and NGO responses, as well as information on their coordination (the institutional assessment)[12]. The aim of this chapter is to indicate gaps in the provision of services and limitations in the use of services (with particular reference to young women) to help inform consideration of the design and foci of bumb'INGOMSO's interventions.

6.1 Frameworks and management for combination prevention

Implementation of HIV/AIDS interventions in BCMM is guided by several frameworks and strategies, including:

- SANAC Preventing HIV among young girls and women implementation strategy 2015 - 2019
- Eastern Cape provincial strategic plan for HIV & AIDS, STIs and TB 2012 – 2016
- Revitalisation of Primary Health Care (r-PHC)

These strategies endorse a combination prevention approach which emphasises multiple, linked interventions that address both the bio-medical and the social determinants of health to improve the prevention of HIV infection in the population. In the last 4 years, the provincial government has invested in services in line with these objectives and the r-PHC agenda which emphasises community outreach and mobilisation to give effect to the combination prevention strategy (HDRC, 2011; ECAC, 2012).

There are many NGOs throughout the Eastern Cape and they provide a wide range of services, often to adults, youth and children. Some work directly for the provincial health programmes. Some collaborate with the ECDOH, acting as intermediaries between communities and the health services. Others work independently providing specific services. There are also government agencies which provide or facilitate services to engage the public in health, social, economic and developmental issues. For the purpose of this report, we focus here on agencies which work with the youth. Much of the information presented here is drawn from scoping discussions with representatives of NGOs.

A particular feature of NGOs which work with the youth in BCMM is that they drive social initiatives in communities, including clinics and schools, ranging from broadcasting direct and indirect messaging on issues such as HIV/AIDS, VAW and GBV, to skills training, to young women's clubs, to sports events, to community and school discussions.

6.2 Behaviour Change Communication (BCC) and mass media

Behaviour change communication (BCC) and mass media are common HIV prevention strategies, popular because they are able to reach a large number of people at relatively low cost. The DGMT has proposed to implement a BCC intervention that targets in-school, out-of-school and post-school youth. This intervention is to be accompanied by a mass media campaign. This section describes

[12] It should be noted that little information could be obtained on the extent and form of networking amongst organisations which is an important measure of co-ordination and of the operation of referral systems. A partial exception is the discussion on social sector engagements which incorporates information obtained directly from representatives of some NGOs.

BCC and mass media activities that are currently active in BCMM, and Annex C provides further detailed descriptions of the service provision from each identified organisation.

6.2.1 Services provided by government

The **Care and Support for Teaching and Learning (CSTL)** programme is a SADC regional initiative running from 2013-2018 which aims to assist member states with mainstreaming care and support into their policies, programmes and processes within their education systems. This flagship programme has been adopted by the Eastern Cape's Department of Basic Education (DBE). The main CSTL activity of the provincial DBE has been the employment of 825 learner support agents (LSAs - peer educators) across the Eastern Cape. They are stationed at the schools which the DBE considers to be high priority (they have a set of criteria to determine this including schools that are underperforming academically and those in high poverty areas), and provide education and support on social issues, engage with learners and refer particularly vulnerable children to receive further social support.

HEAIDS is an initiative of the Department of Higher Education and Training (DHET) and implemented at public universities and TVET colleges. HEAIDS combines the promotion of youth-friendly health services with peer education and behaviour change activities through a model called the **First Things First (FTF) Programme**. For the time being, HEAIDS appears to be more active at universities compared to TVET colleges. The larger number of campuses and smaller enrolment figures are mentioned as a reason that it is more difficult to reach TVET students. Nevertheless, HEAIDS is focused on expanding its services to TVET colleges, particularly in the peer education programme.

Table 2: HEAIDS health promotion activities at TVET colleges in 2015

Indicator	Nationally	Eastern Cape
Number of First Things First activations (health awareness + health screening)	396	58
Number of government condoms distributed	4 722 000	1 080 000
% of students tested for HIV during 2015	13%	15% (3% last year)

Source: HEAIDS (2016) Annual Review 2015

In 2014, HEAIDS commissioned a national survey on HIV-related knowledge, attitudes and behaviours of TVET students and staff (Mbelle et al., 2014). Results from the Eastern Cape showed that only 9.5% of respondents were aware of HCT services being provided on their campus, while 20% were aware of condom distribution. In addition, 22.1% were aware of HIV and AIDS related information being provided at their campuses. It may be expected that through HEAIDS' substantial increase in activities during 2015 and increasing focus on TVET colleges, that there may now be both more provision and more awareness of these services.

6.2.2 Services provided by NGOs

A large number of NGO-run BCC programmes already exist in BCMM with many targeted in the higher risk areas, particularly Mdantsane and Duncan Village. Soul City and loveLife are two national NGOs in the area of HIV behaviour change with a strong presence in BCMM. Both provide a variety of different programmes, accompanied by large national mass media campaigns, which are localised through radio shows, social media engagement and community events.

Most of **loveLife's** youth-targeted programmes are facilitated through **groundBREAKERs (gBs),** 18-25 year olds, trained peer educators, who work for loveLife on a full-time basis and receive a small stipend. Through an initiative with the DOH, loveLife stations gBs at clinics, where they aim to improve service delivery of youth-friendly services. In BCMM, 19 gBs are stationed at eleven clinics (usually two per clinic). gBs also conduct behaviour change communication in schools. The target is that each GB works with five schools in the areas surrounding the health facility at which they are

stationed. In practice however, loveLife is currently active in 98 schools in BCMM. gBs work together with the Integrated School Health Programme (ISHP).

A broader aspect of loveLife's collaboration with the DoH is that the clinics should become 'youth friendly' and adhere to the standards of adolescent and youth friendly services. Reportedly, however, this is not always the case. For example, such clinics are supposed to provide a 'chill' room, a separate waiting room for young patients but there is also another government 'Ideal Clinics' programme which requires that clinics treat all patients equally; hence some clinics refuse to provide a 'chill' room. Therefore, there is room for policy clarity and improved coordination between the NGO sector response and the government response to social sector engagement.

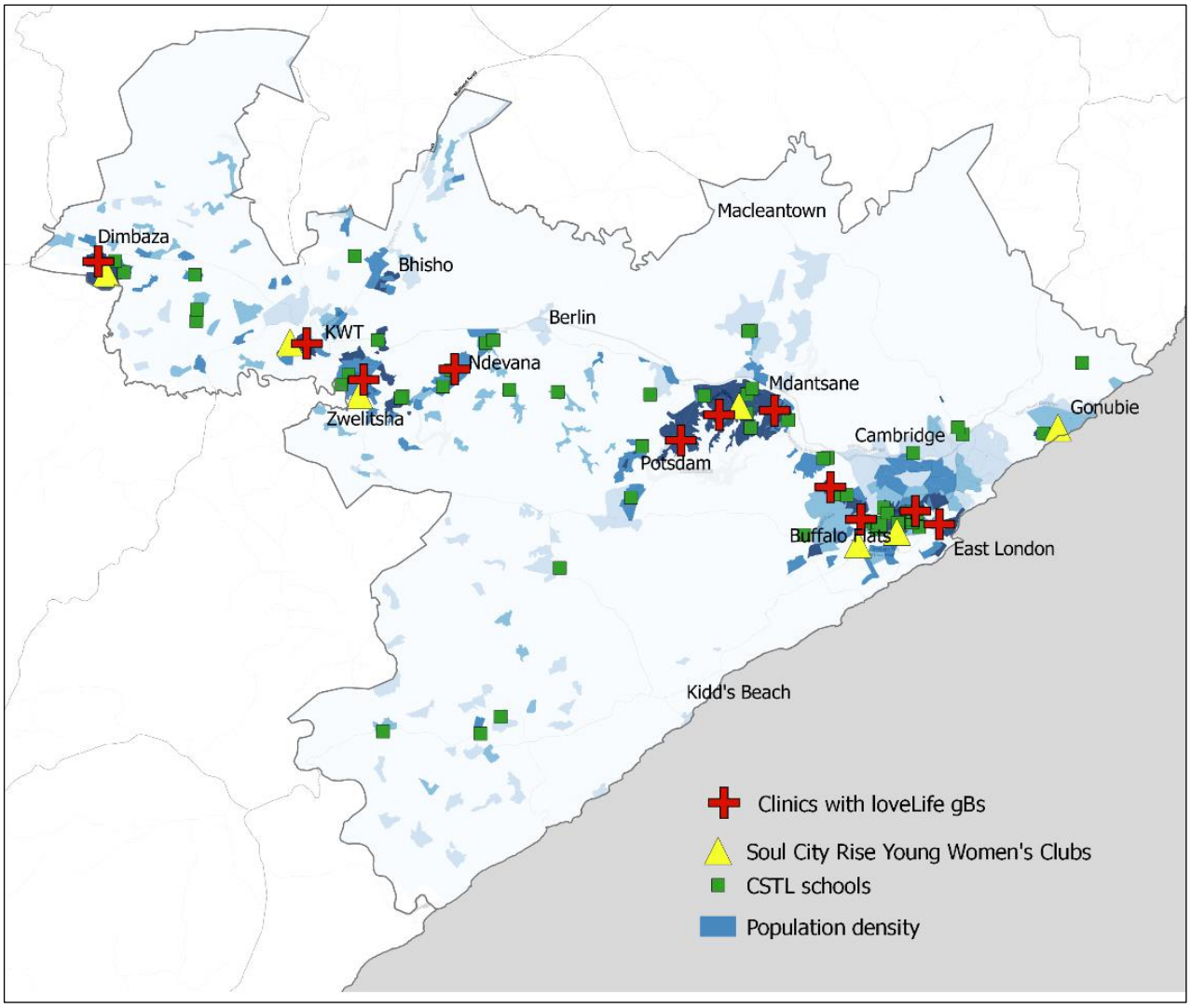
Soul City recently launched a new initiative – the **Rise Young Women's Clubs**, clubs of about 20 young women aged 15-24, which are aimed at empowering young women and linking them to quality services. The clubs are initiated by young women themselves, who then register their club with Soul City. Last year, there were approx. 48 clubs in BCMM, but these clubs are now in the process of re-registering and it is expected that there may be slightly fewer clubs.[13] Figure 16 shows the locations of Rise Clubs that have already registered (32 in total).

Targeting schools is easy, but as a result is done by lots of larger and smaller NGOs and government departments. This runs the risk that youth receive many ad-hoc programmes that lack coordination and may have limited impact.

Figure 16 shows the spatial distribution of CSTL schools, clinics with loveLife gBs and Soul City Rise Young Women's Clubs. The services are noticeably centred in the urban areas of BCMM. There are also no gBs stationed in the Cambridge area or in Mza'Momhle (by Gonubie), which emerged as areas of potentially high vulnerability in the previous sections. It will be important for the DGMT to work in close collaboration with the DBE and other NGOs to ensure that the targeting of the interventions is coordinated with existing interventions.

[13] Some young women thought they would be featured on the Rise Talk Show and lost interest in the programme once they realised this wouldn't be the case.

Figure 16: Spatial mapping of key BCC programmes in BCMM



Sources: DHIS, DBE, personal communication with loveLife and Soul City

6.3 Health services interventions

6.3.1 Management and coordination in the health sector

Official reports reveal institutional constraints to health service delivery in the Eastern Cape generally. For example, the Eastern Cape Department of Health's (ECDOH) performance plan for 2013/14-2015/16 projected decreasing but still high vacancy rates amongst the posts for health professionals; ranging from 30-45% in 2012 and projected to range from 25-40% in 2016 (ECDOH, 2013). Likewise, in 2014, only 26 of the 65 district hospitals were reported to have functional hospital boards (ECDOH, 2015). In 2012, a baseline audit of government health facilities revealed that few complied with national service standards (Health Systems Trust, 2013). In a different vein, the ECDOH reported that it had underspent its annual budget of R17.679 billion for the 2014/15 financial year by 129.189 million (ECDOH, 2015:23).

The r-PHC agenda emphasises collaboration between government departments and NGOs. By the end of 2014, the ECDOH was involving 55 NGOs and CBOs in its HIV programme. Service delivery has increased, aided by the employment of community health workers (CHW) and establishment of 'Ward Based Outreach Teams' (WBOT). By the end of 2014, there were 400 WBOTs involving 1,507 CHWs but only 206 of the provinces 715 municipal wards had these teams (ECDOH, 2015).

