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EVIDENCE FOR HIV PREVENTION IN SOUTHERN AFRICA

EHPSA SHORTS
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Social and behaviour change interventions in HIV prevention for adolescents

2. The role of SBCC in biomedical interventions

INTRODUCTION

Adolescents and young people in eastern and southern Africa are highly affected by HIV and AIDS, with an estimated 2.7 million people aged 15 to 24 years living with HIV. This accounts for more than half the youth HIV population across the globe[1] [2]. Girls are disproportionately affected - they are more than two-and-a-half times more likely to be infected with HIV than boys of the same age.

Despite these striking statistics, when it comes to effective HIV prevention programming, this population group has been left behind, with high rates of new HIV infections occurring from mid-adolescence onwards. The current body of evidence available on effective prevention packages tailored for adolescents and young people in ESA remains limited.

ABOUT THE REPORT

In 2015 EHPSA commissioned MannionDaniels to review the role of social and behaviour change communication (SBCC) in combination prevention programmes for adolescents in eastern and southern Africa. This short article is based on the original technical report, which is available on the EHPSA website at http://www.ehpsa.org/critical-reviews/sbcc

The report employed qualitative techniques, including: key informant interviews with 48 stakeholders at global, regional, and country levels, and an analysis of country case studies. More in-depth insights were obtained from informants in three focus countries—Malawi, South Africa and Tanzania.

1 UNICEF website: https://www.unicef.org/esaro/5482_HIV_prevention.html

2 UNICEF website: https://data.unicef.org/topic/hivaids/adolescents-young-people/#, 2016

The report defined **SBCC** as the use of communication to change behaviours by influencing knowledge, attitudes and social norms. It coordinates messaging across a variety of communication channels to reach multiple levels of society—individuals, communities and policymakers[3].
For decades SBCC has been seen as a key component of combination prevention programmes.
Adolescence: Is defined as age range 10-24 years, disaggregated into three age bands. See EHPSA Critical Review http://www.ehpsa.org/critical-reviews/age-disaggregation.

NEW BIOMEDICAL INTERVENTIONS

The past decade has seen diversification in biomedical tools available to support prevention interventions. These include pre-exposure prophylaxis (PrEP), voluntary medical male circumcision (VMMC), and treatment as prevention (TaSP). When tested in trials or pilot situations these tools have demonstrated marked success in preventing HIV transmission[4 5].

As the evidence for new biomedical prevention technologies mounts, major donors have found it difficult to justify budgets for behavioural interventions and their investment has declined.

Key informants commented that these successes have led to the "re-medicalisation" of HIV prevention: as the readily measurable evidence for new biomedical prevention technologies has mounted, it has become increasingly difficult to mobilise funding from major donors and national governments for behavioural interventions. Instead, more limited and targeted ("optimised") SBCC interventions are incorporated into biomedical packages to increase effective demand for technologies.

THE ROLE OF SBCC IN BIOMEDICAL INTERVENTIONS

SBCC is now frequently integrated into biomedical prevention packages in operational research or real-world programming. The review investigated evidence on the role of SBCC in the two biomedical strategies of voluntary male circumcision (VMMC) and pre-exposure prohylaxis (PrEP).

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3 Johns Hopkins Center for Communications Programs https://ccp.jhu.edu/social-behavior-change-communication/

4 UNAIDS, Fast-tracking combination prevention: towards reducing new HIV infections to under 500,000 by 2020. Geneva 2015. http://www.unaids.org/sites/default/files/media_asset/20151019_JC2766_Fast-tracking_combination_prevention.pdf , p.18

5 Njeuhmeli E, et al. Lessons learned from scale-up of voluntary medical male circumcision focusing on adolescents: benefits, challenges and potential opportunities for linkages with adolescent HIV, sexual, and reproductive health services. *Journal of AIDS*. 2014 Jul 1;66 Suppl 2:S193-9

Voluntary Male Medical Circumcision
While significant progress has been made in ESA since VMMC was introduced, annual figures for circumcision plateaued or declined in eight countries between 2014 and 2015. This indicates a need to reinvigorate focus on the barriers to demand and uptake[6]. It may also point to the need to maintain promotion and knowledge of VMMC with new generations as they enter adolescence.

