POSITIVE PREVENTION: Process of Adapting Healthy Relationships to African context

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Background (contd)

- The SAHARA multi-country research project on positive prevention
  - Eight countries in Sub-Saharan country including four in the Southern African Development Community (SADC) region (viz., South Africa, Botswana, Lesotho and Swaziland) participated in the development/cultural adaptation of a risk reduction intervention for PLWHA
  - The main goal of the overall project was to develop and/or adapt interventions to address the pressing issues of both HIV/AIDS related stigma and HIV prevention among PLWHA

Background

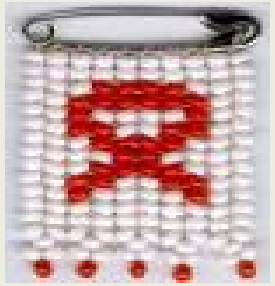
- In Sub-Saharan Africa the number of people living with HIV/AIDS (PLWHA) who are aware of their HIV status has increased as ARV drugs become more widely available and accessible
- PLWHA on ARV treatment experience a rapid improvement in health status resulting in an increased sexual libido
- A public health imperative is thus created to address the prevention needs of PLWHA to prevent them from engaging in unsafe sex practices due to risk compensation (or behavioural disinhibition or treatment optimism).

Phase I: Discovery*

Undertake formative/elicitation behavioral epidemiological studies research so that findings will be relevant to the target group.

Preliminary research

- We undertook both qualitative and quantitative work in each of the four participating countries as follows:
  - Six focus groups of PLWHA (2 men's, 2 women's and 2 mixed groups; plus 2 MSMs in South Africa)
  - Ten to 20 key informant interviews (e.g., 5- 10 policy makers from government, AIDS advocates, & directors of NGOs including for PLWHA, as well as 5-10 health providers, etc.)



* NIH (2001, April 5). *Phases of Behavioural Prevention Research.* Bethesda: NIH

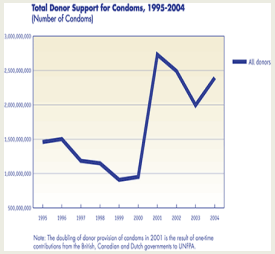
Phase I: Discovery (contd)

Preliminary research (contd)

- 200 – 1000 PLWHA, from existing support groups, treatment centres
  - Participants included MSM, men and women
  - Used PLWHA as fieldworkers as much as possible

Findings

- Having not disclosed HIV status to partners was also independently associated with having lost a job or a place to stay because of being HIV positive and feeling less able to disclose to partners.



Phase I: Discovery (contd)

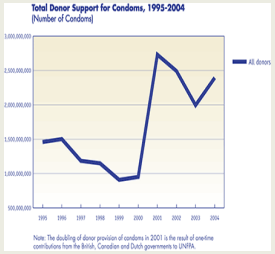
Findings (contd)

- The data also suggested that:
  - HIV-related stigma and discrimination are associated with not disclosing HIV status to sex partners and
  - non-disclosure is closely associated with HIV transmission risk behaviours.

Both key informants and PLWHA were supportive of the need for risk reduction interventions for PLWHA.

Conclusions

- Interventions were urgently needed in Southern Africa to reduce AIDS stigma and discrimination and to assist people with HIV to make effective decisions whether to disclose their HIV status and to practice safer sex regardless of disclosure decisions



Phase II: Exploratory

Based on preliminary behavioral epidemiological data from at-risk populations, begin to adapt, develop, and initially test some preventive interventions that may stop HIV infection and its consequences.

Step 1:

- Once the formative/elicitation research had been completed and the data analysed, the next task was to identify possible interventions
- We looked for interventions that dealt with two main issues among PLWHA:
  - Disclosure
  - Risk reduction

Phase II: Exploratory (contd)

Step 2:

- Two main sources were contacted, namely,
  - A useful resource book on positive prevention which was released in 2005 that was edited by Kalichman (2005)*
  - CDC's Dissemination of Evidence-Based Interventions (DEBI) initiative

- Two interventions that were chosen as possible candidates for adaptation are
  - the Healthy Relationships based on social support groups developed by Kalichman and his associates
  - the clinically-based Options for Health developed by Fisher and his associates.