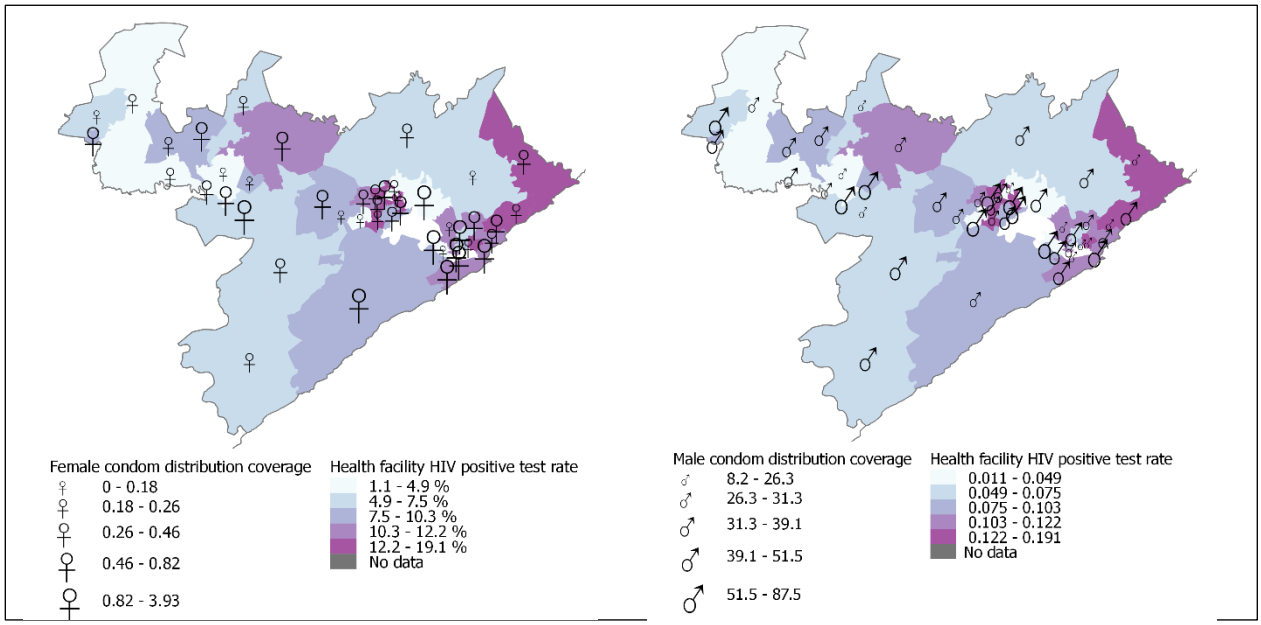
6.3.2 Distribution of key clinical indicators

The 2015 district health barometer estimated that an average of 42 condoms were distributed for every male aged 15 and older in BCMM during the year (Massyn, N., Padarath, A., Barron, P. & Day, C. editors, 2015:177). While this compared well with the national average across districts (average of 38 condoms/man/district) the distribution ratio was much lower than the ratio in the KwaZulu-Natal district of uMgungundlovu (217 condoms/man), the best performing district (ibid).

Figure 17 shows the level of condom distribution coverage across BCMM. The highest number of condoms distributed per male population largely overlaps with the areas of highest health facility HIV positive test rate. Particularly in Mdantsane and East London large numbers of condoms are distributed. Within these urban areas, there may be some disparities although these are difficult to interpret from the data. In East London, for example, it looks like there are somewhat fewer condoms distributed in Duncan Village and Cambridge compared to central East London and Scenery Park. In Mdantsane, it appears that there are fewer condoms distributed in some of the more informal areas on the outskirts of Mdantsane than in the central areas. Dimbaza, Zwelitsha and Ndevana are other areas with high numbers of condoms distributed per male population.

In terms of female condom distribution, we see that coverage in and around East London is generally high. However, coverage is surprisingly higher in some of the more rural areas compared to the big urban towns. Compared to East London, Mdantsane seems to have a lower coverage of female condom distribution.

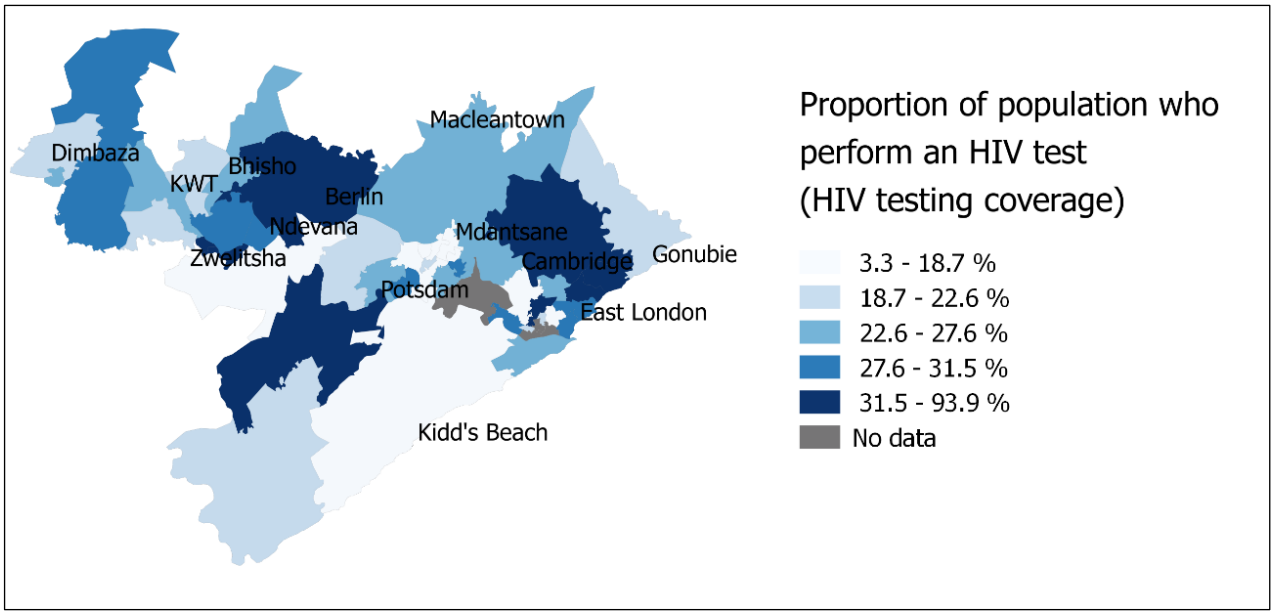
Figure 17. Male and female condom distribution coverage



Notes: Condom distribution coverage is measured as the number of condoms distributed per year per male/female over age 15. Data is for the period from Apr 2015 – March 2016. Source: DHIS.

Figure 18 shows the level of HIV testing coverage across BCMM. From this data, it looks like HCT coverage is particularly low in Mdantsane and Duncan Village. King Williams Town as the other main urban node also has comparatively low coverage, while neighbouring Zwelitsha has high testing coverage. Some of the rural areas, for example around Berlin and between Gonubie and Mdantsane have high coverage.

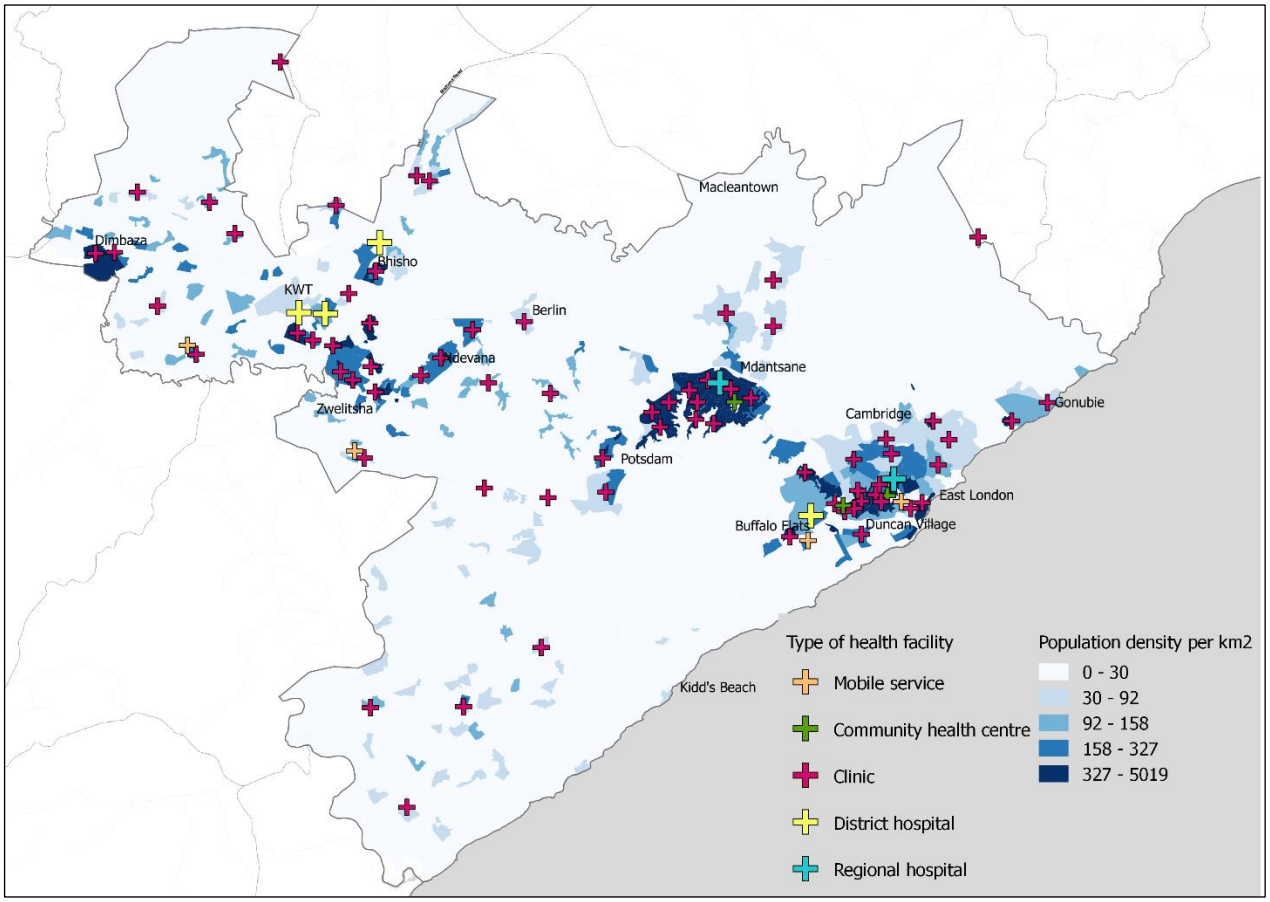
Figure 18: HIV Counselling and Testing (HCT) coverage



Note: HCT coverage is measured as the annual proportion of HIV tests performed among 15-49 year olds per population of 15-49 year olds (excluding antenatal clients). Data is for the period from Apr 2015 – March 2016. Source: DHIS.

Figure 19 shows the distribution of health facilities across BCMM. Clinics are clearly concentrated in the most densely populated regions, but are quite sparse in rural areas with very limited mobile services.

Figure 19: Distribution of health facilities in BCMM



Source: DHIS, BCMM GIS unit.

6.4 Responses to VAW and GBV

The DGMT has proposed to implement systemic strategies to combat VAW in BCMM. The DGMT has proposed to focus on the following strategies:

- Community mobilisation and communication
- Addressing immediate personal constraints for women who are abused (including travel, telecommunication costs, child care and basic necessities at the time of abuse)
- Access to immediate paralegal support and emergency shelters
- Improved police and judicial system responsiveness
- Ensuring that there is growing political and institutional prioritisation of GBV prevention and effective management; and
- Developing effective referral mechanisms across institutions

This section describes how the government and NGOs have been responding to VAW in BCMM, and Annex D provides further detailed descriptions of the service provision from each identified organisation.

6.4.1 Management and coordination to address VAW

Nationally, the social and economic significance of VAW continues to be highlighted; in part, as advocacy for systemic government initiatives and, in part, to find solutions (DSD, 2014; KPMG, 2015; Tshwaranang, nd; Vetten, 2014; Wakefield, 2014; Waterhouse et al, 2014). Responses to date can be categorised as initiatives to provide protection for victims of violence and initiatives to prevent and, over time, to minimise the problem. Both sets of responses involve government and non-government agencies and, frequently, the interventions embody both agenda. With regard to the situation in BCMM, there are initiatives involving national departments as well as NGO programmes, some of which are closely aligned to government programs and others which are independent initiatives.