The review identified a clear role and need for SBCC to enhance enabling factors and mitigate deterrents to VMMC—specifically around fear and pain perception; partner knowledge and support; and dispelling myths and misconceptions.

There is already good evidence for the contribution of SBCC in VMMC. For example, a study in Zimbabwe showed that mass media and targeted inter-personal communication played a critical role in correct knowledge, and intention to circumcise. Over 68% of men (with no differences by age) had heard of VMMC as a HIV prevention intervention[7]. In this study 71% cited radio as a key source of information followed by newspapers (28%). The role of interpersonal communication was also important with 28% highlighting promotion through health and community workers and via peers and relatives (26%). Another study in Zimbabwe and Tanzania also showed increased VMMC uptake as a result of SBCC programmes[8].

The shifting conceptualisation of SBCC—from an essential stand-alone pillar of combination prevention to playing a support role in biomedical interventions—has had a profound impact on SBCC policy and programming.

Pre-Exposure Prophylaxis
PrEP has been proposed as a key tool for prevention amongst high-risk populations, including young women and girls. However, as PrEP is a more recent prevention technology than VMMC, there is a limited body of evidence on its uptake and effectiveness amongst adolescents and young people. Nevertheless, from experience to date on adolescent ART programmes and early PrEP trials, it has been shown that there is a need for SBCC to generate demand, to inform and educate, and to promote adherence to PrEP.

There are at least 12 current demonstration projects and trials involving PrEP and adolescents in the region. Many of these include SBCC approaches such as:

- Motivational interviewing and counselling;
- Empowerment sessions including life skills and comprehensive sexuality education; and
- Adherence clubs, SMS reminders.

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6 UNAIDS, Prevention Gap Report 2016, Geneva 2016 (http://www.unaids.org/en/resources/documents/2016/prevention-gap), p.6

7 This exceeded average HIV prevention knowledge levels in the region. Hatzold K Mavhu W Jasi P et al, Barriers and motivators to voluntary medical male circumcision uptake among different age groups of men in Zimbabwe: Results from a mixed methods study, *PLoS ONE* 2014 May 6. 2014. https://doi.org/10.1371/journal.pone.0085051

8 Njeuhmeli E, et al, 2014. 0p cit

In all cases SBCC packages share some common approaches. For example:

- They have been "optimised" to specifically target PrEP-related behaviours rather than others in order to increase cost effectiveness and enable scale up post-trial; and
- They recognise the need for enabling factors beyond HIV prevention such as negotiation skills, sexual and reproductive health, and livelihoods.

As interventions are still under development, it was not possible for the review to evaluate the quality of content or efficacy of these packages.

CONCERNS OF KEY INFORMANTS

Some informants expressed a concern around limitations when integrating SBCC into biomedical interventions. The approach often tends to use optimised or scaled-down SBCC tools, and it is not clear whether the selection of SBCC tools is based on current evidence of "what works". For example, in a number of biomedical programmes, key informants highlighted that SBCC approaches now tended towards a limited range of interpersonal techniques such as counselling, a short knowledge and skills component, and sometimes use of mobile SMS reminders.

In principle, this approach may be important if it offers cost effectiveness and facilitates scale-up. However, in light of the gaps in our knowledge of what works, a focus on innovation and evidence-based packages is critical to quality programmes. It will be essential to examine and compare the effectiveness of different SBCC optimised packages within biomedical prevention, and better understand their role in improving acceptance, demand, uptake and adherence within the prevention and treatment continuum.

CONCLUSIONS

The review concluded that SBCC has an important role to play in supporting biomedical interventions for adolescents. This role could be strengthened by clear, evidence-based guidelines on SBCC for biomedical preventions such as TasP, condom programmes, VMMC and PrEP. Informants also pointed to the importance of SBCC to maintaining achievements in levels of broader HIV knowledge and more positive societal norms and attitudes around HIV stigma and interventions such as condom use.

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