- Both are theoretically-based, rigorously evaluated interventions that were developed and tested in the USA.

* Kalichman, S. C. (2005). *Positive Prevention Reducing HIV transmission among PLWHA.* New York: Kluwer Academic/Plenum Publishers.

Phase II: Exploratory (contd)

Step 3:

- A cultural adaptation workshop was organised in Cape Town with delegates from each of the four participating SADC countries in attendance

- Workshop on Healthy Relationships was facilitated by Prof Seth Kalichman who developed the original intervention in the USA with his colleagues.

  - Summary report of the main findings from each of the four participating countries were presented

  - It was found that the main themes from the four countries were generally consistent with each other

Phase II: Exploratory (contd)

Step 3 (contd)

- ensure that all intervention materials were contextually relevant
  - Changes to the implementation manual were undertaken where necessary
  - We replaced the US-developed video clips which were a major part of the original intervention with South African video clips from popular local movies and television shows
  - A major innovation was to create some storyboards using the video clips for use in venues where there was no electricity and video clips could therefore not be used.

Original intervention materials

In rural African settings, participants could not relate to a woman in a bar

Adapted intervention materials

Phase II: Exploratory (contd)

Step 4:

- As the intervention is fairly complex and requires some understanding of the complexities of human behaviour, it was decided to use professionals as facilitators to run the small groups
  - In Botswana facilitators were social workers
  - In South Africa facilitators are social workers, psychological counsellors and health promoters

- Facilitators worked in pairs consisting of one male and one female

Phase II: Exploratory (contd)

Step 5: Botswana pilot study

- Acceptability, feasibility and fidelity of intervention were tested on 10 experimental groups and 10 control groups with 3 months follow-ups
- Data are currently being analysed
- Lessons learnt from the Botswana pilot used in larger South African study in Phase 3 especially during training.

Phase 2: Exploratory (contd) - Pilot study of Healthy Relationships in Botswana in 2006

Tent where lunch was served for participants in the pilot

Phase III: Efficacy

Having demonstrated preliminary efficacy (internal validity) of prevention interventions, conduct a selected number of randomized, clinical trials of interventions initially tested in Phase II to ensure that there is sufficient external validity to justify scaling up these interventions.

Current South African study

- The HSRC was funded by the USA's President's Emergency Plan for AIDS Relief (PEPFAR) through the USA's Centres for Disease Control and Prevention (CDC) in 2006 to undertake a large-scale public health evaluation of a culturally adapted Healthy Relationships intervention in Mthatha in the Eastern Cape Province of South Africa.

Training in Mthatha on Healthy Relationships

Two weeks training with project staff on adapted Healthy Relationships including one week with two facilitators from Botswana

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Training involves didactic lectures as well as demonstrations of activities by the trainers followed by a lot of role playing by staff under training

Phase III: Efficacy (contd)

Current South African study (contd)

- A quasi-experimental field trial is being conducted until July 2009.
- It involves 60 experimental groups and 60 control groups, with 6-months follow-up assessments to determine durability of the effects.
- The ultimate goal is to determine how well it works in South Africa and to scale it up throughout the country and Sub-Saharan Africa.
- The report of the findings will be available by September 2009.

Phase IV: Effectiveness

If behavioral interventions have been demonstrated to work, the next step is to demonstrate that they can be transferred to other settings with other populations, that they work in real-life settings in non-government organizations and public clinics, and that they are cost-effective.

- Yet to be undertaken
- If found efficacious, need to modify slightly to fit various contexts in the rest of Sub-Saharan Africa and implement
- Issue of levels of cadre who deliver the intervention is critical – should investigate if it can be implemented by lay counselors such as VCT and/or adherence to be widely available and also more cost effective.

Conclusions

- In developing or adapting an intervention it is critical to take into account the context – this is accomplished through formative/elicitation research
- It is necessary to undertake impact evaluation of the adaptation to determine efficaciousness/effectiveness of the intervention
- Scaling up is done following efficacy trails under real life conditions in various settings by organizations working on the ground

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