A foundation for addressing VAW is the Department of Social Development's 'Integrated Programme of Action' (DSD, 2014). This programme emphasises extensive collaboration between government and civil society organisations in the general form of multiple interventions at multiple levels of society. For example, the programme refers to high-level forums to monitor interventions (e.g. the Justice, Crime Prevention and Security (JCPS) cluster of government departments; National Planning Commission) and to continue investigations into the nature of the problem (e.g. National Council on Gender-Based Violence). The programme also emphasises structured interventions such as the School Safety Framework to guide collaboration between different departments. Other foundations include a wealth of legislation to support interventions; for example, the 2008 Child Act which enables adolescents to access sexual and reproductive health services without parental consent, and joint departmental policies and programmes which are akin to that of the DSD (e.g. the Integrated School Health Policy, DOH and DBE, 2012).

Thus, various legal and operational frameworks are in place that guide the implementation and integration of interventions to address VAW. A particular feature of these foundations and mechanisms is government funding support for NGOs to design and implement practical interventions (Vetten, 2014). A feature of these interventions is that they address VAW directly and indirectly in a multiplicity of ways. In view of these features, illustrations of interventions in BCMM are presented in the following sub-section.

6.4.2 Government response to VAW and GBV in BCMM

The Department of Social Development's (DSD) Victim Empowerment Programme (VEP)

The Department of Social Development (DSD) responds to violence against women and children through its **Victim Empowerment Programme (VEP)**. The DSD has six service offices (mapped in Figure 20) in BCMM that provide psychosocial support and counselling, including to survivors of VAW. Aside from their own service offices, the DSD registers non-governmental and civil society organisations under their VEP. The VEP organisations and DSD offices refer clients between themselves. There are 12 organisations registered under the VEP in the current year.

The DSD estimates that across BCMM, their associated VEP organisations receive approximately 400 clients a month. Of these, it is estimated that 289 were seen by counsellors at the DSD's service offices last month. These figures are significantly higher over the festive season and school holidays.

The National Prosecuting Authority's (NPA's) Thuthuzela Care Centres (TCCs)

Thuthuzela Care Centres (TCC) are led by the NPA's Sexual Offences and Community Affairs Unit (SOCA) in partnership with various departments and donors. They are one-stop support facilities for survivors of rape based at hospitals. TCCs aim to coordinate the various agencies involved with providing support to rape survivors, by guiding victims of violence trough a system of care and support which involves trained counsellors, medical examinations, police, lawyers, social workers and, as necessary, temporary shelters (NPA, n.d., see Annex D).

In BCMM, there are two TCCs, one at Cecilia Makiwane Hospital in Mdantsane and one at Fort Grey Hospital in King Williams Town (mapped in Figure 20). Each TCC is supported by two staff from the **Masimanyane NGO**.

The objectives of the TCCs are to reduce secondary victimisation increase conviction rates and reduce the cycle times for cases (NPA, n.d.). They have been hailed as best-practice models, yet they seem to have their challenges. Research conducted in 2014 (Vetten, 2015) reports that the delivery of an NPA-led service in public health facilities inevitably created some tensions between the NPA and the DOH on roles and responsibilities. In addition, both NGO and NPA and health staff were often unclear as to what services NGO staff were meant to provide. Aside from containment and debriefing, downward task-shifting occurred quite often with NGO staff performing HIV counselling and also rapid finger-prick testing in some cases. Masimanyane staff report that it is under consideration that their staff receive training in rapid HIV testing so that they can also provide these services at the TCCs in BCMM. Masimanyane staff did not speak of any tensions in BCMM's TCCs but praised the good relationships that TCCs had developed with the near-by police stations.

The Department of Justice and Constitutional Development's (DOJ & CD's) dedicated Sexual Offence Courts

Sexual Offence Courts are courts that are especially equipped to provide a suitable environment in which survivors of sexual offences can testify. Sexual offence courts were established in 1993 but phased out in 2005 due to budget constraints. They were re-established in 2013. In BCMM, the Magistrate's court in East London is the only dedicated sexual offences court.[14]

A taskforce on the re-establishment of sexual offence courts reports that during the time that the courts were not in operation (2004-2010), "referral rates of cases to the prosecution have declined by at least 40%, the conviction rates have dropped by at least 20% and the cycle times have increased by at least 8 months" (DOJ & CD, 2013, p.25).

[14] Mdantsane Magistrate's Court used to be a sexual offences court under the old model prior to 2005. Information from personal communication with Mrs Gwintsa, Director of Legal Services at the DOJ & CD

Policing services from the South African Police Service (SAPS)

SAPS has Family Violence, Child Protection and Sexual Offences Units (FCS units) across the country whose mandate includes handling crimes of sexual violence and violence against women. These units were initially established in 1995, temporarily disbanded in 2006 but re-established in 2011. It is not clear where these FCS units are based in BCMM.

There is no specific information available on how well these function. In the Eastern Cape, a monitoring survey (Shukumisa, 2014) reports that only 20% of police stations had information about hospitals providing PEP to rape survivors or a list of organisations providing services to rape survivors.

6.4.3 NGO response to VAW and GBV in BCMM

Masimanyane is the largest NGO in the Eastern Cape that addresses issues of violence against women. They currently employ 62 staff and have their head offices in central East London. Masimanyane seeks to support women at all stages of the continuum of care that survivors of VAW progress through, including support at Thuthuzela Care Centres, police stations, courts, in communities and through a range of counselling services (see Annex D). In this way, women stay in the Masimanyane network, and it is easier to follow up with them and provide continuous support where required.

From the information that could be obtained it appears that there are 3 organisations that currently offer **shelters for abused women**. All of these shelters fall under the DSD's VEP. The DSD and Masimanyane report that shelters refer women between each other when they have no spaces available. There are also several smaller community-based safe houses within BCMM. In addition, various organisations provide **counselling and psychosocial support** to women affected by VAW.

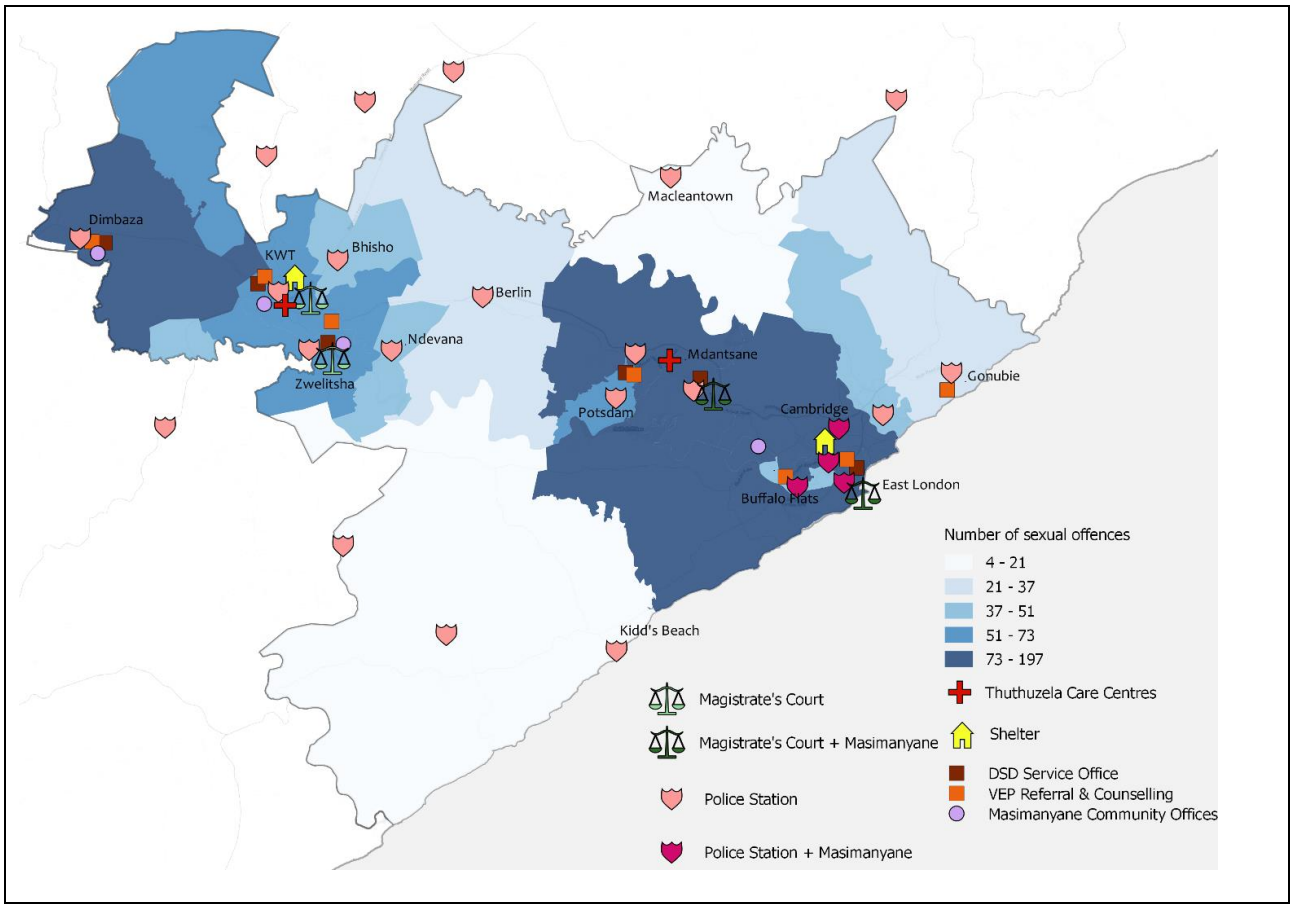
Figure 20 shows the distribution of services to address VAW in BCMM against a backdrop of the number of sexual offences reported in each area. On the one hand, services appear to be fairly well distributed with an emphasis on those areas that experience higher numbers of sexual offences (Mdantsane and East London). Dimbaza, which also has higher numbers of sexual offences, has comparatively less available services than King Williams Town – although it is likely that the services in King Williams Town would attempt to reach out to Dimbaza.

Despite the spread of services, overall it seems that the service delivery for VAW may not be adequate:

- There are no shelters for women in Mdantsane (although there would likely be smaller safe houses)
- There is no Thuthuzela Care Centre in East London
- There is only one dedicated sexual offences court in East London, and Masimanyane staff are only stationed in Mdantsane and East London, leaving a noticeable gap in court support in the areas around King Williams Town
- Masimanyane's support services at police stations are only available in East London

In particular, this means that for an individual that enters the support system, it appears difficult to access a comprehensive range of services without travelling some distance.

Figure 20: Spatial mapping of services to tackle VAW



Notes: 'Magistrate's Court + Masimanyane' means courts where Masimanyane staff are stationed. 'Police station + Masimanyane' means police stations where Masimanyane staff are stationed. Masimanyane staff are stationed at both Thuthuzela Care Centres. 'VEP Referral & Counselling' means projects registered under the DSD's VEP programme for 2016/2017. Locations of services are approximations.

6.5 Improving access to economic opportunities

South Africa has high levels of structural unemployment and one of the reasons for this is the mismatch between skills acquired through schooling and tertiary education to job requirements in at the work place. While some of this mismatch is a result of larger, macro level issues such as the quality of the education systems, it is also exacerbated by micro level factors including information, entry and mobility barriers to entering the workplace. Bumb'INGOMSO focuses on these micro level issues and is expected to have three focal areas:

- The expansion of access to information about opportunities (e.g. financing, further study and work opportunities)
- Expansion of competency-based training in conjunction with the Buffalo City TVET College (and the King Hintsa TVET college in the OR Tambo district); and
- Work-link strategies for unskilled and vocationally-trained workers

We attempt to describe the status quo in BCMM aligned to these initiatives in turn below. There was very limited data and reports that highlight availability of services on the below.

6.5.1 Access to information

1. The national youth development agency (NYDA) is tasked with developing initiatives to advance the economic development of young people. One of the initiatives run by the NYDA

are youth advisory centres (YACs) and these are walk in facilities where youth can receive a range of job link services. The services offered include:

- Internet access
- Assistance with developing business plans / profiles
- Training on elements of starting/running a business, e.g. entrepreneurship, financial management
- Career guidance
- CV and interview preparation
- Access to a job portal

There are three YACs in Buffalo City, located in Duncan Village, King William's Town and East London. These are run by Buffalo Municipality, and are staffed by two permanent employees one of which also conducts outreach activities. The number of beneficiaries (14-35) accessing services from these in BCMM is not clear as results are reported for the Eastern Cape as a whole. However, in the 2014/15 financial year, the NYDA reported facilitating 46 jobs through YACs, enrolling 1038 learners in a Matric rewrite programme and providing job related information to just over 16 000 beneficiaries through various access points in the Eastern Cape (National Youth Development Agency, 2015). In 2016, 11 outreach workshops were conducted through BCMM and the municipality estimates that approximately 60 people use the youth centres daily.

