Public health evaluation of the *Healthy Relationships* positive prevention programme in four districts of the OR Tambo District in the Eastern Cape, South Africa

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Background

- The number of people in South Africa who are aware of their HIV positive status continues to grow as a result of both HCT and PMTCT programmes as well as the wider availability of antiretroviral (ARV) treatment.

- Due to more effective treatments. people living with HIV/AIDS (PLWHA) now live longer and healthier lives including having sex.

- Also the availability of ARVs might encourage unsafe sexual behavior among PLWHA who are not yet on ART due to behavioural disinhition/risk compensation.

Background (contd)

- In late 2005 our research team undertook some formative research among PLHIV which involved both qualitative and quantitative research in Cape Town, and we obtained the following findings from a survey involving a sample over 1000, half of whom were on ARV treatment:

  - Of the (85%) participants who were currently sexually active, (42%) indicated that they had sex with a person that they had not disclosed their HIV status to in the previous 3-months (Simbayi et al., 2007a, 2007b).

Background (contd)

- Participants who had not disclosed to all of their sex partners:
  - were significantly more likely to have multiple sex partners,
  - HIV negative partners,
  - partners of unknown HIV status,
  - and unprotected intercourse with non-concordant sex partners

- 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

Background (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

Positive prevention

- The NSP identifies a strategy known as positive prevention (or prevention for positives) as one of the main strategies that should be used in the fight against HIV/AIDS.
- Positive prevention targets PLWHA who know their HIV+ status to take personal responsibility for HIV prevention.
- Positive prevention is beneficial in two main ways:
  - as primary prevention whereby there is prevention of passing the HIV infection to the sexual partners with whom people who are living with HIV/AIDS (PLWHA) have sex.
    - Indeed some PLWHA continue to engage in unsafe sex practices and often do not disclose their HIV status.

Positive prevention (contd)

- as secondary prevention whereby PLWHA themselves are prevented from becoming infected by a different strain of HIV (secondary infection) to the one which they already carry and possibly are receiving some ART treatment in response to.
  - Indeed very few PLWHA, let alone many other people who are HIV-negative, know about the HIV status of their sexual partners.

Positive prevention (contd)

- Until recently, HIV prevention efforts in most countries in the world have focused primarily on encouraging the majority of people, including those not at risk, to engage in safe(r) sex practices.

- Among the safer sex practices promoted are:
  - Abstaining (A) from having sex or delaying of sexual debut
  - Being faithful (B) to a single sexual partner, and avoid having multiple sex partners
  - Using condoms (C) consistently when having sexual intercourse
  - Not sharing unsterilised drug equipment.

Positive prevention (contd)

- Positive prevention has been the mainstay of prevention in some countries especially the USA since 2002.
- Clearly, from a public health perspective it is far more efficient to reduce transmission of HIV from people living with HIV/AIDS than in trying to increase condom use among masses of mainly uninfected people the majority of whom do not even believe that they are at risk.
- However, people who know they are HIV positive have been completely ignored in terms of prevention efforts in the Sub-Saharan Africa HIV epidemic until only in the past few years.

Positive prevention (contd)

- The delay in addressing the prevention needs of PLWHA apparently stemmed from multiple factors including
  - early emphasis on vulnerable at-risk populations,
  - denial of continued transmission risks among people who know that they are HIV infected,
  - fear of negative social repercussions against already stigmatized people with HIV in the form of 'blaming the victim', and
  - HIV/AIDS having high mortality in a context of few effective treatments.

Positive prevention (contd)

- **With the advent of effective combination ARV therapies, everything in AIDS changed, including the willingness of researchers, programme implementers, and policy makers to address sexual and drug use practices among people who know they are HIV positive.**

  "*With increased access to antiretroviral (ARV) treatment in developing countries throughout the world, … there is an unprecedented opportunity to forge a comprehensive response to the global AIDS epidemic by integrating HIV prevention interventions into expanding treatment programmes*" (Global HIV Prevention Working Group, 2004).

Positive prevention (contd)

- To date, there are a large number of evidence-based positive prevention interventions that are available in the world.
- Most of, if not all of, them have been developed and successfully tested in the USA where they are also being rolled out (for a recent review, see Gilliam & Straub, 2009).
- Very few of these interventions, if any, have been developed and/or culturally-adapted and evaluated in South Africa.
- The exception are the Options for Health and Healthy Relationships programmes – two USA-developed interventions that our team has been working one for the past 5 years.
- Our project here in OR Tambo District focused on Healthy Relationships.

Aims of the Marang Positive Prevention Project

- In 2006 we were funded by the USA's President's Emergency Plan for AIDS Relief (PEPFAR) through the USA's Centres for Disease Control and Prevention (CDC) to, among other things, undertake a public health evaluation of a culturally-adapted *Healthy Relationships* which is existing CDC intervention for promoting HIV status disclosure and behavioural risk reduction strategies for PLHIV.

- The ultimate goal was to determine how well *Healthy Relationships* works in SA and to scale it up throughout the country and sub Saharan Africa if it was found to be efficacious

The Healthy Relationships programme

- The Healthy Relationships intervention is a multi-session, small-group (10-12), skills-building programme for both HIV-positive men and women.
  - Five 2-hour sessions over 2.5 weeks/ 3-hour sessions over 5 days
- The programme is designed to reduce participants' stress related to safer sexual behaviours and disclosure of their sero-status to family, friends, and sexual partners.

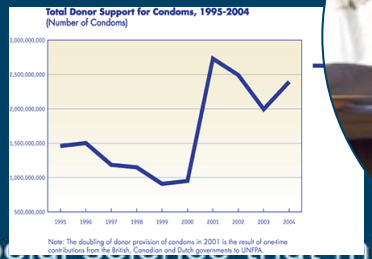
- The programme is based on Social Cognitive Theory, which states that persons learn by observing other people successfully practice a new behaviour.

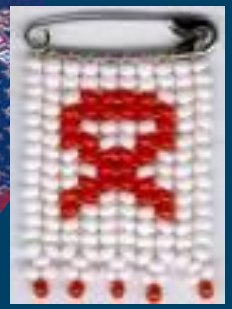
The Healthy Relationships programme (contd)

- Paired Peer &/or Professional Male and female Counsellor Teams facilitate the groups
- Focus on HIV Status Disclosure Skills & Safer Sex Negotiation Skills
- Heavy Reliance on Videotapes
- Use of Movie-Clips/Storyboard for Negotiation Skills

Healthy Relationships

Framed within the context of managing stress related to HIV disclosure and practising safer sexual behaviour





