

HEALTH COMMUNICATION CAPACITY COLLABORATIVE

HIV/AIDS

Second HIV Consultation Considers Community-Level Factors

In November 2013, the Health Communication Capacity Collaborative (HC3) convened a group of experts in Johannesburg, South Africa, to discuss community-level factors (CLFs) and their impact on HIV outcomes. Sixteen participants attended from 10 countries: Malawi, Zambia, Zimbabwe, South Africa, Tanzania, Cameroon, Swaziland, Uganda, Mozambique and the U.S.

The consultation's goal was to examine the evidence, identify strengths as well as gaps and provide recommendations on the role of CLFs and their impact on HIV outcomes related to prevention, as well as uptake of services and linkages to care and support. The community-level factors examined during the consultation were social and structural support, social norms, social capital, community efficacy, stigma, and gender norms. Expected outputs from the meeting were:

- Share the evidence focused on CLFs and improved HIV outcomes
- Highlight critical, causal connections between the impact of SBCC interventions on norms and ultimately on HIV related outcomes
- Build consensus and provide recommendations for measuring intermediary CLFs, which influence HIV outcomes
- Provide evidence-based recommendations to the field on the most effective replicable interventions and CLFs which empower communities to achieve behavior and social changes needed to strengthen HIV combination prevention efforts
- Develop further recommendations on how best to scale up successful community-level interventions, which have a proven impact on HIV outcomes

REVIEWING THE EVIDENCE

A review of the literature conducted prior to the consultation looked at the available evidence focused on the impact of CLFs on HIV outcomes in low- and middle-income countries. The results were synthesized into a document presented on the first day of the consultation.

In total, 85 articles met the inclusion criteria, demonstrating a wide range of both CLFs and



HIV outcomes. CLFs explored included stigma, social capital, social norms, empowerment, gender norms, social exclusion, community mobilization, collective efficacy, resiliency and community-based organization (CBO) membership among others. Below are some of the highlights from the synthesis of the evidence that took place on the first day.

Condom Use

A number of CLFs identified in the literature had an impact on condom use. Urban environments and neighborhoods with little migration were found to be associated with increased condom use.¹ Community HIV knowledge and increased HIV interpersonal communication were also found to increase condom use in multiple studies as they can help eliminate myths and stigma.^{2,3,4} It was found that communities with strong social capital understood the collective benefits of condom use and could predict intentions to use them.^{1,5,6} This was also seen in communities with high collective efficacy and social cohesion – if the community perceives it is capable of collectively preventing HIV, it can contribute to an increase in condom use.^{4,7,8,9,10,11,12,13,14}

Multiple Concurrent Partners

Community demographics, gender and cultural norms as well as social capital were identified as having an association with multiple concurrent partners.^{1,15,16,17,18,19,20,21} In a study examining data from 20 sub-Saharan African countries, urban environments with cash employment opportunities had higher rates of multiple concurrent partnerships; these partnerships were most prevalent in societies where "sexual norms are widely permissive." ¹⁵

PMTCT

Higher community socio-economic status, as well as higher mean educational status, positively correlated with increased involvement in PMTCT. ^{22,23} Community support was also found to reduce stigma surrounding accessing PMTCT services. Women were found to be more likely to feel comfortable seeking services if they had increased community support, whether through CBOs or through friends and families.²⁴ The positive impact of male involvement was noted in multiple studies but many CLFs created barriers for men's participation.^{23,25,26} These included antenatal care (ANC) services and providers that failed to include men, or to sensitize men to ANC and educate them on its importance.^{23,25} In some communities and cultures, male participation was viewed as emasculating and socially discouraged.²⁵

HIV Counseling and Testing

Communities with high levels of membership in organized groups were more likely to use HIV counseling and testing (HCT) services, and use them more frequently, than communities with low membership.^{22,27,28} Stigma, a continuing problem for almost all HIV outcomes, was associated with a reluctance to test.^{29,30} Among woman in Central Asia, stigma was associated with decreased HIV testing as well as decreased receipt of results.³¹ Social support was found to increase an individual's likelihood of disclosing their status to a main partner and encourage self-efficacy to access HTC. ^{32,33} Improved community capacity was associated with community action for health and significantly and positively related to HIV testing.²⁸ more supportive environment for those affected by HIV.^{41,42,43} Stigma reduction was also found to be essential in building community support and ensuring adherence.^{37,41,44,45} Multiple interventions in Africa found that social support resulted in higher adherence and that has now emerged as a predictor of treatment success.^{35,37,41,45,46,47,48} A study in South Africa measuring viral load found community support was the most important predictor of treatment success. In Malawi and Ethiopia, community support was associated with not only better adherence but also a lower death rate over time.^{48,50} Likewise, community support was essential for sustaining adherence to ART among pediatric clients in Kenya.⁵¹

Care and Support

Community education and community wealth both had positive associations with the level of care and support for people living with HIV (PLHIV).⁵² Several studies found stigma reduction led to an increase in social support for PLHIV at the community level.^{52,53} Social capital was important for care and support because communities with a large and wide-ranging set of social networks were found to be better able to confront risk and vulnerability and allow for greater social inclusion.^{54,55,56} The advantages of a community safety net included the provision of both emotional and materials support.⁴³ An intervention in Nigeria designed to mobilize communities began to change social norms over a two-year period and provided opportunities for economic empowerment and networking.57

Transmission and Risk

Higher community income inequality was associated with increased HIV rates in women, but not men.⁵⁸ Two Zimbabwe studies found young females who were members of well-functioning community groups