2. There is one youth desk in each of BCMM's wards, which provides similar career guidance services. There is also a youth council to involve youth in decision-making processes at the municipality, but this seems to be largely a political platform.

3. The Local economic department (LED) has satellite offices (SMME centres) in the same areas as the Youth Centres (Mdantsane, Duncan Village, King Williams Town). These are not specifically aimed at youth but offer training, opportunities for exhibitions of small businesses/initiatives, roadshows (e.g. at the Rand Easter Show, or IDZ) and advice (e.g. they refer to other institutions for businesses seeking accreditation or for further training).

Based on this available information, it is difficult to make general statements on the quality of services these institutions offer, or the extent to which beneficiaries find them accessible. However, it appears the YACs are the main source of information for would be job seekers, but there is only one centre in a single the township (Mdantsane) and this would not be readily accessible to youth in other townships and informal settlements.

6.5.2 Post-school competency based training programmes

Universities

The University of Fort Hare is the closest University to BCMM, including a campus in East London an offers diploma and degree courses through five faculties (Education, Law, Management & Commerce, Science & Agriculture, Social Sciences & Humanities).

TVET Colleges

There are two public TVET colleges in BCMM, Buffalo City Public TVET College located in East London and Lovedale TVET College in King Williams Town. The Buffalo City college admission requires completion of grade nine or higher at a minimum, and offers three types of courses – occupational training courses, business studies programmes and vocational training. The occupational courses are geared at preparing students meet industry and company specific competencies through training e.g. for the automotive sector. The business studies programmes are aimed at students who want to train further at higher education institutions and offer diploma level courses in business and financial management, human resources, educare (early childhood

development) and engineering. Vocational training specialises in ten priority skills and offer national certificate courses. Examples of certificate courses include office administration, IT and computer science, tourism, and engineering.

Lovedale also offers national certificate and national N diploma courses, and has two campuses in BCMM, one in Zwelitsha and another in King William's town. The third campus is in Alice. The King Campus offers business courses, and Zwelitsha Campus offers engineering courses.

Sector education and training centres (SETAs)

The government through the department of labour set up 23 SETAs to deal with skills shortages in South Africa through facilitating training for out-of-school youth and anyone who needs additional skills and further training. These SETAs work across various sectors including banking, education and health. We did not find any information in the public domain of the full list of training programmes under implementation in BCMM (if any) across the SETAs.

6.5.3 Work-link programmes for recent graduates

There's a Buffalo City Municipality skill development initiative but specific details on the scope of the initiative are not available. Recently, the initiative enrolled 40 youngsters as part of the youth driver education programme, but again, details on this not available. Details are not clear but this appears to be funded through a mayoral bursary facility that has an annual budget of R1.2m

One of the strategies to link graduates to work in BCMM is through the use of business incubators and hubs. There are two prominent hubs in BCMM, both in the automotive sector. One is the Mercedes Benz learning academy funded by the Jobs Fund and Mercedes. The academy has 14 full time instructors and enrolled 180 learners in 2016.The second is the automotive hub in Mdantsane. This is a collaboration between BCMM, Automotive Industry Development Centre (AIDC), Eastern Cape Development Corporation (ECDC), The Jobs Fund and the Provincial Economic Development, Environmental Affairs and Tourism.

6.6 Support for Female Sex Workers and Incarcerated Offenders

Once the other four intervention areas have been established, the DGMT plans to develop further interventions that focus on two high-risk groups or to incorporate these groups into existing interventions. We refer here to the intention to focus on female sex workers and incarcerated offenders.

6.6.1 Coordination of services for female sex workers

Government programmes to engage sex workers appear to be evolving slowly since the drafting of a 'National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers' in 2012, amidst apparent reticence of the national government to incorporate sex workers in the national HIV/AIDS strategy for 2012-2016 (Scheibe et al, 2016). In contrast, there is an established HIV policy and programme for offenders in South Africa's prisons, though its operational effectiveness has often been questioned (Spiegler, 2012).

NGOs are at the forefront of initiatives to develop and implement programmes that confront the high risk of HIV infection and the high incidence of physical and sexual abuse amongst female sex workers (NACOSA, 2012; Fick, 2006; Scorgie et al, 2011; SWEAT, 2012; SWEAT, 2015). To date, NGO interventions have focused on workshops for sex workers and supporting NGOs, peer educator-based outreach initiatives to promote health seeking behaviour, and referrals to sex-worker friendly health services (Impact Consulting, 2015).

There is relatively little information on the coordination of sex worker-focused interventions in BCMM. A representative of SWEAT stated that the government health services were generally supportive but also highlighted several challenges; notably the lack of legal support services in the face of persistent police harassment and lack of psycho-social support. In the case of legal support, the challenge is that the Women's Legal Centre, an NGO which operates in some cities and towns and provides assistance to sex workers, does not have a branch in BCMM. With regard to psychosocial support, the reference was to the limitations of existing health services to assist sex workers with the range of health problems they experience, ranging from drug addiction to regular experience of abuse.

The TB/HIV Care Association is also active in providing access to medical care for offenders in prisons and has a programme serving the correctional facility in East London. There is little other information of services for offenders, though the Department of Correctional Services runs an HIV programme at the female prison in East London. A representative of NICRO, a national organisation which works with people who come into conflict with the law and assist with the social rehabilitation of offenders, stated that they run a crime prevention programme in BCMM.

6.7 Summary

There are a range of existing interventions in BCMM which provide reference points for bumb'INGOMSO's proposed interventions and, as importantly, strategic principles for the design of the later interventions. The existing agenda is for combinations of interventions which address the social and biological determinants of health. Inevitably, the proposed interventions of bumb'INGOMSO will need to be designed such that they complement each other in practice. Accordingly, the following chapter outlines the logic of combination prevention interventions to support the detailed planning of the proposed interventions.

7 The logic of combination prevention

In the 90s and through the early 2000s, research focused on what was driving the HIV epidemic in sub-Saharan Africa. This focus shaped the nature of HIV programmes at the time: predominantly uncoordinated HIV intervention programmes at national level, many of which focused on biomedical and behavioural interventions aimed at individuals (Auerbach et al., 2010). In the past decade however, the key shift in HIV prevention has stemmed from the realisation that the HIV interventions need to broaden their focus; that is, to incorporate attention on individual behaviour within a perspective which also takes into account the conditions in which people live as underlying 'drivers' of HIV epidemics and as factors which influence the extent to which people can protect themselves from HIV (*ibid*). The outcome is the combination prevention model, formulated by UNAIDS (2010), which emphasises a combination of interventions that address the particular structural, behavioural and biomedical HIV drivers of HIV epidemics in different settings (i.e. it emphasises context-sensitive interventions).

The core principles of this model are:

1. An evidence based participative planning process that ensures collaboration from all relevant stakeholders particularly individuals and communities affected by HIV;

2. Clear identification of transmission pathways in the most affected populations;

3. Nuanced understanding of the scale and intensity of an epidemic; its geographical distribution and variation;

4. Identification of the structural factors that may be propagating or sustaining the local epidemic (UNAIDS, 2007).

Annex E provides two examples of combination prevention interventions in sub-Saharan Africa to illustrate these principles. The sub-sections below outline recent assessments of these interventions which are directly relevant for the proposed interventions.

7.1 Young Women

Baxter and Karim (2016) review and propose combination prevention options for young women in Africa. The authors conclude that the interventions work only if two key conditions are met:

1. They should be combined rather than being a set of different interventions;

2. The content of the interventions are selected and designed for the specific context in which they are to be implemented.

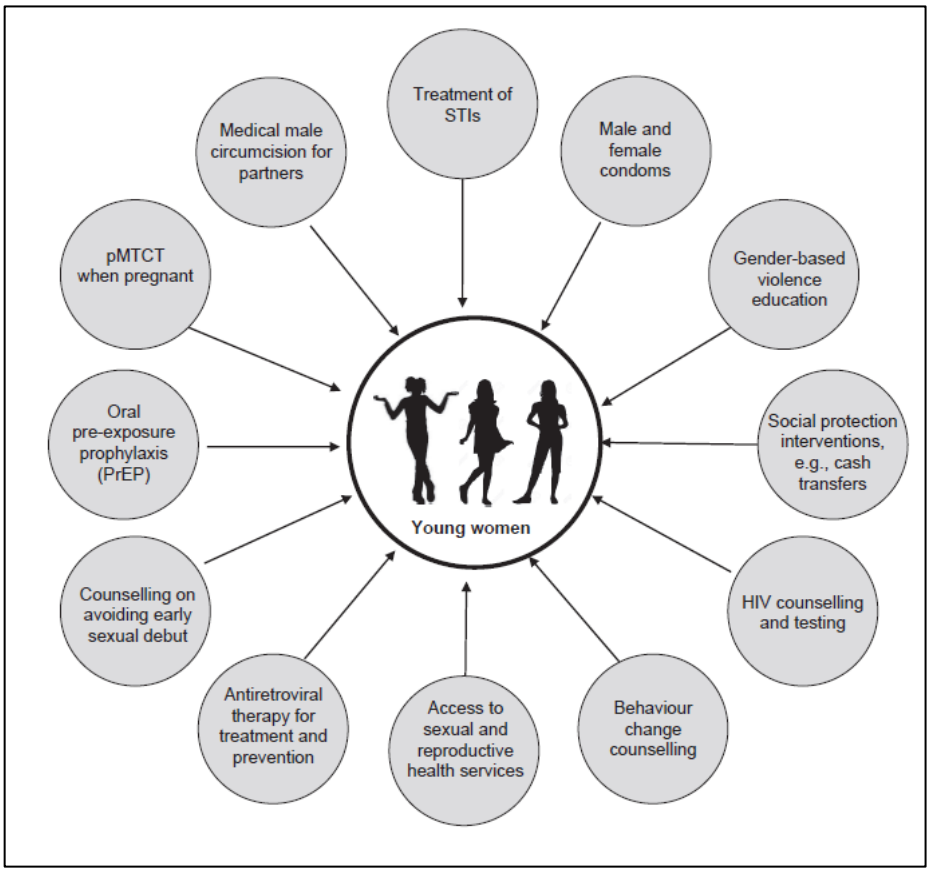
This means that there can be any number of particular interventions, as is illustrated in Figure 21, but there must be an emphasis in their design and implementation on integration and co-ordination of the different components. This has a clear set of implications for the targeting of the intervention and the prioritisation of activities:

- From the subset of young women that can be reached by the programme, priority should be based on socio-economic vulnerability, with those that are exposed to multiple dimensions of vulnerability targeted. The study shows that these are likely to include, for example, young women who are out of school that live informal settlements which have the lowest levels of access to social amenities and employment opportunities.

- Synergies across interventions should be a product of a careful design process, and not a fortuitous coincidence. As such, the programme should clearly define 'contact' points between the target populations and the various interventions, and at these contact points, exposure to all of the relevant bumb'INGOMSO activities be made available. An example of such would be behaviour change and communication messages and access to economic opportunity pamphlets available at health facilities that are part of the health services.

In practice this requires strong collaborative planning and management by the different agencies involved in implementing bumb'INGOMSO that draws from a clear understanding of how each of the interventions fit together in relation to the beneficiaries and the programme level targets.

Figure 21: Combination prevention options for young women



Source: African Journal of AIDS Research 2016, 15(2):115

Other recent research has highlighted a particular issue which deserves the attention of proposed interventions amongst adolescent girls and young women (Crankshaw et al., 2016).The researchers contend that high HIV prevalence is often matched by high-unmet contraception need and high rates of unintended pregnancy, and that such pregnancies are often linked to high rates of HIV-1 transmission. Exploring this issue was beyond the scope (time and resources) of the secondary research for this report. However, the work of Crankshaw et al., indicates a possible practical focus for the proposed behaviour change and health service interventions; that is a focus on preventing unintended pregnancies as a means to reduce HIV transmission.