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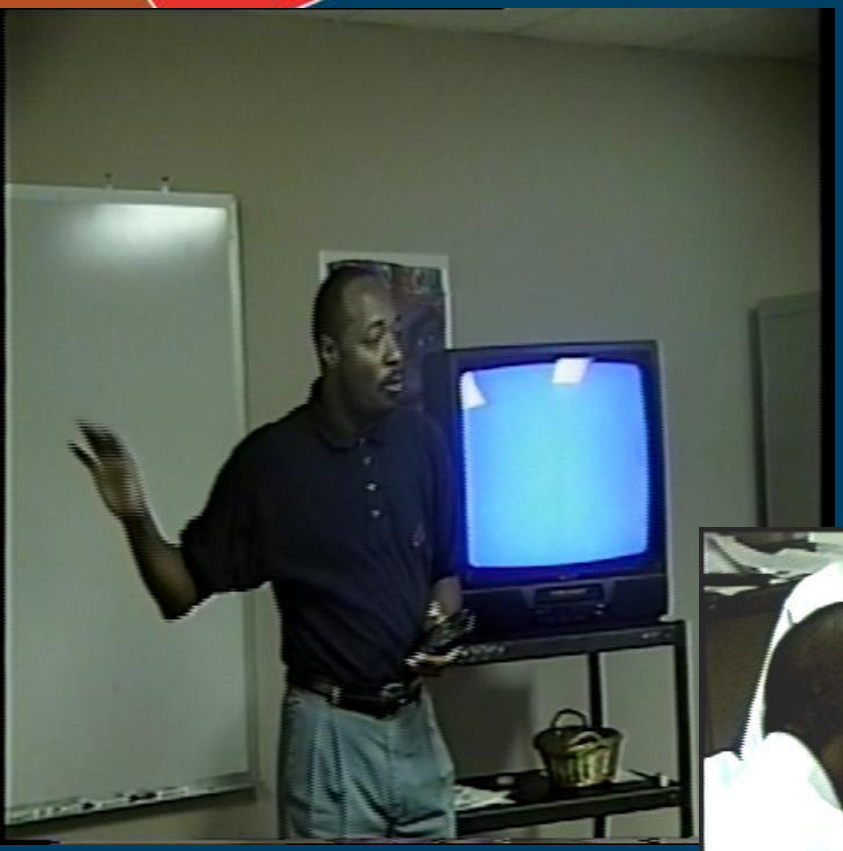
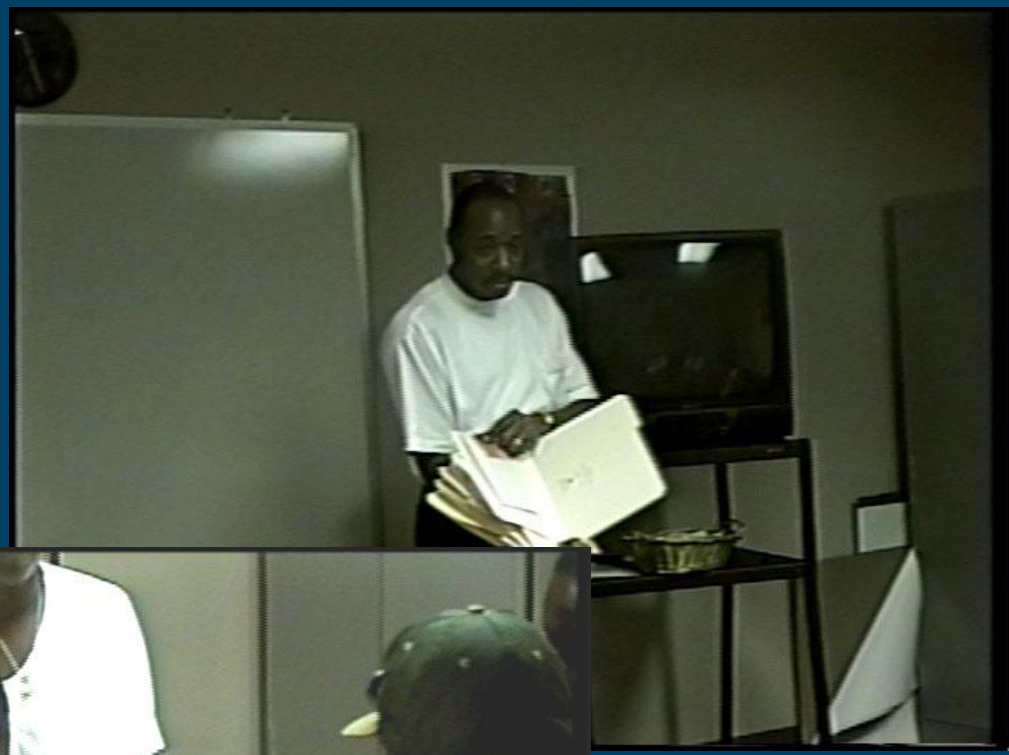
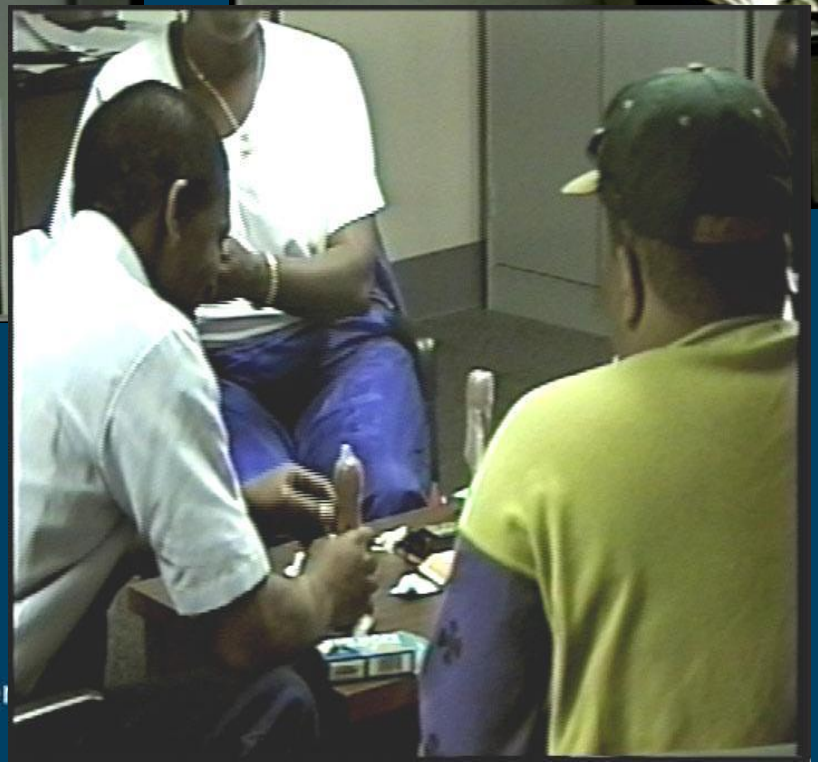
Healthy Relationships…

- The intervention is:
  - **Support group-based**
  - **Deals with gender issues**
  - **And destigmatisation as well as the challenge of disclosing their HIV status to sex partners.**

Highly interactive group sessions







Healthy Relationships…Sessions 1 & 2
Stress and disclosure to family and friends

Social science that

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Sessions 3 & 4
Disclosure decision skills for sex partners

