

Social & Behavioural Interventions (SBI) for HIV prevention that work!



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**Malawi National HIV Prevention Symposium,
Lilongwe, Malawi**

July 1, 2014

HAST @ HSRC is a UNAIDS collaborating Centre for HIV prevention research

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2. Best practice behavioural HIV prevention interventions
3. Malawi's BCC programmes
4. Strategic recommendations of behavioural HIV prevention interventions that work

RCTs assessing behavioural HIV prevention interventions

Author	Behavioural intervention	Target group
Kamali et al. 2003	Syndromic management of STI & behaviour change interventions on transmission of HIV-1 in rural <u>Uganda</u> : A community RCT.	Adults in rural Uganda
Koblin et al. 2004	Effects of a behavioural intervention to reduce acquisition of HIV infection among MSM: The EXPLORE RCT study	Men who have sex with men (MSM)
Ross et al. 2007	Biological and behavioral impact of an adolescent sexual health intervention in <u>Tanzania</u> : A community RCT	Youth in Tanzania
Corbett et al. 2007	HIV incidence during a RCT of two strategies providing VCT at the workplace , <u>Zimbabwe</u> .	Business employees in Zimbabwe

Data adapted from Padian et al. 2010.

RCTs assessing behavioral HIV prevention interventions

Author	Behavioural intervention	Target group
Jewkes et al. 2008	Impact of stepping stones on incidence of HIV & HSV-2 and sexual behaviour in rural South Africa: Cluster RCT.	Youth (15–26 yrs) in <u>South Africa</u>
Patterson et al. 2008	Efficacy of a brief behavioral intervention to promote condom use among female sex workers in Tijuana and Ciudad Juarez, Mexico.	Female sex workers living in Tijuana, <u>Mexico</u>
Cowan et al. 2009	The Regai Dzive Shiri project: The results of a cluster RCT of a multicomponent HIV prevention intervention for young people in rural Zimbabwe.	Adolescents in rural <u>Zimbabwe</u>

Data adapted from Padian et al. 2010.

Summary: Social & Behavioural HIV prevention interventions that work

Level of evidence	Social & Behavioral Interventions	% Effectiveness or efficacy
Good evidence	Male condom use HCT for PLWHA	78% condom use [SA population survey, 2008] 68% reduction in high risk sexual behaviors [Meta-analysis & 1 community RCT]
Promising evidence	Stepping Stones counseling study IMAGE microfinance study	Lowered the risk of HSV-2 by 34.9 per 1000 people exposed; less IPV and less transactional sex [comm RCT] IPV was reduced by 55% [comm RCT]
Weak or No evidence	Abstinence-only interv's HCT on untested Stepping Stones IMAGE - Microfinance Concurrency (MCP)	7/13 reported sex [Systematic Review in US] No impact of C&T on behavior of untested Did not lower incidence of HIV-1 No effect on HIV incidence [comm RCT] No conclusive evidence in Africa (Lurie, 2009)

2. Best practice behavioural interventions for youth (1989-2001)

Type of Program	Number of Studies	Improved Knowledge and Attitudes †	Improved At Least One Behavior Among Some Participants †
All Programs	39	32/35	22/29
School	21	17/19	9/14
HIV/AIDS education	13	11/12	6/7
General RH* education	8	6/7	3/7
Mass Media	6	5/6	5/5
Media only	1	1/1	1/1
Media with social marketing	5	4/5	4/4
Community	4	4/4	4/4
Youth development	1	1/1	1/1
Peer education	3	3/3	3/3
Workplace	4	4/4	2/2
Health Facility	4	2/2	2/4
Youth-friendly services	3	1/1	2/3
Youth center	1	1/1	0/1

Source: Finger B, Lapetina M, and Pribila M eds. (2002). Intervention Strategies that Work for Youth: Summary of FOCUS on Young Adults. End of Program Report. Youth Issues Paper 1

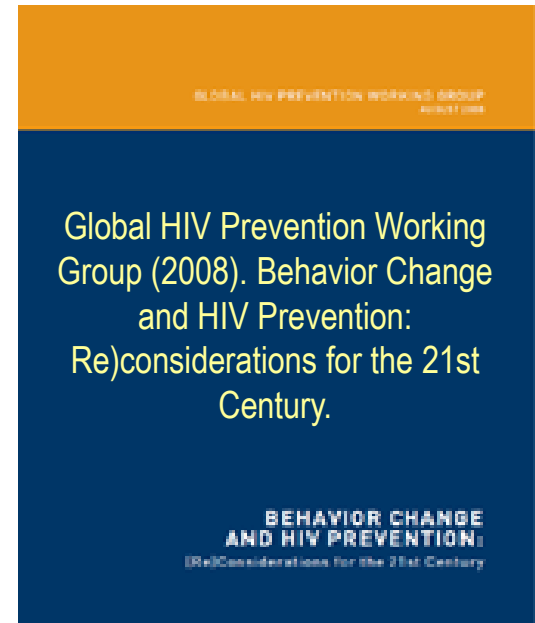
2. Best evidence behavioural HIV prevention interventions

“Behavioral HIV prevention works. Some have been pessimistic that it’s possible to reduce HIV risk behaviors on a large scale, but this concern is misplaced”

Dr. Helene Gayle, co-chair of the Working Group

CDC’s AIDS Prevention Research Synthesis (PRS) project identified 18 best evidence, theory-based behavioural interventions demonstrating “*best evidence*” of efficacy for reducing HIV risk. They were **targeted at heterosexual men and women, MSM, Youth, PLWHA and low income populations.**

Source: Lyles et al. (2007). Best-evidence interventions... *AJPH*, 97, (1): 133-43
CDC PRS (2001). Compendium of HIV prevention interventions with evidence of effectiveness



Regional evidence of epidemic decline: Changes in sex behaviour

Knowledge of HIV and AIDS may be widespread, but not usually sufficient and accurate, and knowledge alone is usually insufficient to change behaviour

- **Partner reduction** the most significant factor in reducing epidemics in Uganda, Kenya, Zimbabwe - probably linked with fear, seeing people die, reinforced by policy and programming.
- **Condom use**: also contributed
- **Age at sexual debut**: contributed in Kenya and possibly Uganda, probably not in Zimbabwe where it was already high (but impact is more to delay infection than reduce life-time risk)

3. Malawi's BCC programmes

- **Comprehensive knowledge of HIV** was low @ 45% (MDHS, 2010)
- **High risk sexual behaviours**: 40% of men 15-24 reported having 2 more partners and not using condom at last sexual intercourse [MDHS 2010]. 31.4% of women aged 15-24 reported having 2 more partners and not using condom at last sexual intercourse [MDHS 2010]
- **Age of sexual debut**: Malawi made marginal progress between 1996 and 2000 but not more recently...
- **Reduction in concurrent sexual partners**: female behaviour but not male behaviour has changed for the better.
- Only 3% women and 47% men **used a condom in their last episode of higher-risk sex**.

GAPS:

- Lack of **targeted behavioural interventions**;
- Low **coverage** of behavioural interventions;
- Inadequately addressed **structural barriers** to behaviour change...

4. Strategic recommendations of behavioural HIV prevention interventions that work

“It is critical to note that there is **no “magic bullet” for HIV prevention**. None of the new prevention methods currently being tested is likely to be 100 percent effective, and all will need to be used in **combination** with existing **prevention** approaches if they are to reduce the global burden of *HIV/AIDS*.”

Source: Global HIV Prevention Working Group (2008)

Newsday

April 10, 2001

**To Fight AIDS, Use Both
Treatment and Prevention**

Highly Active HIV Prevention or Combination Prevention