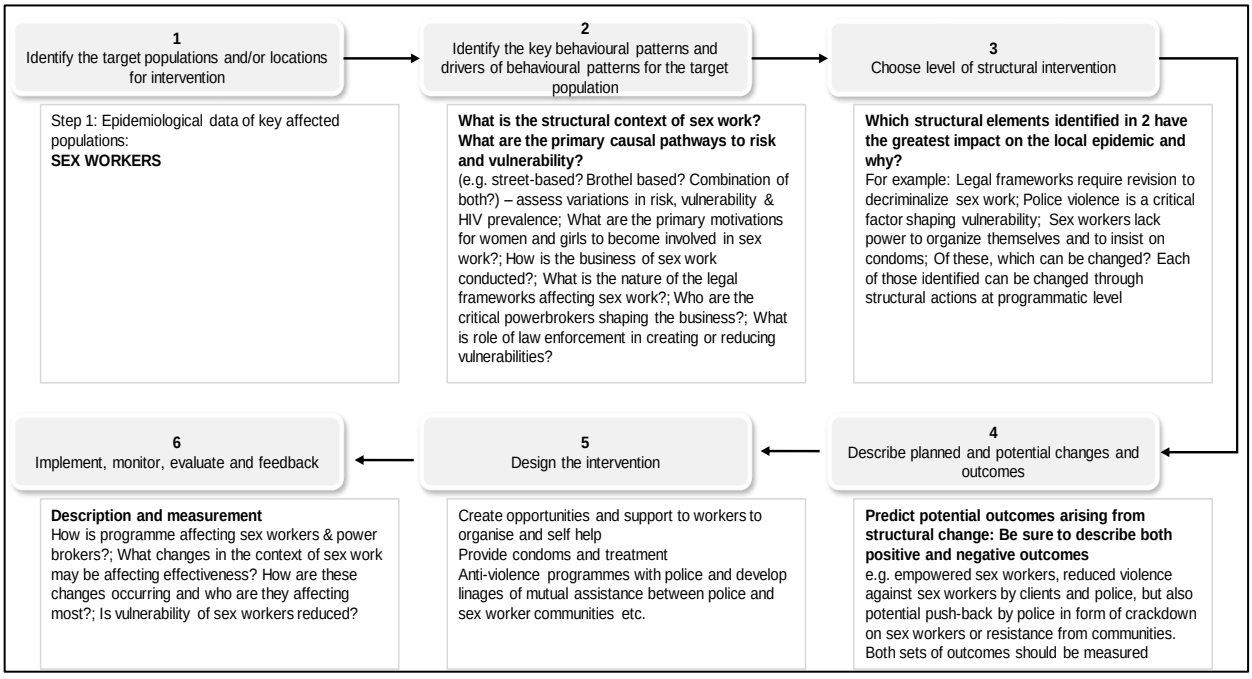
7.2 Female Sex Workers

A recent Lancet article (Gail-Bekker, Johnson, Overs et al. 2015)[15] reviews the evidence on combination prevention for female sex workers. The review considered HIV prevention programmes and interventions that included randomised control trials (RCTs), observational studies, consensus papers and peer reviewed programme reports. The conclusion was that effective HIV prevention projects for these women include biomedical, behavioural and structural interventions which are led and implemented by them. Furthermore, the review showed that, in principle, increasing the supply of condoms and advocacy for their use can reduce HIV incidence among FSWs and their clients by up to 70% and if these interventions are complemented by others such as post-exposure prophylaxis there can be a further 40% improvement to whatever prevention rates are achieved.

7.3 Implications for bumb'INGOMSO

HIV transmission is driven by a variable number of factors directly and indirectly in different settings; hence, the content of interventions need to be varied. In other words, what works depends on identification of the key drivers in a particular setting, definition of the scope and focus of the combination of interventions, specification of intended outcomes, and monitoring of progress to enable modification of the interventions in due course and as necessary. Auerbach et al (2010) provide a useful summary of steps for the design of interventions, illustrated in Figure 22 (using design of an FSW intervention as an example). In short, the steps involve developing a theory of change. In practice, this entails considerable collaboration between different agencies and such an exercise would be one means to guide the collaborative planning process.

Figure 22: Steps in planning structural interventions



Source: Auerbach et al 2010:6

[15] This study identifies 5 ongoing HIV prevention trials (FACTS 001, ASPIRE, RING study, FACTS 002 and CHAMPS-SA PLUSPILLS PrEP) in South Africa, the latter two of which are under evaluation. It would be useful to track these evaluations and incorporate lessons learnt into bumb'INGOMSO.

8 Conclusion

There are many gaps in the information available from BCMM that is can be used to understand the micro epidemic and thus be used to inform implementation of the bumb'INGOMSO. Nonetheless, by triangulating the different pieces of evidence, drawing on literature from related sources and using local knowledge from practitioners in the different intervention areas, it is possible to create an evidence based HIV intervention in BCMM. Particular foci for the intervention are the behavioural drivers of the HIV epidemic in BCMM, VAW and IPV, and young women's perspectives on existing interventions that target them, including the perceived effectiveness of communications projects..

The report provides foundations for discussion between interested parties on the design and foci of the project's interventions. The data and analysis presented in the report are one foundation for consideration of where and what issues would be most useful to BCMM's efforts to curb its HIV epidemic. The project's combination prevention approach is another foundation for that approach lies at the heart of current government HIV intervention policies and programmes. The challenge is to ensure that this approach is at the heart of the interactions between this project's service providers and government and other CSO service providers. In this instance, there are existing, collaborative projects and programs that provide reference points for adopting this approach from the start. Specifically, the r-PHC agenda provides key premises for the project's behaviour change and communication (BCC) and health service interventions; respectively, 'BCC programmes aimed at in-school, out-of-school and post-school youth to achieve a positive change in risk behaviour'; and an 'intervention to support existing health services, to improve 'youth friendly' services with a focus on HCT, contraception and STI treatment in public clinics and in GP practices.' For example, for the CSOs which will be implementing the project's BCC and health interventions, it would be appropriate to specify a 'PHC package(s)' in consultation with the health services and founded upon 'social compacts' in communities where the interventions will occur. Likewise, it is incumbent on the government health, education and welfare services and the CSOs to define mutually supportive referral mechanisms (which will depend in large part on co-ordination, leadership and teamwork).

With regard to the project's VAW agenda, the intent is to devise an "intervention that acts as a systemic response to gender-based violence, involving community mobilisation and improving the co-ordination, accessibility and use of GBV-oriented services." Accordingly, the design of this intervention would be broader than defining a 'PHC package' yet draw on the principles of the r-PHC agenda, paying particular attention to the design of a 'referral system' and definition of 'outreach teams and inter-sectoral collaboration.' In this instance, the desired 'systematic response' would seek to create a different environment to the one in which VAW occurs. In reality, this would be creation of opportunities and mechanisms which, first, increase the level of reporting of VAW and victim care and support and, secondly, means to minimise the occurrence of VAW by establishing prevention and protective mechanisms. Such opportunities and mechanisms exist already via the DSD's Victim Empowerment programme and the Thuthuzela centres. However, as is indicated in the description of services for VAW, there is limited presence of personnel and agencies within communities to strengthen these opportunities and to prevent (i.e. reduce the incidence of) VAW. Consequently, existing interventions are missing a vital component for creating a different environment to that which allows VAW to flourish. In the case of female sex workers, there are even fewer opportunities and mechanisms. Nonetheless, the introduction of mobile clinics to serve sex workers is an apt illustration of a practical way of establishing regular presence of services in communities, in this instance for that of sex workers. Mobile clinics go to where the female sex workers are and provide services at times when they are needed (i.e. at night).

The one bumb'INGOMSO intervention which, it seems, has yet to be integrated with the others is the "programme to increase economic opportunities for vulnerable young women, involving communication of educational, training and links to jobs". There is limited information on post-school education, training and links to jobs in BCMM and on communication initiatives to enhance the

broadcasting of this information. Therefore, this component of the project stands out as one requiring further elaboration, particularly how it would draw on the strategic principles for the other interventions discussed above.

There are two particular findings directly related to the bumb'INGOMSO's focus on 15-29 year old girls and women. One is concentration of adolescents and young adults in BCMM's urban areas. The second is the challenge that the project faces with regard confronting the vulnerability of young women in the context of the seemingly high levels of violence against women. In the absence of detailed information, it is appropriate that the more information is obtained from CSOs working in this field. Furthermore, a systemic response in the context of current understanding of the nature of VAW in South Africa presumes interventions which change the environmental conditions that foster such violence. This is a demanding task, even if defined in terms of creating 'enabling environments' for girls and women to confront the perpetuation of violence with community and external support as well as to secure protection as victims. That scale of this task reiterates the importance of the project being founded on the principles and premises of the combination prevention model and, we suspect, implementing the approach more consistently that might have been the case in other BCMM interventions.

9 Recommendations

1. Allow review of intervention proposals to ensure that they are aligned with the framework for HIV interventions in BCMM.

Bumb'INGOMSO does not have to do everything and try be the comprehensive response. Instead, the intervention must look for the strategic opportunities that could enhance the collective effort, or create a tipping point by saturating multi-faceted interventions in specific communities. The imperative here, therefore is that, individually, each intervention needs to add value to existing interventions of their kind and, collectively, they should be mutually supportive if they are to adhere to the logic of combination prevention.
This presumes collaborative planning between the contracted NGOs and consultation with organisations currently implementing interventions in BCMM. For example, it is likely that large organisations such as the DBE, loveLife and Soul City already have plans for expansion of their behaviour change communication programmes into areas they have identified as lacking interventions.

2. A necessary consideration is where the project's resources should be directed in BCMM. The question is whether the interventions should focus on one area/settlement or in two or more areas/settlements and on what grounds, to have the greatest 'impact'. The mapping exercise draws attention to different options in terms of the variations in the health facility positive test rate and other indicators of risk and vulnerability.

Furthermore, one impression from the secondary research is that the many interventions in BCMM are fragmented and have limited reach into the populations they target. While these interventions may be having beneficial effects, the beneficial effects may potentially be greater and achieved more quickly if different organisations concentrated their resources in particular areas/settlements.

Bumb'INGOMSO should consider the option of concentrating resources of the different interventions in one area/settlement with a view to 'saturating' it with co-ordinated interventions. While this would be the overall focus of the proposed interventions, there would need to be particular sub-initiatives which have particular agendas; for example, specific VAW-oriented services in particular health and community facilities within a settlement and/or a number of BCC initiatives which target different age groups (and needs and interests) of adolescent girls and young women.

3. Whatever option is chosen with regard to where the interventions will be conducted, engagement with the relevant residents in the affected community/ies is vital if the interventions are to be effective in changing the environments which foster the problems they seek to resolve. This would be about creating 'enabling environments' for the behaviour change, health, VAW and economic empowerment interventions to take root.

The nature of the interventions will have implications for the design of the primary study. It is not possible at this stage to define the implications in detail. However, it can be said that some of the information required will need to come from qualitative research, as this will likely be appropriate for providing a 'baseline' for interventions that may be focused on particular populations of young women in particular settlements/localities and on changing particular environmental conditions. In sum, the design of the primary study will need further discussion and will depend on the intervention plans that are proposed and approved for the bumb'INGOMSO project.

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Annex A Indicators and data sources for mapping the HIV epidemic in BCMM

	Indicator(s)	Source(s)	Level of disaggregation	Spatial mapping performed?
Demographic data	Population density Age & Gender Education status Employment status Household income Location of informal settlements Access to services	Census 2011 BCMM GIS Unit	Sub-place level Ward level	✓
HIV indicators	HIV prevalence Number of people testing positive for HIV Density of people testing positive for HIV	DHIS	Facility level	✓
Self-reported sexual behaviour	% reporting early sexual debut (< 15 years) % reporting condom use at last sex % in age-disparate relationship (5+ year age difference) % having multiple sexual partners	National Prevalence, Incidence and Behaviour Survey National HIV Communications Survey	District level, age, settlement type	✗[16]
Knowledge and attitudes towards HIV	Perceived susceptibility to HIV infection Knowledge of HIV transmission Awareness of HIV status	National Prevalence, Incidence and Behaviour Survey	District level, age, settlement type	✗[16]
Uptake of health services	Number of male condoms distributed Number of female condoms distributed HIV testing coverage (number of people 15-49 tested for HIV per population)	DHIS	Facility level	✓[17]
Prevalence of gender-based violence	Number of sexual crimes reported to police	SAPS Crime Statistics	Police station level	✓

[16] Data from national surveys were not representative at a low enough level of disaggregation to allow for mapping. No local level data sources were identified that would allow mapping. National surveys and local research were summarised in the literature review.

[17] These data were taken as indicators of health service availability and uptake and are mapped in the services mapping chapter

Data preparation

Data were available aggregated by different spatial levels, depending on source. For example, some indicators from the census are released in a Community Profile format which is aggregated to the so-called sub-place level. Other data were available only at facility level (e.g. indicators per health facility or per police station). Data on sexual violence were available for each police station. Since data on the police station boundaries (the areas for which a police station is responsible) were also available, the areas within the boundary could be shaded according to the number of sexual offences reported at the respective police station. The mapping of clinical data was more complex because there was no available information on the health facility's catchment area. This meant that it was not possible to delineate the geographical boundary of each facility's catchment area – which would have been important in identifying those areas that are underserved. To be able to show the distribution of clinical factors across the municipality, the data were aggregated at the ward level (i.e. data from all facilities located in a ward were aggregated).