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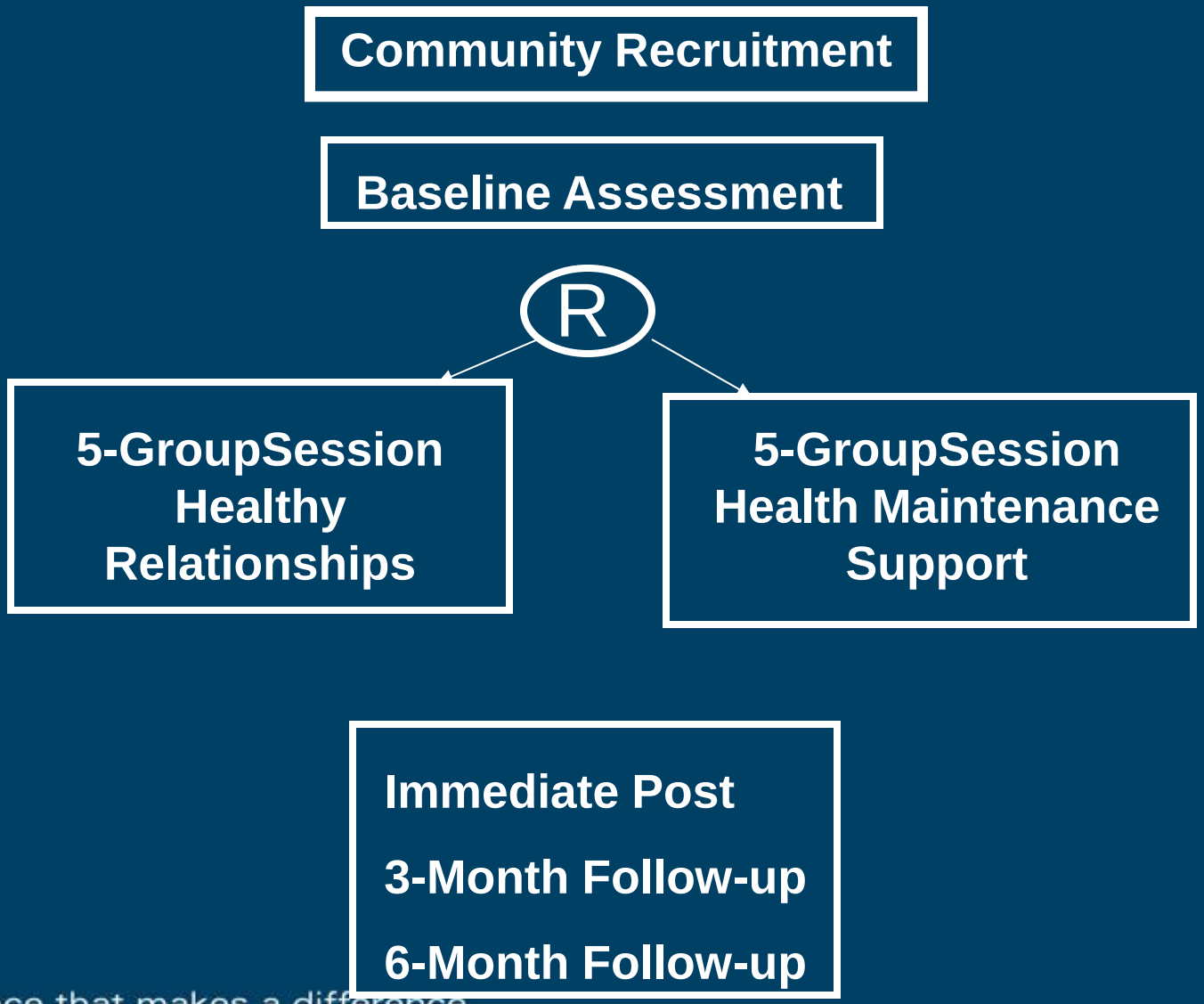
Sessions 4 & 5
Sexual Risk Reduction skills