Access to Services and ART

Multiple studies found that strengthening social support for those living with HIV was associated with an increase in uptake of antiretroviral therapy (ART).^{24,35,36,37} The structure of a community, particularly in relation to CBOs, was a critical determinant of access to HIV services including ART.^{24,35,38,39} In Nigeria, a study found that the strength of engagement from CBOs could increase both availability and utilization of HIV services.⁴⁰

Adherence

By increasing the communal knowledge of the benefits of ART, misconceptions were likely to be reduced, leading to a



had lower rates of multiple partnerships and were less likely to get infected with HIV. The authors believed that may stem from an increase in self-efficacy for these women.^{59,60} Youth who were members of sports clubs in their communities were found to have lower rates of HIV than those who were not members.⁶⁰

GENDER EQUITY

The second day of the consultation included an in-depth gender equity conversation, including how CLFs influence gender equity and how genderequitable communities can have an impact on HIV outcomes. Questions ranged from "How do we support gender equitable communities?" and "How can we measure gender change and outcomes?" to "How do we improve community expectations of girls and women?".

One idea considered for positively influencing gender norms was to work with traditional leaders, religious structures and schools to explore the positive and negative effects of gender norms. Other ideas included encouraging more discussion between couples, finding ways to encourage them to do things together, better defining male involvement and understanding how to encourage it by asking men what practical solutions might help.

Economic opportunities for women are also needed at the community-level to create a more genderequitable environment. Participants strongly believed that gender must be considered in programs from the beginning, not added as an afterthought. Not only should gender be included as an integral element of programs, but also as its own separate program that can be taken to scale.

Because working with communities and understanding community structures are key to achieving more gender equity, participants agreed that both individual and community factors need to be examined in combination with solutions generated by the community. A portion of the discussion also focused on the challenge of measuring change in gender equity. A suggestion was made to develop an improved standard scale for use across countries with measures at both the individual and community level.

STIGMA and SOCIAL NORMS

Participants also discussed the impact social norms have on HIV outcomes during the second day of the consultation. Suggestions on ways to tackle stigma included encouraging more couple communication, the use of radio diaries and video to model positive behavior and attitudes, and creating safe spaces where people are free to talk, learn and face common fears. Politicians can play a role too by publicly getting



tested for HIV. Programs should provide opportunities for hearing the voices and seeing the faces of PLHIV.

Social norms go hand in hand with CLFs and need to be interwoven in any discussion about them. Some of the social norms discussed that impact HIV outcomes included norms around child marriage, sexual practices, adolescent peer pressure, alcohol use, teen pregnancy and societal structure. Participants discussed what interventions they have seen work or believe might work to tackle these issues. These included the use of role models, such as musicians, politicians or religious figures; community mobilization and positive deviance; capacity building of community leaders; and finally the need for political will. Many shared examples of successful programs though noted that the results of most of these interventions have not been published in the peer-review literature. This indicated a need for more rigorous studies around influencing social norms and their impact.

GAPS and the WAY FORWARD

The literature survey and discussion during the consultation revealed multiple gaps in exploring the impact of CLFs on HIV outcomes. A clear need emerged for a stronger definition of community-level factors to ensure combination prevention programming considers CLFs when designing interventions. While the literature described various aspects related to CLFs, no strong definition was identified.

Other gaps identified included:

- Few robust evaluations of gender equitable interventions exist or adequately capture the complexity of gender equity as it influences HIV outcomes.
- No community pathways model currently exists that captures the most salient CLFs or describes

their influence on HIV prevention, care and treatment.

- There is minimal evidence on interventions positively associated with decreasing stigma and improving HIV outcomes.
- Organizing evidence around specific key populations is currently missing.
- Improvements are needed to bridge the gap between disciplines and encourage sharing of best practices.
- An overall gap is evident in evaluations of interventions addressing CLFs.

To address some these gaps, several participants agreed to assist with the development of briefs outlining the evidence related to CLFs across HIV outcomes, participate in webinars related to CLFs, and participate in the development of journal manuscripts to advance the field in the peer-review literature.

This consultation provided an opportunity to bring together experts to dive deeper into the issues surrounding CLFs and the impact they have on HIV outcomes. CLFs are an essential component in high impact combination prevention programming which influence everything from the number of concurrent partners one may have to whether a person living with HIV remains on treatment.

Many participants commented on the insights they gained from the consultation renewing their commitment to continue working at the communitylevel to reduce HIV transmission while also ensuring those living with the virus have the social support and self efficacy to access and adhere to their treatment. HC3 invites further discussion on this topic and recognizes the power and necessity of community engagement and leadership in the HIV response.



Consultation participants from left to right: Jessie Mbwambo, MD, Muhimbili University of Health & Allied Sciences; Joseph Kagaayi, MBChB, MPH, Rakai Health Sciences Program; Todd Koppenhaver, USAID/Southern Africa; Beth Deutsch, USAID/Malawi; Obrian Nyamucherera, MSc, CIET Africa; Glory Mkandawire, HC3 Swaziland; Kirsten Böse, HC3 Project Director; Sereen Thaddeus, MA, MPH, USAID/Mozambique; Suzanne Leclerc-Madlala, Phd, USAID; John Lengwe Kunda, PhD, Millennium Challenge Account Zambia; Lynette Mudekunye, Regional Psychosocial Support Initiative (REPSSI); Kim Ahanda, USAID; Flavien Ndonko, PhD, GIZ; Florence Kayambo, Jhpiego; Lynn Van Lith, HC3 HIV Team Lead; Caspian Chouraya, MD, MSc, Elizabeth Glaser Pediatric AIDS Foundation; Beth Mallalieu, HC3 Program Officer.





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