Annex B Organisations contacted during data gathering

Organisation	Key contact person	Information requested
Provincial and municipal departments		
Eastern Cape Department of Health	Marius Potgieter, DD Information Systems, Buffalo City Sub-district	DHIS data
Eastern Cape Department of Education	Sharon Maasdorp, Directorate for HIV/AIDS and Social Planning	1. EMIS data 2. Programmes run by the DoE
Eastern Cape Department of Social Development	Siviwe Sixaba, Coordinator of the Victim Empowerment Programme	Scope of the Victim Empowerment Programme
Department of Justice and Constitutional Development, Eastern Cape Regional Office	Mokhibo Gwintsa, Director of Legal Services	1. Location of magistrates courts 2. Sexual Offences Courts
SAPS	Brigadier N. Klaas	Sexual offences data
BCMM GIS Unit	Noludwe Gunguta	Spatial data
BCMM Municipality Special Programmes	Shaun Petzer & Masixole Kataza	1. Scope of the unit's activities for HIV prevention 2. BCMM policies on youth, gender, HIV
BCMM Municipality Youth Advisory Centres	Shaun Petzer, Special Programmes unit Xolelwa Majiza, LED Representatives from the Youth Advisory Centres in Duncan Village & Mdantsane	Scope of activities in BCMM
NGOs & CSOs		
Eastern Cape AIDS Council	Nophiwe Ludidi, coordinator of young women and girls programme	Local HIV research
Eastern Cape NGO Coalition	Portia Klaasen	Information on NGOs
Eastern Cape Socio-economic Consultative Council	Esethu Magwentshu	Local sociodemographic research
loveLife	Michael Ceskio, BCMM programme coordinator	Scope of activities in BCMM
Masimanyane	Lesley Ann Foster, director	Scope of activities in BCMM

Masithethe Counselling Services	Jackie Orsmond	Scope of activities in BCMM
NICRO	Tony, provincial coordinator Emmy, manager East London office	Scope of activities in BCMM
Soul City Institute	Pienaar Motabene, provincial coordinator	Scope of activities in BCMM
SWEAT	Babalwa Mboxela, provincial coordinator (EC & KZN)	Scope of activities in BCMM
TB/HIV Care Association	Phebe Gribble, HIV prevention programme manager	Scope of activities in BCMM

Annex C Services for BCC and mass media in BCMM

This annex provides additional information to the services mapping of organisations that provide BCC and mass media campaigns in BCMM, presented in section 6.2.

C.1. Services provided by the government

Care and Support for Teaching and Learning (CSTL)

The Care and Support for Teaching and Learning (CSTL) programme is a SADC regional initiative running from 2013-2018 which aims to assist member states with mainstreaming care and support into their policies, programmes and processes within their education systems. The scope of the programme is broad: the Department of Basic Education (DBE) lists nine priority areas including nutritional support, health promotion, social welfare services and psychosocial support (DBE & MIET, 2010). Provinces, districts or individual schools design their own programme in line with these priorities. Nationally, the DBE lists its HIV and AIDS Life Skills Education Programme, which is implemented in all public schools, as an initiative that falls under CSTL (Figure 23).

Figure 23: National HIV and AIDS Life Skills Education Programme

Programme Example: HIV and AIDS Life Skills Education Programme

The HIV and AIDS Life Skills Education Programme was initiated in 2000 and is implemented in all public institutions with a focus on learners in Grades 1–12. The main objectives of the Life Skills Programme are to integrate HIV and AIDS and relevant life skills into the school curriculum as a strategy to mitigate the spread of HIV and AIDS, and to provide care and support for learners who are infected and affected by HIV and AIDS. In this regard, a cross-curricular approach has been adopted. Although life skills and HIV and AIDS education is primarily located in the Life Orientation learning area, some aspects of the programme have also been integrated into other learning areas.

The Life Skills HIV and AIDS programme focuses mainly on curricular activities as per the following focal areas:

- Training of educators to teach aspects of the programme within the curriculum;
- Peer education activities for learners to support curriculum implementation;
- Capacity building of School Management Teams to develop school support plans or action plans for HIV and AIDS; and
- Care and support activities for learners and educators.

Source: DBE & MIET (Media in Education Trust) Africa (2010) Care and support for teaching and learning: National support pack. Durban: MIET Africa

The main CSTL activity of the provincial DBE has been the employment of 825 learner support agents (LSAs - peer educators) across the Eastern Cape. They are stationed at the schools which the DBE considers to be high priority (they have a set of criteria to determine this including schools that are underperforming academically and those in high poverty areas). There is one learner support agent stationed per school, who provides education and support on social issues, engages with learners and refers particularly vulnerable children to receive further social support. Learner support agents are youth who have completed matric but are not in other education/ training/ employment; they receive a monthly stipend.[18] In addition, according to the DBE's annual report for 2014/2015,

[18] Personal Communication with Sharon Maasdorp, Eastern Cape DBE Directorate for HIV/AIDS and Social Planning

training of teachers in sexual and reproductive health and the distribution of HIV/AIDS, TB and Life Skills learning materials was foreseen for 2015/2016.[19]

Higher Education and Training HIV/AIDS Programme (HEAIDS)

HEAIDS is an initiative of the Department of Higher Education and Training (DHET) and implemented at public universities and TVET colleges. HEAIDS combines the promotion of youth-friendly health services with peer education and behaviour change activities through a model called the **First Things First (FTF) Programme**. The programme has the following components (HEAIDS, 2016):

- **Activation events:** Activation events combine health promotion (incl. condom distribution), health screening services (HIV testing, STI testing, TB screening), and counselling and referral of students. They held at TVET colleges and universities. 95% of the HIV testing performed through HEAIDS occurs at these activation events.

- **Four peer educator programmes:** Women's Health Empowerment, Men's Health Empowerment, Drug and Alcohol Abuse Prevention Programme and LGBTI Programme. In 2015, 4895 peer educators were trained across South Africa (3349 in TVET colleges and 1546 at universities). The increase in peer educators at TVET colleges was 124% compared to last year, with demand still outweighing supply. As a result, peer educator training is being expanded in 2016 and to be organised and delivered at provincial level.

- **HIV curriculum development:** This programme, funded by the National Skills Fund (NSF), aims to develop the capacity of university and college staff to integrate HIV content into their curricula. The University of Fort Hare has received a grant of R400,000 for this purpose, while TVET colleges are expected to benefit from overall activities of the programme rather than being allocated individual grants.

- **Future Beats Youth Development Programme:** Future Beats is a radio programme aired on community and college radio stations. Through capacity building, programme managers and volunteer journalists are equipped to produce HIV-related content for their radio shows. The programme expanded to the Eastern Cape in 2015, but there is no available information on whether it is being implemented in BCMM.

For the time being, HEAIDS appears to be more active at universities compared to TVET colleges. The larger number of campuses and smaller enrolment figures are mentioned as a reason that it's more difficult to reach TVET students. Nevertheless, HEAIDS is focused on expanding its services to TVET colleges, particularly in the peer education programme.

C.2. Services provided by NGOs

loveLife

loveLife is a leading national NGO in the area of HIV behaviour change communication, and provides a variety of different programmes. Most of loveLife's youth-targeted programmes are facilitated through groundBREAKERs (gBs), 18-25 year olds, trained peer educators, who work for loveLife on a full-time basis and receive a small stipend. gBs work together with mpintshis (volunteer peer educators). The key national and BCMM-specific youth-targeted services that loveLife provides are (loveLife, 2015):[20]

[19] The Annual Report for 2015/2016 is not yet available.
[20] Information from loveLife's Annual Report 2014 and personal communication with Michael Ceskio, coordinator of loveLife in BCMM.

- **Public Service Announcements:** In 2014, loveLife reached 4,503,000 listeners with 47 features on the Unhlobo Wenene SABC radio station in the Eastern Cape. They also reached 827,000 listeners with 47 features across six community radio stations, which was more than double the number of listeners than the next highest province (Gauteng, 355,000 listeners).

- **Adolescent and Youth Friendly Services (AYFS):** Through an initiative with the DOH, loveLife stations gBs at clinics, where they aim to improve service delivery of youth-friendly services. In BCMM, 19 gBs are stationed at eleven clinics (usually two per clinic). The gBs are responsible for welcoming youth to the clinics and making sure that they feel comfortable. While young people wait to be seen by a nurse or doctor, the gBs provide various different educational and engaging sessions on issues such as HIV/AIDS, TB and STIs, contraception, sexual and reproductive health, and teenage pregnancy. These peer educations are managed by a professional nurse employed by the health facility, who is trained to work with the youth. Under this initiative, loveLife also trains nurses and health facility staff in the provision of youth-friendly services. Typically, one nurse per facility is trained, but since staff turnover is high, this can often lead to the only trained nurse leaving the facility, particularly as the training itself may equip the nurse with skills that allows her to access other job opportunities.

- **BCC in schools:** gBs also conduct behaviour change communication in schools. The target is that each GB works with five schools in the areas surrounding the health facility at which they are stationed. In practice however, lovelife is currently active in 98 schools in BCMM. gBs work together with the Integrated School Health Programme (ISHP). When the nurses visit the schools for the ISHP screenings, the GBs accompany them and conduct BCC sessions while learners are waiting for their turn to be screened. Lovelife has two different curricula: 'Love for life' is a programme that is focused mainly on HIV, while 'Living my life' is a programme focused on self-esteem and motivation.

- **BCC at sports events:** In collaboration with the Department of Sports and Recreation, loveLife also stations gBs at sports pitches in schools and communities. The sport gBs coordinate various different sports events, and conduct healthy living sessions during these events. There are four sports gBs in BCMM, one at the Legacy pitch and three stationed in schools.

- **Born Free dialogues:** These dialogues are designed to help young people connect with their parents around pertinent social issues. Nationally, in 2014, the majority focused on HIV/AIDS (29%), with 19% focusing on teenage pregnancy, 18% on substance abuse and 13% on healthy sexuality. The Eastern Cape was the province with the highest number of participants in these dialogues, with 8,746 participants from 385 dialogues.

- **Ilovelife.mobi:** loveLife has also recently launched *ilovelife.mobi*, a mobile app which encourages young people to go for health tests and provides health-related information. Users can earn 'tokens' (rewards: e.g. airtime) if they perform certain activities (e.g. TB screening) and log them on the app.

Soul City

Soul City is a social change communication project that operates in several southern African countries. Soul City is best known for its 'edutainment' show "Soul City It's Real", which is aired on national television and now in its 12th season, which has a focus on gender-based violence. Soul City has also produced other television shows, including Soul Buddyz television drama, and its recent launch of the Rise Talk Show, a 'feminist television talk show'. One of Soul City's biggest initiatives are Soul Buddyz Clubs (468 in the Eastern Cape) – social clubs for 8-14 year olds to

discuss a range of social issues. These were not reviewed in detail since the target group are children younger than DGMT's targeted age group.

Recently, Soul City has launched a new initiative – the Rise Young Women's Clubs, clubs of about 20 young women aged 15-24, which are aimed at empowering young women and linking them to quality services. The clubs are initiated by young women themselves, who then register their club with Soul City. Soul City targets existing groups of women in organised settings, e.g. in schools, churches, CBOs, sports clubs, choral groups, TVETs, because they have found it easier and more sustainable to engage groups that already exist. While Soul City does not have particular targets for reaching out-of-school youth, the programme manager estimates that 40% of the club members are not currently in school/training (although these women may be employed / have finished matric).

Soul City provides training, a club starter pack (with links to other NGOs in the area), support visits, a monthly 'Rise' magazine, and organises various events where club members come together. Clubs usually have a mentor, who can be a community member, teacher or member of the organisation that the club developed from (e.g. church, sports coach).

The idea behind the model is to put young people in charge of addressing social issues which affect them, and encouraging them to take responsible action to shape their own lives. The clubs arrange monthly meetings to discuss issues that are important to them (they set their own agendas). In addition, they organise community-based events or guest speakers to come and speak to them.

As part of their current national focus on addressing GBV, Soul City has trained local radio stations in developing programming on GBV. They have also worked with some of the Rise Clubs to conduct GBV advocacy campaigns in their communities, research on GBV in their communities and to be involved in some of the radio programming.