The original Milwaukee Pilot Study Design

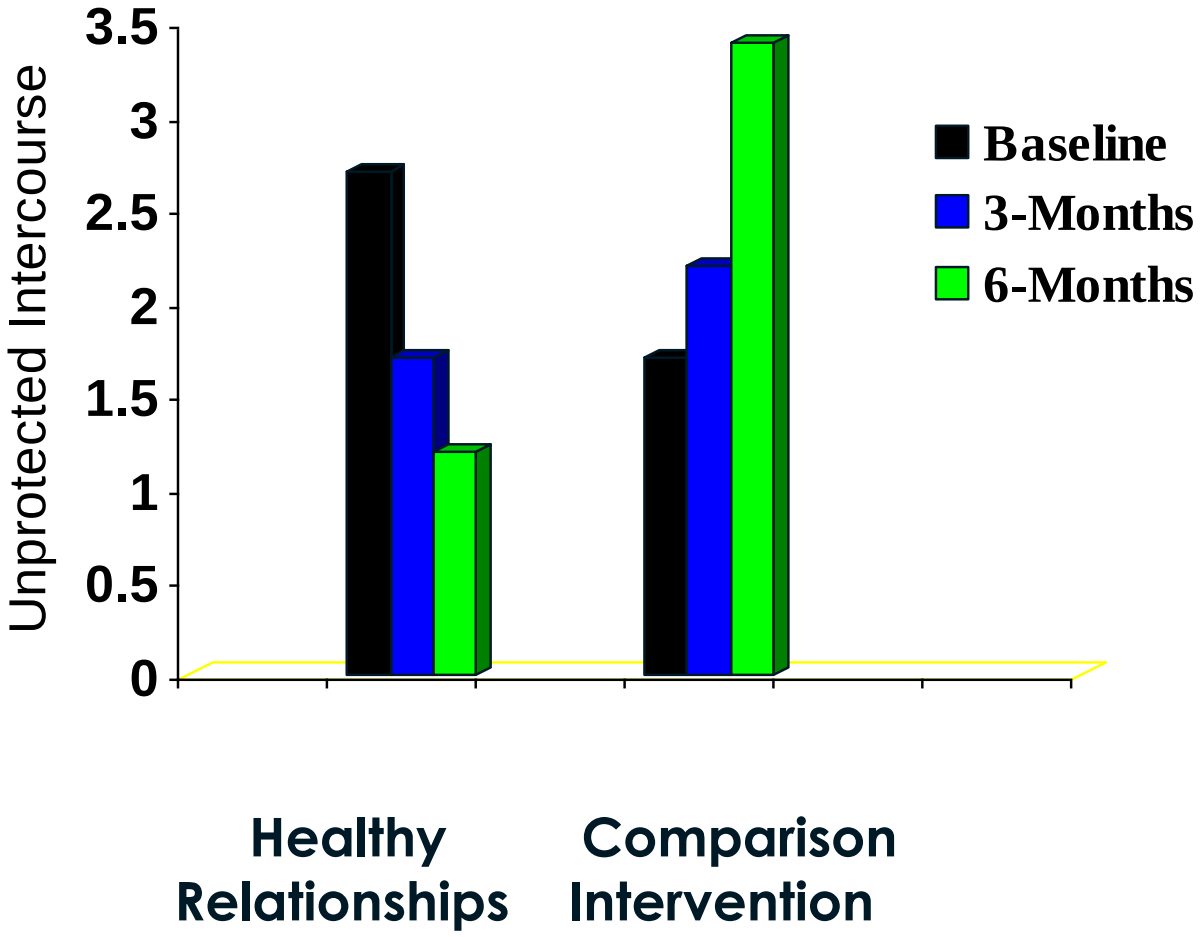


Characteristics of Participants

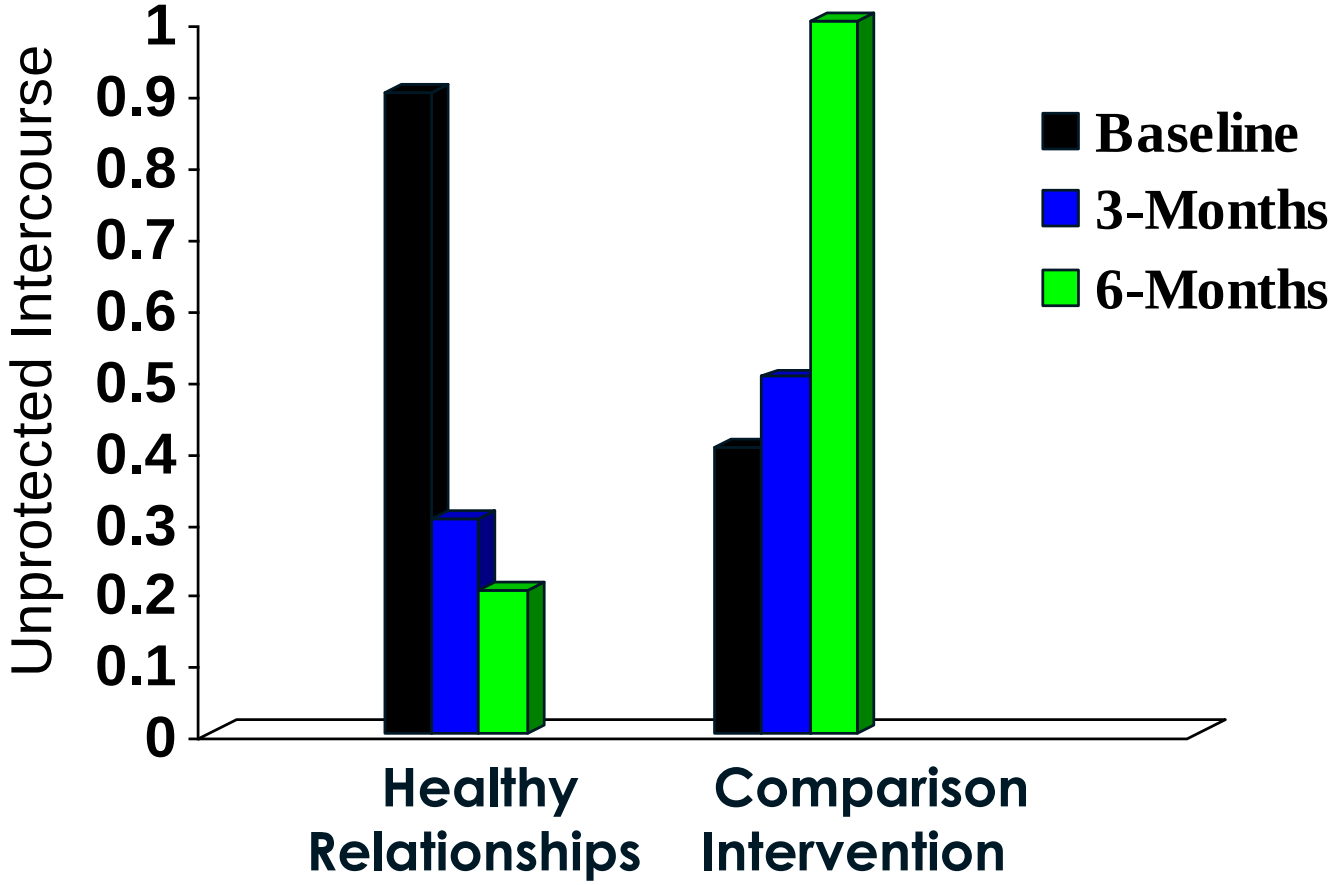
- 233 HIV+ men & 99 HIV+ women recruited from community services

- Mean age 40.1 years
- 39% heterosexual
- 74% African-American, 22% white
- 56% incomes under $10,000
- 53% currently received disability benefits

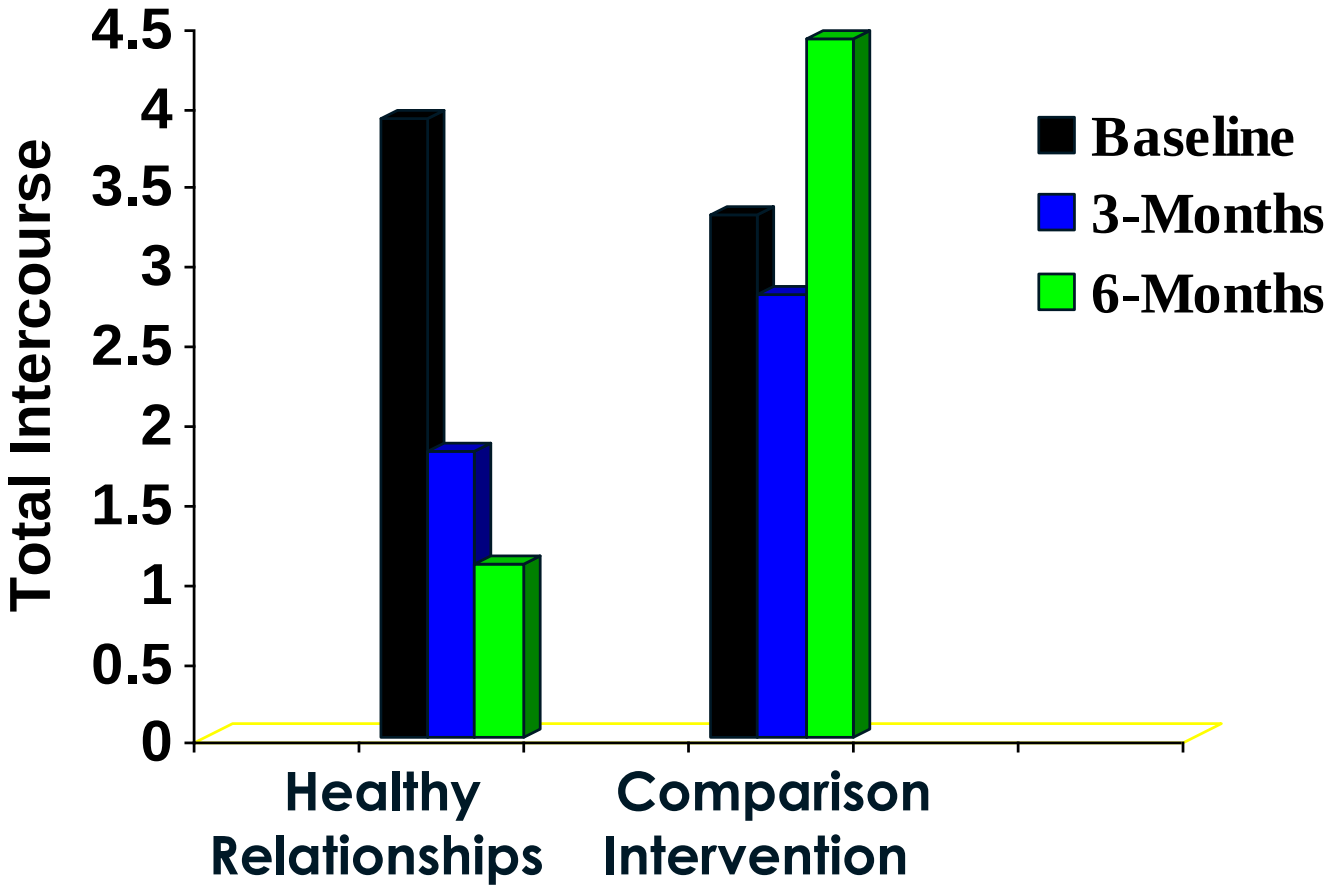
Differences in Unprotected Intercourse All Sex Partners in Past 3-months



Differences in Unprotected Intercourse Non-HIV+ Sex Partners in Past 3-months



Differences in Total Intercourse Non-HIV+ Sex Partners in Past 3-months



How was Healthy Relationships implemented in the Eastern Cape?

- Service providers for people living with HIV (anti-retroviral (ARV) sites, community health centres, non-governmental organisations (NGOs) etc. were contacted to take part in the study
- Established and irregular support groups were recruited into the study
- Healthy Relationships-5 days per week
- Lunch served everyday
- Sessions were held on site in their regular meeting location

Research sites

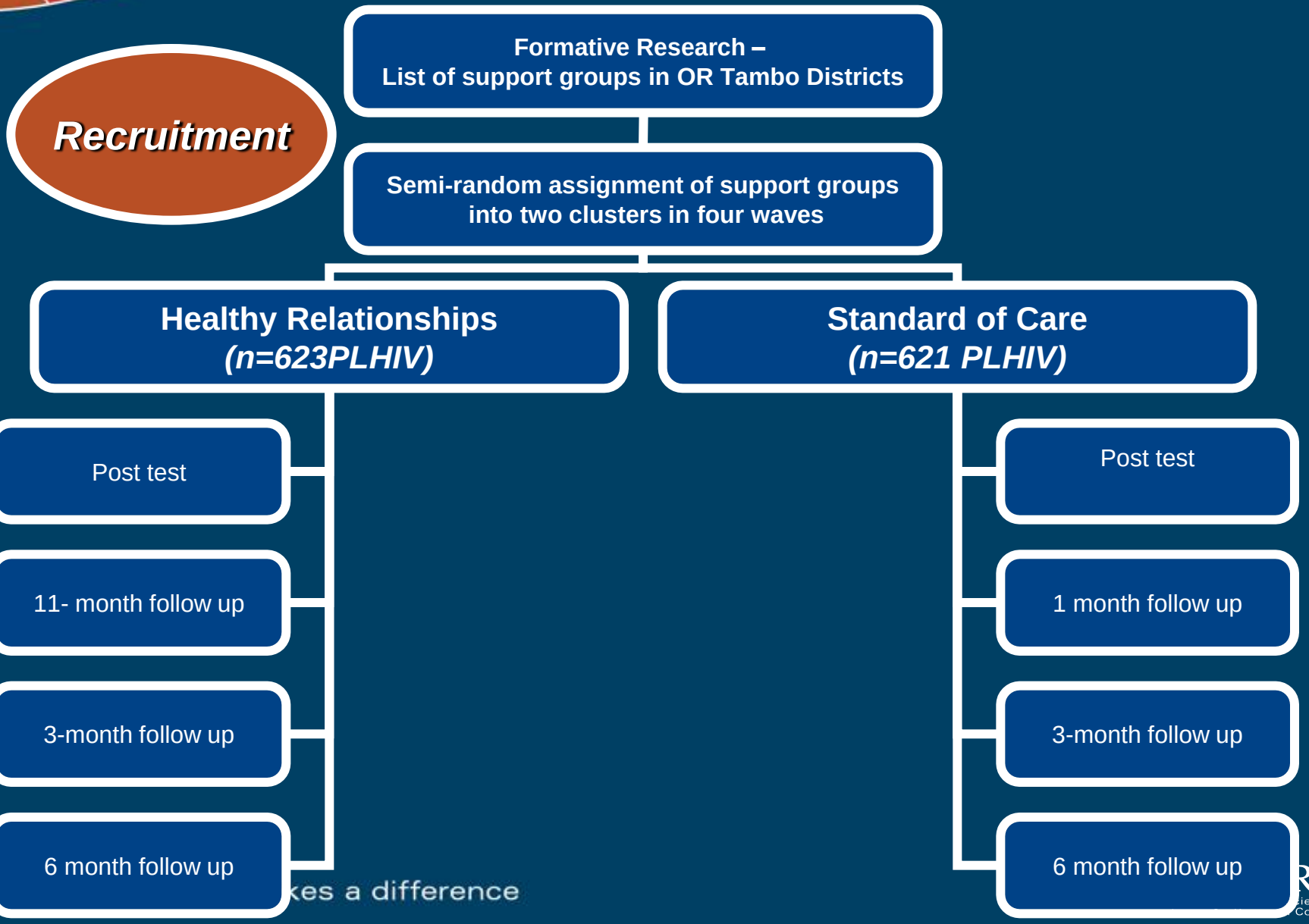
- Four municipalities/LSAs in OR Tambo District
  - King Sabata Dalindyebo,
  - Nyandeni,
  - Mhlonto and
  - Port St Johns