Last year, there were approx. 48 clubs in BCMM, but these clubs are now in the process of re-registering and it is expected that there may be slightly fewer clubs.[21]

Other

There are several other organisations in BCMM which are involved in BCC:

- **Masimanyane** runs Human Rights Clubs in 30 schools in BCMM. They also run a programme on teenage pregnancy, which trained 5400 young people across the Eastern Cape in 2015 on SRHR and gender equality.
- **Masithethe Counselling Services** (former Lifeline) conducts awareness talks in schools, and currently has a longer-term sexual and reproductive health programme in Sakinkhamva High School in Beacon Bay. During the school holidays, they train teenagers through a Teenage Personal Growth course to become peer educators in their schools.
- **CMR** reached 80 teenagers last year with their 'No Apologies' programme on making responsible life choices.
- **NICRO** runs a Safety Ambassadors peer education programme in 3 schools, training 20-30 young people per school on a broad range of social issues, with a focus on crime prevention.

It is likely that there are several other smaller initiatives which we were not able to identify through desk-based research.

[21] Some young women thought they would be featured on the Rise Talk Show and lost interest in the programme once they realised this wouldn't be the case.

C.3. Detailed locations of BCC activities in BCMM

Details of BCC activities in BCMM	
Locations of Rise Young Women's Clubs	
Bongweni Township	2 clubs
Dimbaza	1 club
Duncan Village	3 clubs
King Williams Town	14 clubs
Mdantsane	8 clubs
Mza'Monhle	4 clubs
Health facilities where loveLife groundBREAKERs are stationed	
Central Clinic	East London
John Dube	Scenery Park
Alphendale Clinic	Buffalo Flats
Gompo CHC	Duncan Village
Mdantsane NU1	Mdantsane
Mdantsane NU8	Mdantsane
Mdantsane NU16	Mdanstane
Ndevana	Ndevana
Zwelitsha	Zwelitsha
Ginsberg	King Williams Town
Dimbaza CHC	Dimbaza
Schools in BCMM at which Learner Support Agents of the CSTL Programme are stationed	
East London education district	King Williams Town education district
Alphendale SSS. AW Barnes Primary School. Buchule High School. Duncan Village Primary Ebenezer Majombozi Embekweni Primary Eric Mntonga High School. Floradale High. Goodhope SSS Greenpoint SSS. John Bisseker SSS. Lujiza Primary. (CSTL Pilot School) Lumko High Masibulele Primary School (CSTL Pilot School) Masixole High School. Mzamowethu High School. Mzokhanyo SSS Ngwenyathi High School Nkangeleko Primary School. Nkwezane Primary School Nompumelelo Primary School. Nowawe High School. Parkside Primary Pefferville Primary Qaqamba SSS Sakhikamva SSS Sandile Primary. (CSTL Pilot School)	Archie Velile Breidbach S.S Dimbaza Central JSS Gasela High School Ilitha S.S Luxomo JSS Manezi Primary Masikhanyise primary Mbulelo Benekana S.S Mpumelelo S.S Nosizwe High School Simzamile S.S Xolani S.S Zama Primary School Zanempucuko S.S ZK Matthews SSS Zukhanye S.S

Sinethemba High School. Sinovuyo High School. Sophathisana SSS. St Lukes Primary. (CSTL Pilot School) Thandulwazi PS. (CSTL Pilot School) Thandulwazi PS. (CSTL Pilot School) Tsholomnqa High School Umthiza High School. Unathi High School. Vulamazibuko High School. Wongalethu SSS. Zwelemfundo Public School Zweliyandila SSS	

Annex D Services for addressing VAW in BCMM

D.1. Government response to VAW and GBV

The Department of Social Development's (DSD) Victim Empowerment Programme (VEP)

The DSD responds to violence against women and children through its Victim Empowerment Programme (VEP). The DSD has six service offices in BCMM which provide psychosocial support and counselling, including to survivors of VAW. They do not at present offer other support, such as skills training or legal support but refer clients to SAPS, Thuthuzela Care Centres, courts and FAMSA depending on their needs.

Aside from their own service offices, the DSD registers non-governmental and civil society organisations under their VEP. The VEP organisations and DSD offices refer clients between themselves. There are 12 organisations registered under the VEP in the current year. They provide the following services:

- **Five White Doors of Hope:** The White Doors of Hope (or Victim Empowerment Centres) are staffed by lay counsellors whose role it is to receive and do an initial assessment of the clients that arrive and then to refer them to a social worker, either at one of the DSD's service offices or one of the other VEP organisations which provide counselling services.
- **Four shelters for abused women:** These shelters are discussed further in the sections on Shelters.
- **Three mentorship programmes:** These programmes seem to run a variety of skills training, social support and mentorship programmes, and refer their participants to DSD service offices or other VEP counselling services when issues of GBV are raised.
- **Two counselling services:** These services are discussed further in the section on Counselling and psychosocial support.

The DSD estimates that across BCMM, their associated VEP organisations receive approximately 400 clients a month. As an estimate, of those approximate 400, 289 were seen by counsellors at the DSD's service offices last month. These figures are significantly higher over the festive season and school holidays. All DSD service offices and VEP organisations are listed in 0.[22]

Another initiative that falls under the VEP are the Khuluseka One Stop Centres, launched in 2011, for victims of violence and crime, including domestic violence, GBV, rape, sexual abuse, human trafficking and all man-made and natural disasters. These facilities cater to the immediate needs of victims and provide multi-sectoral, comprehensive services. They are a direct response to the difficulties that victims (especially victims of GBV) may face in accessing services, such as transportation costs, slow response times by police and health services and telecommunication costs. The package of services offered includes a shelter, health care, police services, legal assistance, counselling and psychosocial support (Gender Links, 2014). There is very little information available on the current state or planned expansion of this initiative. It appears that 3 centres have been opened in the Eastern Cape, though none in BCMM (Watson, 2015). However, understanding this initiative further and exploring its interactions with Thuthuzela Care Centres (described below) would be of interest due to the similarities between this model and the one-stop support model proposed by the DGMT.

The National Prosecuting Authority's Thuthuzela Care Centres

Thuthuzela Care Centres (TCC) are led by the NPA's Sexual Offences and Community Affairs Unit (SOCA) in partnership with various departments and donors. They are one-stop support facilities for

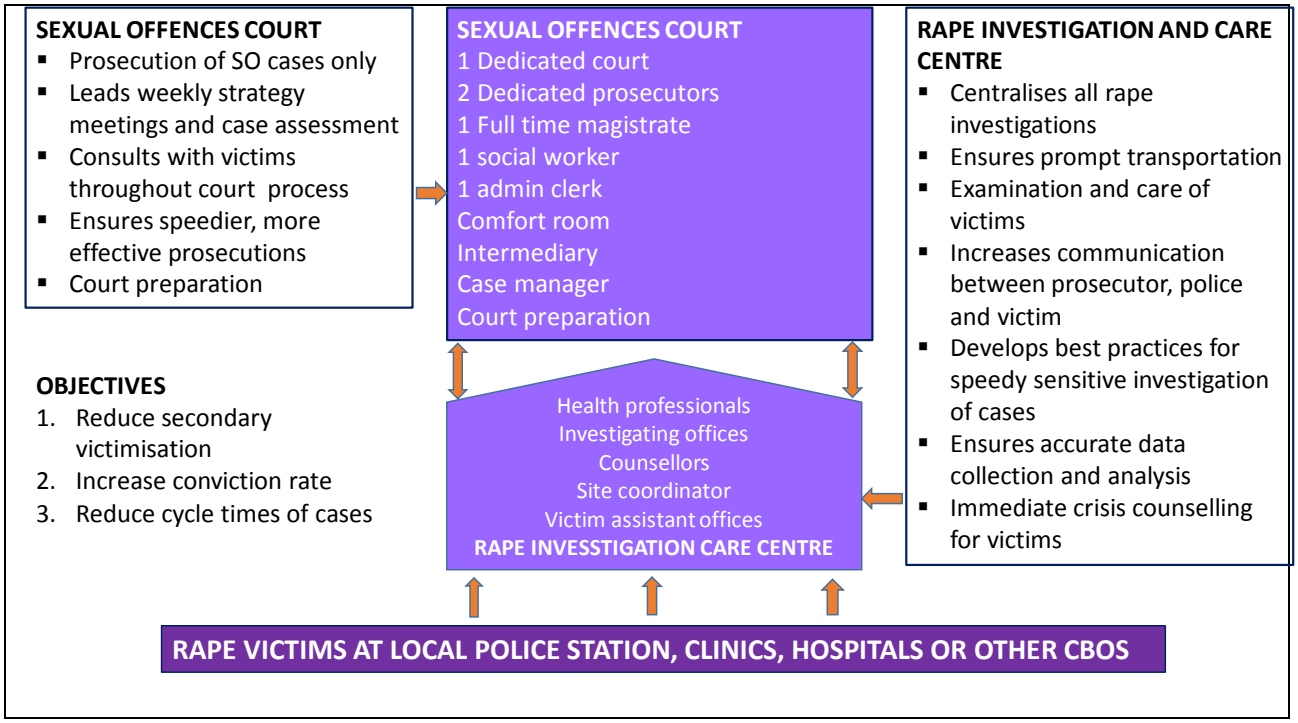
[22] Information through personal communication with Mrs Siviwe Sixaba, Coordinator of the VEP at the EC DSD

survivors of rape, where individuals are provided with the immediate support they require. TCCs aim to coordinate the various agencies involved with providing support to rape survivors (NPA, n.d.):

- Survivors of rape who report their cases to the police are transported to the TCC to be treated in a more friendly and suitable environment.
- At the TCC, a medical examination is performed by a doctor, and other health services are provided.
- There is a police officer on call at the centre who takes the statement.
- A nurse arranges follow-up visits and long-term counselling. (There are generally some counsellors on site, either from the DSD, DOH or NGO staff).
- The individual is transported home or taken to a place of safety.
- There are also specialist prosecutors and victim assistant officers who prepare the individual for court.
- TCCs often also have NGO staff that assist with containment (comforting and explaining of the procedures) and debriefing. NGO staff typically receive stipends through NACOSA or the DSD.

Figure 24 describes the TCC model, including their connection to sexual offences courts which are discussed further in the section below.

Figure 24: The Thuthuzela Care Centre Model



Source: Mosaic Training, Service and Health Centre & NPA, Thuthuzela Care Centres: Turning victims into survivors

In BCMM, there are two TCCs, one at Cecilia Makiwane Hospital in Mdantsane and one at Fort Grey Hospital in King Williams Town. Each TCC is supported by 2 staff from the **Masimanyane NGO**, who help out particularly during the night shifts. Masimanyane staff provide initial containment services, such as taking down patient histories, providing initial support, sometimes they work with doctors to translate, and then handling referral and debriefing. Because many women stay within the

network of services that Masimanyane provides (described later), staff are able to track the progress of many women who arrive at the TCCs.

Masimanyane staff estimate that Cecilia Makiwane receives approx. 9-12 cases a day, and Fort Grey Hospital 5-7 cases a day. In 2012, another report (Vetten, 2015) reports a monthly average of 72 cases for Cecilia Makiwane, suggesting that the number of cases would have increased significantly over the past 4 years (to approx. 270 cases a month now), although it is possible that the NGO's estimates are over-estimations.

The Department of Justice and Constitutional Development's dedicated Sexual Offence Courts

Sexual Offence Courts are courts that are especially equipped to provide a suitable environment in which survivors of sexual offences can testify. Sexual offence courts were established in 1993 but phased out in 2005 due to budget constraints. They were re-established in 2013. The services they provide include (DOJ & CD, 2014):

- **Court preparation services:** Explanation of the court processes. Witnesses are welcomed by a Court Preparation Officer (CPO).
- **Pre- and post-trial trauma debriefing** delivered by the CPO
- **Private testifying room** if the witness does not wish to testify in the presence of the accused
- **Private waiting rooms** for both adults and children
- **Witness fee services** which cover the cost of transport and food while in court
- **Intermediary services** for children and persons with mental disability

In BCMM, the Magistrate's court in East London is the only dedicated sexual offences court.[23]

Policing services from the South African Police Service (SAPS)

SAPS has Family Violence, Child Protection and Sexual Offences Units (FCS units) across the country whose mandate includes handling crimes of sexual violence and violence against women. These units were initially established in 1995, temporarily disbanded in 2006 but re-established in 2011.

There is no specific information available on how well these function. In the Eastern Cape, a monitoring survey (Shukumisa, 2014) reports that only 20% of police stations had information about hospitals providing PEP to rape survivors or a list of organisations providing services to rape survivors.

It is not clear where these FCS units are based in BCMM, but Table 3 shows the number of specialist detectives available for each of the police stations that were included in the monitoring survey (Shukumisa, 2012). It was however noted that many of these detectives are not stationed at the police station.