Project Sites in OR Tambo District, Eastern Cape, South Africa

Sampling method & Recruitment

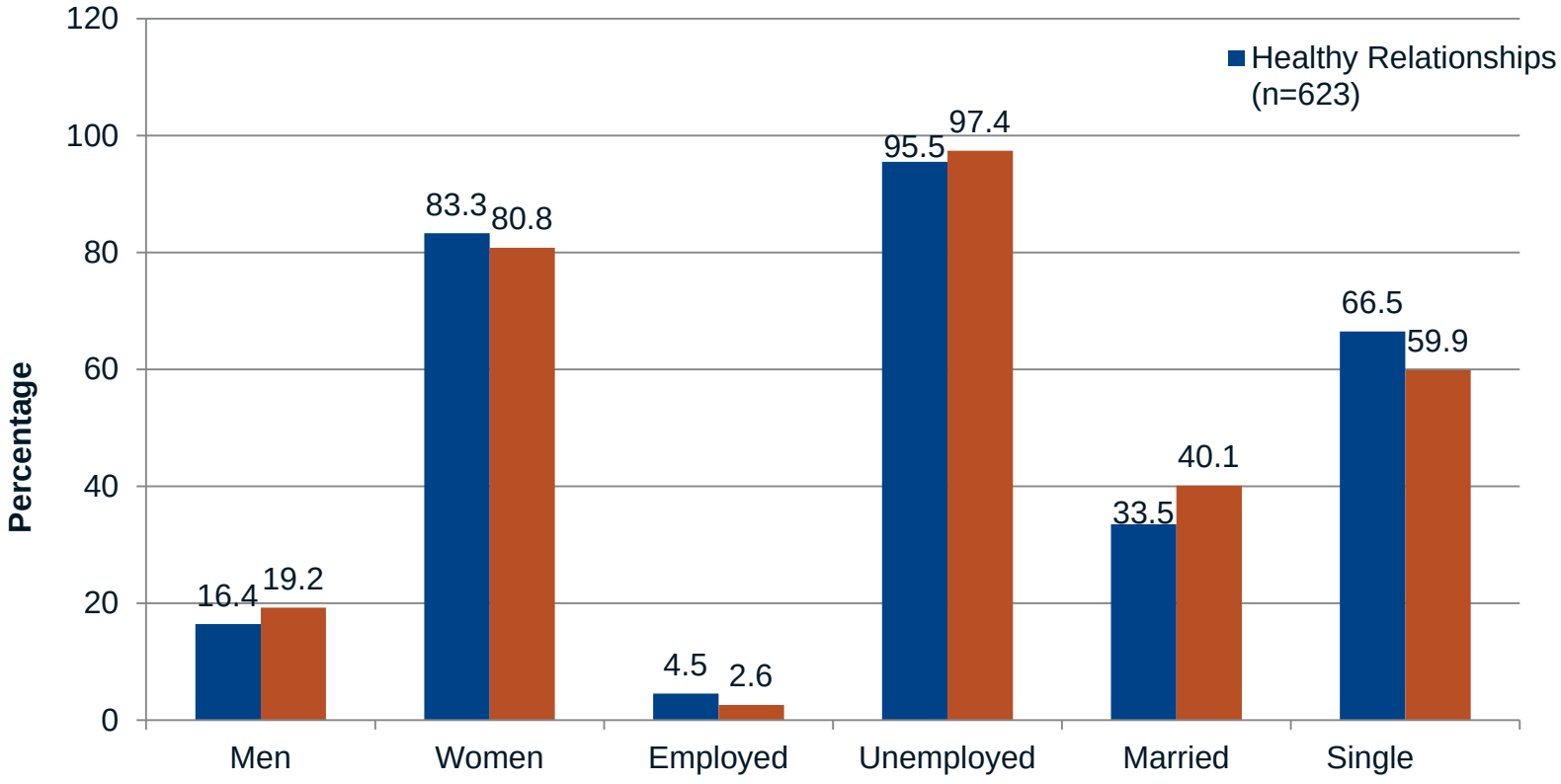
- Listed all existing PLWHA support groups in each municipality - some were very large >100 PLWHA
- Divided support groups into two groups based on clusters cut out by main roads
- Randomly assigned one group into intervention condition and the other into control/comparison group
- Obtained one to three small groups of 8-12 PLWHA out of each group
- Conducted study in four phases starting in KSD, Nyandeni, Mhlonto and Port St Johns municipalities/LSAs
- Design called for 60 groups in each arm of the study

STUDY DESIGN



Results

Baseline characteristics (1)



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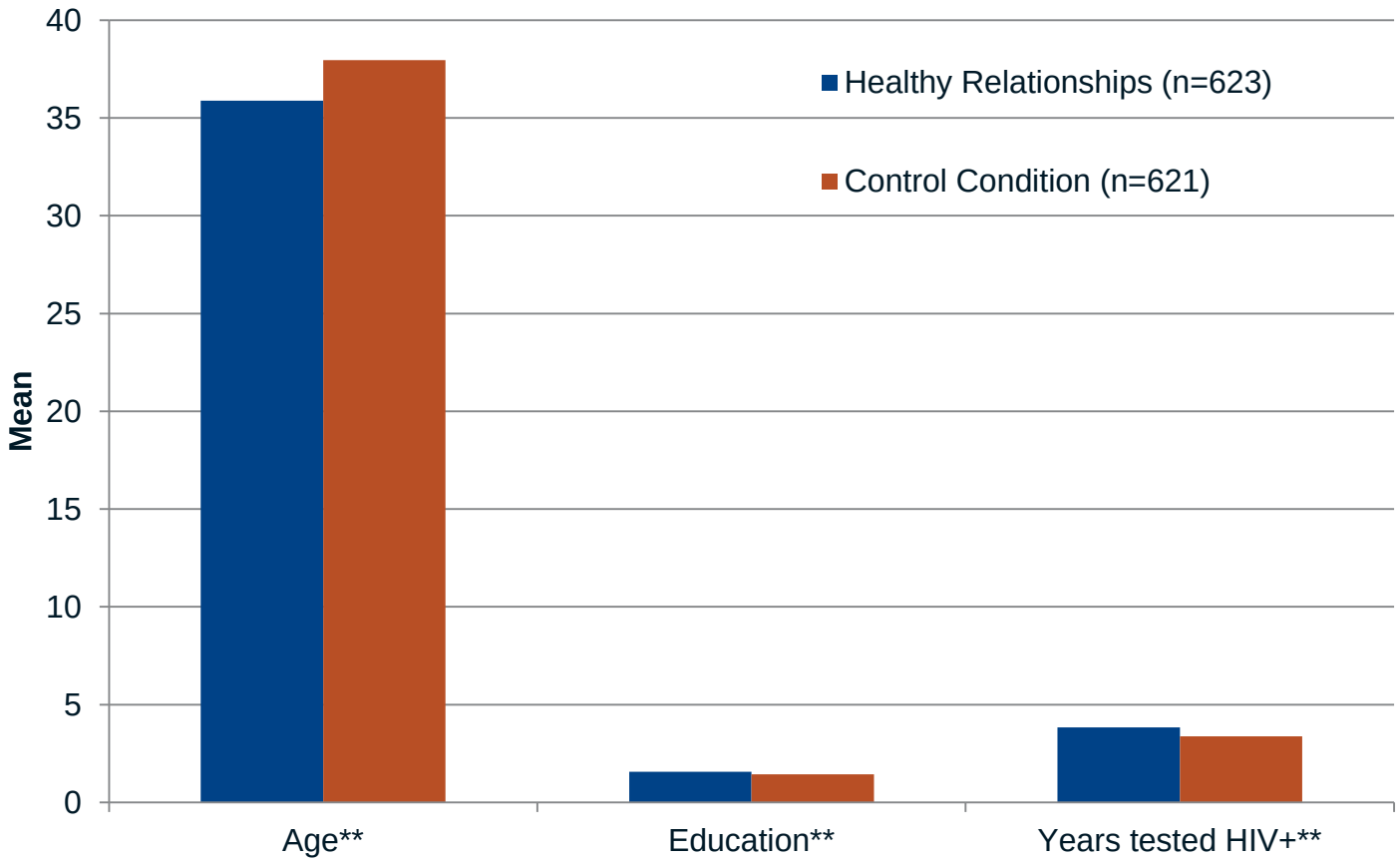
Baseline characteristics (2)



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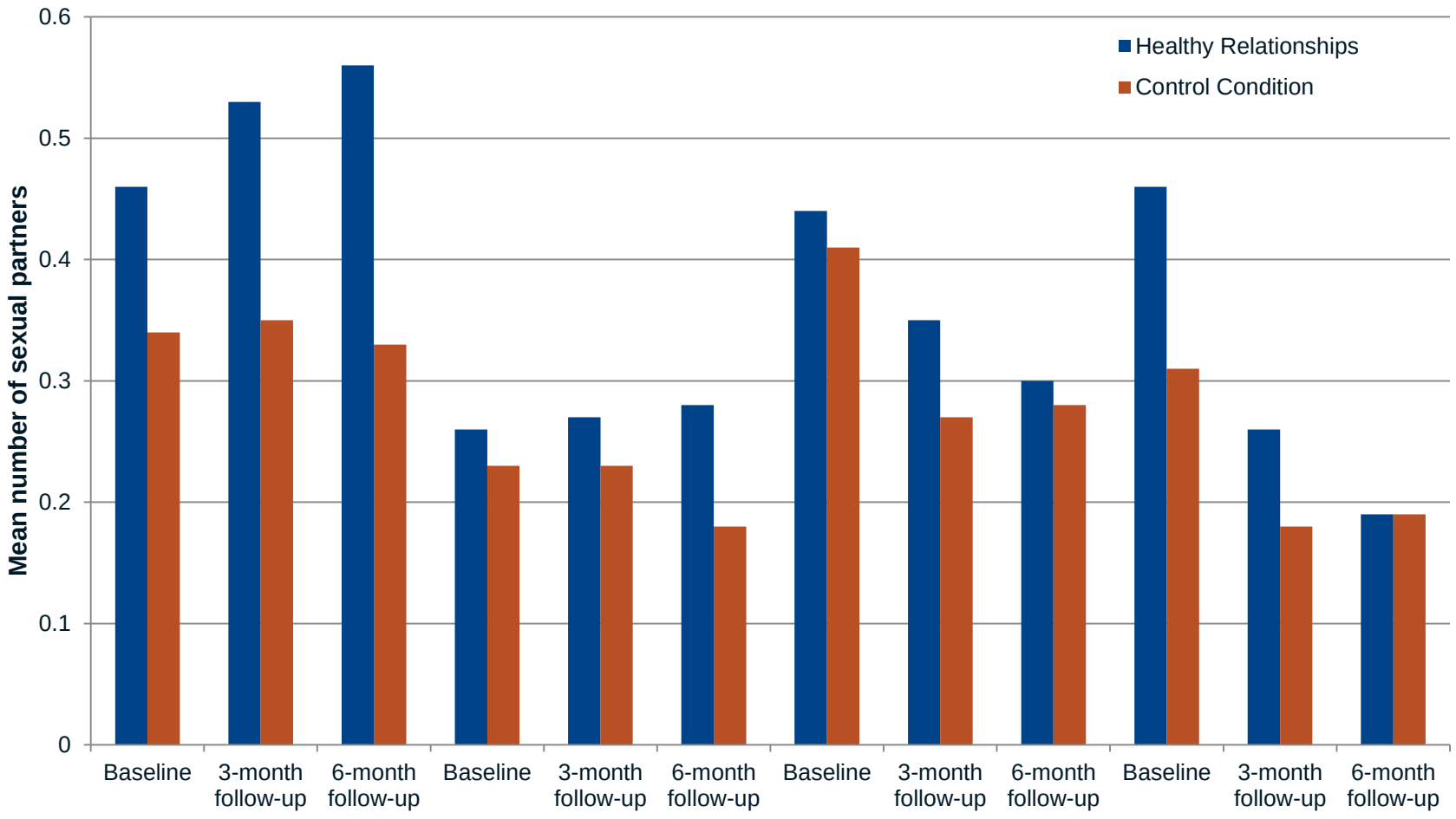
Sexual Partners and knowledge of partners HIV status