Table 3: Number of specialist detectives available per police station

Number of specialist detectives available per police station	
Beacon Bay	10
Bisho	4

[23] Mdantsane Magistrate's Court used to be a sexual offences court under the old model prior to 2005. Information from personal communication with Mrs Gwintsa, Director of Legal Services at the DOJ & CD

Dimbaza	4
East London	22
King Williams Town	20
Zwelitsha	2

Source: Shukumisa (2012) Monitoring the implementation of sexual offences legislation & policies: Findings of the monitoring conducted in 2011/2012.

However, at a national level, it has been noted that 1) women are not well enough represented in the FCS units and 2) FCS units do not have victim-friendly rooms (a 2014 report states that only 14 out of 176 FCS units had functional victim friendly rooms. The extent to which this may be a problem in BCMM was not ascertained.

Legal Aid South Africa

Legal Aid is an independent body that has a mandate from the South African Constitution to provide tax-funded legal assistance to those unable to afford it otherwise, including on cases of domestic violence. Legal Aid has justice centres in central East London and King Williams Town (Legal Aid, 2015).

D.2. NGO response to VAW and GBV

Masimanyane Women's Support Centre

Masimanyane is the largest NGO in the Eastern Cape that addresses issues of violence against women. They currently employ 62 staff and have their head offices in central East London. Masimanyane seeks to support women at all stages of the continuum of care that survivors of VAW progress through, including support at Thuthuzela Care Centres, police stations, courts, in communities and through a range of counselling services.

The various services that Masimanyane offers in BCMM provide support to survivors of VAW at various stages. In this way, women stay in the Masimanyane network, and it is easier to follow up with them and provide continuous support where required. Masimanyane's services include:[24]

- **Staff placed at police stations:** Masimanyane has social workers stationed in 4 police stations in BCMM: Fleet Street, Duncan Village, Buffalo Flats and Cambridge.
    - Masimanyane staff provide women who come in to lay charges with support, debriefing and paralegal advice. They help them with filing applications for protection orders, maintenance orders and divorce.
    - Masimanyane staff work hand-in-hand with the police officers stationed at the station. In some cases, they become involved in advocacy work at the police stations, or provide ad hoc training to police officers.

- **Staff placed at the Thuthuzela Care Centres:** Masimanyane has staff placed at both TCCs in BCMM. Their involvement is described in more detail in the section on Thuthuzela Care Centres.

- **Shelter for women:** Masimanyane has recently opened a shelter for women who have experienced VAW. This is described in more detail in the section on Shelters.

- **Counselling, support and community advocacy:** Masimanyane has community offices in Scenery Park, Zwelitsha and Dimbaza. These centres conduct a range of activities, including counselling and support. They engage with communities and traditional leaders and conduct community advocacy. They are responsible for outreach activities to the areas surrounding those where the offices are based. Masimanyane has one larger centre in King Williams Town, the Empeliswini HIV & AIDS Centre.

[24] Information from personal communication with Masimanyane staff and Lesley Ann Foster, Director of Masimanyane

  - There are a total of 8 social workers at the centre, 4 of which are responsible for providing counselling to women referred from the TCC.
  - This centre is specifically focused on HIV and provides community programmes, training and education workshops and HIV testing.

- **Staff placed at Magistrate's Courts:** Masimanyane has 2 people stationed (per court) at East London and Mdantsane magistrates' courts (with plans of expanding to Zwelitsha).
  - The staff support women who are attending trial and also conduct advocacy.
  - One person per court goes out into the community to provide services there.

- **Advocacy and empowerment work:** Nationally, Masimanyane is involved in advocacy and training, producing inputs to legislation on women and children, producing shadow reports (state monitoring) and networking nationally and regionally. Masimanyane also provides 2-3 years of leadership training to women to help them advocate for important issues in their communities. They directly engage with local and provincial government to advocate on issues such as improvements in the provision of toilets or the building of a pedestrian bridge. Masimanyane brings these women together to then advocate with government at the national level.

Table 4: Scope of Masimanyane's services during 2015

Type of service	Activities performed
Police stations	
Fleet Street	• 1864 clients (1675 new clients, 1466 females) • 1 Training (TCC staff),13 participants. • 3 talks, 83 female participants.
Buffalo Flats	• 1274 clients (1229 new clients, 997 females) • 3 workshops, 146 participants • 12 talks, 3374 participants.
Duncan Village	• 758 clients (634 new clients, 572 females) • 4 talks, 101 female participants. • 1 workshop, 49 participants
Cambridge (since July 2015)	• 236 Clients (229 new clients, 194 females) • 1 workshop on SRHR, 17 young participants • 1 awareness campaign 174 participants • 5 talks, 835 participants • 4 dialogues, 234 participants
Magistrate's courts	
East London	• 2 Workshops, 107 participants • 3 talks, 62 participants
Mdantsane	• 1357 clients (1044 new clients, 1102 females) • 5 talks, 441 participants
Other	
Shelter	• 12 female clients and 11 children (June to December 2015)
Empilisweni Centre	• 1635 participants for HCT. • 156 participants counselled of which 89 females and 67 males. • 68 workshops and 2100 participants. • 47 awareness campaigns and 8059 participants. • 19 talks and 2201 participants. • 16 dialogues and 828 participants. • 5 radio talks 68000 listeners. • 5 Trainings and 99 participants.
Psychosocial counselling sessions	• 14,350, of which 13,073 with females
Community awareness activities	• 33 community dialogues • 6 door-to-door campaigns • 49 community awareness campaigns

	• 121 community workshops • 37 talks in communities • 23 talks in schools

Source: Statistics provided by Masimanyane's director, Lesley Ann Foster.

Shelters for abused women

From the information that could be obtained it appears that there are 3 organisations that currently offer shelters for abused women:

1. **Masimanyane** has recently opened a shelter for women in central East London, which can accommodate 10 people at a time.

2. **Khanyisa Community Based & Safe Home** operate two shelters in King Williams Town according to the DSD.

3. **CMR** operate two shelters in East London according to Masimanyane staff.

All of these shelters fall under the DSD's VEP. The DSD and Masimanyane report that shelters refer women between each other when they have no spaces available. There are also several smaller community-based safe houses within BCMM.

Counselling and psychosocial support

Various organisations provide counselling and psychosocial support to women affected by VAW. Aside from Masimanyane, some of the other organisations active in this field include:

- **Masithethe Counselling Services** (formerly East London Lifeline) is located in central East London, and are active primarily in Southernwood, Buffalo Flats, Braelyn, Beacon Bay, Gompo and Cambridge. They provide counselling services on a range of different issues. They aren't able to isolate their figures to counselling sessions specific to domestic violence, but as a VEP centre, such cases get referred to them. Between January and July 2016, they have provided 1298 counselling sessions.[25]

- **CMR** is a Christian community-based organisation which is active in East London, including in Reeston, Mza'Momhle and Ducats. CMR reached 349 persons with services for domestic violence last year, including conducting 120 counselling sessions and referrals to places of safety. They also worked with 99 cases of alleged sexual abuse with children (amongst a total of 973 sessions on child abuse and neglect) (CMR, 2015).

- **FAMSA** is a national organisation with a branch in central East London, which offers a range of counselling and educational/preventative services to children, youth and adults.

- **NICRO** is a national organisation with a branch in central East London. They work primarily with people who come into conflict with the law. In this context, they provide counselling and support to families or couples affected by GBV in settings that would usually include the offender. However, they also offer counselling services to the general public. Their staff at the East London branch estimate that they receive 20-40 cases related to domestic violence each month. NICRO also conducted SETA-accredited training on GBV and HIV for 160 police officers in the Eastern Cape during 2015 (NICRO, 2015).

[25] Information from personal communication with Jackie Orsmond, Masithethe Counselling Services.

Masimanyane staff estimate that there are about 30-40 women's groups working around VAW in communities in the Eastern Cape. Masimanyane itself is part of the Women's Ikhwelo Network, a network of community-based women's group that deal with violence against women and HIV/AIDS.

D.3. Detailed locations of services for addressing VAW in BCMM

Details of services for VAW in BCMM		
Locations of the DSD's service offices		
Mdantsane NU1	Zwelitsha	
Mdantsane NU11	King Williams Town	
Dimbaza	East London	
Organisations registered under the DSD's Victim Empowerment Programme (VEP)		
Name of organisation	Location	Type of service
Khanyisa Community Based & Safe Home	King Williams Town	Shelter
CMR Safe Home	East London	Shelter
Masimanyane Safe Home	East London	Shelter
Gilgal Victim Empowerment and Information Centre	Mdantsane	White door Containment & referral
King William's Town Victim Empowerment Centre	King William's Town	White door Containment & referral
Dimbaza Victim Empowerment & Information Centre	Dimbaza	White door Containment & referral
Resurrance	East London	White door Containment & referral
Buffalo Flats White Door Centre of Hope	East London	White door Containment & referral
Zingce Ngayo Multi-Purpose Academic	East London	Mentorship
Ithemba Mentorship Programme	Sweetwater	Mentorship
Catch Projects	Gonubie	Mentorship
Masimanyane Women's Support Centre	East London	Containment, counselling, social & legal support
East London Lifeline (Masithethe Counselling Services)	East London	Counselling
Thuthuzela Care Centres		
Cecilia Makiwane Hospital	Mdantsane	
Fort Grey Hospital	King Williams Town	
Sexual Offence Courts		
East London Magistrates Court		
Masimanyane Women's Support Centre programme locations		
Staff based at police stations	Fleet Street Buffalo Flats Duncan Village East London	
Staff based at Thuthuzela Care Centres	Cecilia Makiwane Hospital, Mdantsane Fort Grey Hospital, King Williams Town	
Staff based at Magistrate's Courts	East London Mdantsane	
Community-based offices (counselling & psychosocial support)	Scenery Park Zwelitsha Dimbaza Empilisweni HIV/AIDS Centre, King Williams Town	

Annex E Two case studies on combination prevention strategies in sub-Saharan Africa

Box 1: Case Study: Empowering girls and young women living with HIV in Uganda

The Problem:
Girls and young women in Uganda are disproportionately affected by HIV but they also face sexual and gender-related violence and a lack of access to sexual education, health services, social protection and information.

The Intervention:
The Link Up project works with young people, including girls and young women living with and affected by HIV (aged 10–24) to help reduce the number of unplanned pregnancies, new cases of HIV transmission and HIV-related maternal mortality. The Community Health Alliance in Uganda (CHAU) has partnered with Mildmay to empower girls and young women living with HIV to access quality integrated sexual and reproductive health and rights (SRHR) and HIV services. Their work includes peer education, counselling services, training for services providers (in particular to use softer communication skills so that women and girls feel comfortable accessing their services) and the provision of an integrated package of services.

Interim results:
Massive uptake of services at facilities indication a real need. Between October 2013 and December 2015, more than **3,500** young women and girls living with HIV accessed services to prevent onward transmission, including treatment adherence support, peer education and counselling. Young mothers living with HIV were also supported in preventing vertical transmission in an environment in which they could freely discuss concerns about their own health and the health of their babies. Similarly, in the same period, more than **30,000** young women and girls who tested negative were provided with an integrated package of SRHR/HIV prevention services such as family planning, HIV testing, peer education and male and female condoms.

Source: International HIV/AIDS Alliance (2015:13)

Box 2: Combination prevention for people who use drugs in Kenya

The Problem:
Injecting drug users are a well-known HIV high risk group but in sub-Saharan Africa HIV prevention programmes tend to focus on the drivers of HIV among the general population. This has meant rising HIV prevalence levels among this population group, even when prevalence among the general population is going down.

The Intervention:
Community action on harm reduction (CAHR) project aims at expanding harm reduction services to drug injecting users through a combination of structural, behavioural and biomedical interventions.

Structural interventions

- Advocacy for harm reduction policies
- Human rights advocacy against discriminatory practices

Biomedical interventions

- ARV treatment and STI treatment through a referral system
- Community based rapid HIV testing
- Needle syringe exchange programmes
- Condom distribution and promotion

Behavioural interventions

- Peer education and outreach by people who use drugs
- Stigma reduction programmes through sensitisation and training of policy makers and the police

Interim results:
To date, more than 8,800 people who use drugs have accessed CAHR-supported services, 6,500 beneficiaries accessed voluntary counselling and testing services, and more than 350 people who use drugs initiated ART. There has been a massive increase in the number reporting using a clean syringe in last injection from 52% at the beginning of the project to 88%.
Source: International HIV/AIDS Alliance (2015:16)