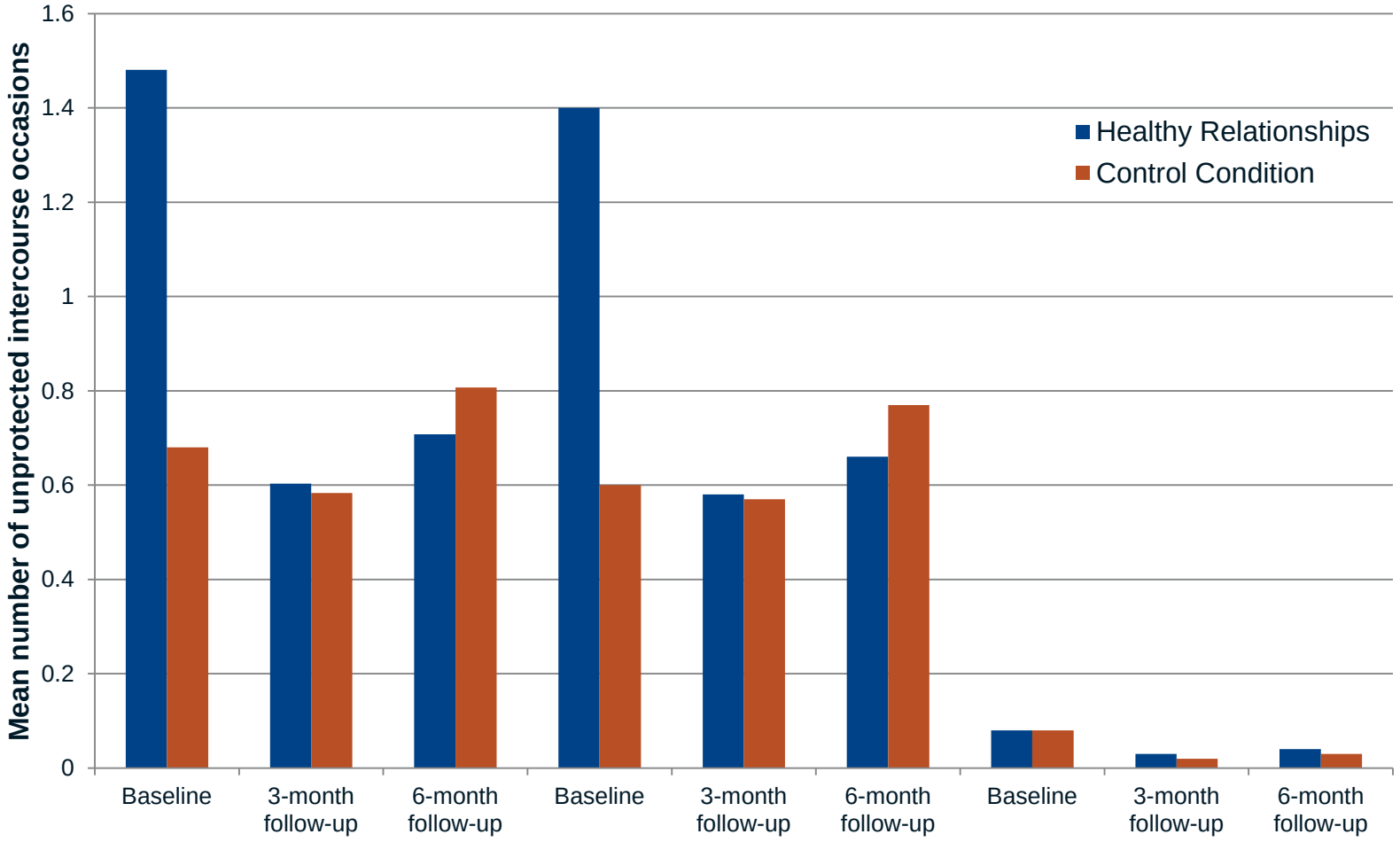
Number of HIV+ sex partners

Number of HIV-sex partners

Number of unknown HIV status partners

Numbers of partners undisclosed

Sero-concordant unprotective sex with HIV+ partners

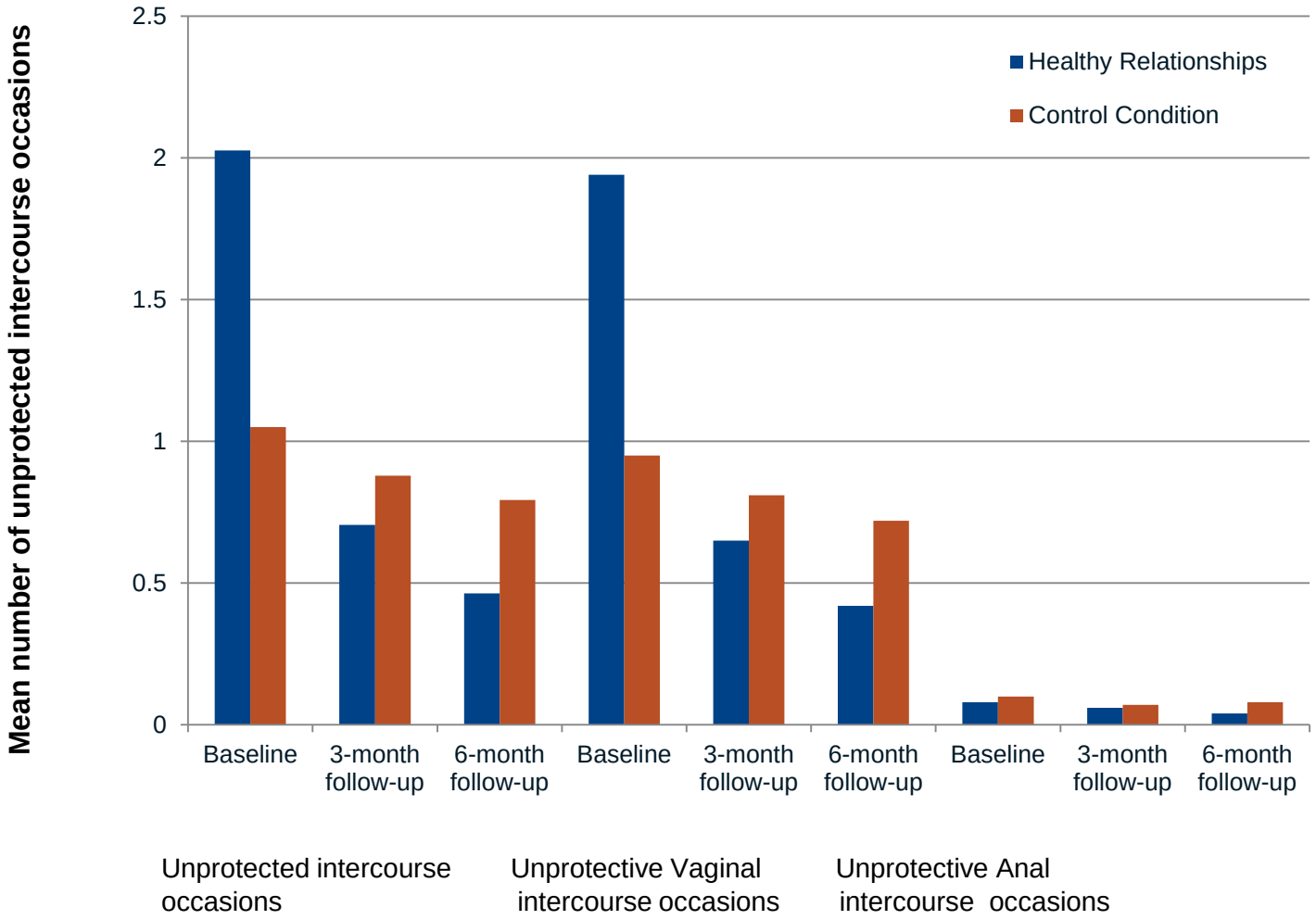


Unprotected intercourse occasions

Unprotective Vaginal intercourse occasions

Unprotective Anal intercourse occasions

Serodicordant unprotective sex with HIV- partners



Summary of findings

- **There were no significant differences found between the two groups on any of the key behavioral outcomes measured such as**
  - **Disclosure**
  - **Disclosure efficacy (data not shown)**
  - **Condom use during vaginal or anal sex**
  - **The number of sexual partners**

Conclusions

- The Healthy Relationships intervention did not reduced risk behaviour. Therefore, the study did not replicate the original study which was conducted in the US in 2001.
- The intervention also did not influence disclosure efficacy.
- This is the first attempt at replicating the original Healthy Relationships intervention which is being rolled out in the USA that we are aware of.
- It is possible that both groups seem to have benefited from something else in this study or from study setting.

Way forward

- There is a need to interrogate these findings to determine why the intervention did not work.
- Do PLWHA in OR Tambo District perhaps engage in some activities which are different from the USA?
- How applicable are the theoretical concepts used in South Africa?
- Was the intervention implemented with fidelity?
- Was the quasi-experimental study design used too poor to allow any conclusion?
- Can we change some aspects of the intervention in order to make it more effective?

THANK YOU

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