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Broadening sexual health promotion for young people in sub-Saharan Africa

KEY POINTS

- Most sexual health promotion programmes for young people focus on individual behaviour change, implying that this behaviour is largely volitional and shaped by individual perceptions.
- Community-wide interventions aim to modify everyone's norms and behaviours, including the most powerful in society, not just young people who have little influence.
- Behaviours that put people at risk are often driven by underlying structural factors. If these remain unchanged, there is limited scope for changes of knowledge, norms, intentions or skills at the individual level to have much effect.
- Interventions that involve the target communities in determining their own priorities for change, and how to go about it, build on people's existing motivations and thus have a far greater chance of long-term sustainability.

The continuing need for prevention

Prevention of new HIV infections remains extremely important. Although increasingly available in sub-Saharan Africa, antiretroviral treatment is not the solution to the epidemic. It requires massive international aid which is threatened by the global financial crisis; it is not universally available; health systems cannot cope with the numbers infected; generic treatments are not always effective and can have serious side-effects; and there is the likelihood of resistant strains emerging.

With respect to other sexually transmitted diseases and unwanted pregnancies, prevention remains as important as ever. Although some sexually transmitted diseases are treatable, this depends on symptoms being recognized and treatment being readily available, both of which are doubtful in sub-Saharan Africa, especially among the young. Unwanted pregnancies lead many young women to curtail their education early, while nearly half of all deaths due to unsafe abortion occur in Africa.

Problems with biomedical prevention

Biomedical approaches to prevention so far have the strongest evidence of success, in particular male circumcision and syndromic management of sexually transmitted diseases. The efficacy of several other biomedical interventions, however, has not yet been demonstrated, such as microbicides, mass treatment with antiretroviral therapy or the diaphragm. Furthermore, great expectations for biological prevention are often based on the assumption that a programme's 'efficacy', that is its demonstrated effect in a research trial, is equivalent to its impact when rolled out in the real world in non-research conditions, that is 'effectiveness'. There are several reasons why this might not be the case, such as resource constraints, the variable expertise and motivation of health workers, and unanticipated negative consequences of the intervention. For instance, with male circumcision there is the danger of behavioural disinhibition. This demonstrates that biomedical approaches often still need to be accompanied by behavioural interventions and should be part of combination prevention.

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Reasons to move from promoting individual behaviour change to broader / structural interventions

Most prevention programmes, such as school-based sex education or improved health services, aim to achieve individual behaviour change. In general they appear to have only a small impact on behaviour, even when carefully developed, based on good research evidence, adequately financed and well delivered. Some of the most important reasons relate to inadequate attention being paid to **structural factors**, that is **the underlying patterns of social systems that shape behaviour and are beyond an individual's control**.

♦ Programmes that focus on individual behaviour imply that the behaviour is largely volitional and shaped by individual perceptions. This belittles the extent to which individual behaviour is shaped by the wider society, and it overlooks the other factors that might shape sexual behaviour in any given situation, such as the availability of condoms, the effects of alcohol or, most important, negotiation with one's sexual partner and the power differentials involved.

♦ Although many behavioural interventions try to modify norms, or ideals of behaviour, this influence is often submerged by the dominance of other social norms held by the wider society. For new norms to endure and lead to behaviour change they need to be constantly reinforced through social interaction: "…shared meanings are created and sustained – a process which happens, as it were, *between* people, not simply in their private thought worlds" (Pool and Geissler, 2005).[1] Generally, coexisting groups within a society hold different norms and it is the powerful groups which define the most publicly acceptable norms. If the target group is young people, who are generally of low status in sub-Saharan Africa, their views have little influence in wider society.

♦ Community-wide interventions aim to modify everyone's norms and behaviours, including the most powerful in the society, not just young people who have little influence. Studies of how innovations diffuse in society suggest that if the opinion leaders can be persuaded to change, there is much greater chance that the wider population will do so.

♦ Most interventions are introduced by outsiders and can be seen as external impositions. Even in sub-Saharan Africa, for many communities HIV/AIDS is of low importance in their daily lives. Re-focusing interventions provides the potential to involve target communities in determining their own priorities for change and how to go about it. This means building on people's existing motivations, which has a far greater chance of long-term sustainability and success; the challenge is to find how they are congruent with public health goals.

♦ Behaviours that put people at risk are often driven by underlying structural factors. If these remain unchanged, there is limited scope for changes of knowledge, norms, intentions or skills at the individual level to have much effect. A key reason to widen the focus of interventions is to address these underlying factors. These can operate close to the risk, for instance the availability of condoms, the effects of alcohol or poor negotiation skills, or they can operate at some distance from the risk but drive it, for instance poverty or gender inequality. Important structural factors, which are interrelated, include: lack of economic options for women other than to become wives and mothers young; men's greater power over women (economic, physical, normative); the perception of female sexuality as an economic resource; lack of access to youth-friendly sexual health services, modern contraception or condoms; the clandestine nature of adolescent sexual relationships; and the widespread sense of inevitability of misfortune.

♦ Finally, broadening the focus of interventions often means that they come to encompass other high priority policy goals, such as improving general health care, literacy, economic livelihoods, etc. The eight Millennium Development Goals all relate to factors underlying HIV vulnerability. Expanding goals to include other policy priorities means there is greater chance of political support and resources, particularly in a period of funding cuts.

[1] Pool R, Geissler W. 2005. *Medical Anthropology*. Open University Press, London.

Encouraging examples of broader / structural interventions

There are many examples of broader interventions that appear to have great potential. Some have good evidence of effectiveness but others do not. In the table they are classified in two ways: according to distance from the risk behaviour and the main mechanism by which it operates.

Table 1. Some examples of broader/structural interventions to prevent HIV

	Close to outcome	**Distant from outcome**
Mechanism:		
Material infrastructure		Road improvements to reduce drivers' overnight stops (Burma) Re-housing vulnerable (USA)
Economic		Micro-finance for women (S. Africa: *IMAGE*) Microcredit for orphaned girls (Zimbabwe: *SHAZ!*) Cash incentives to say in school (S. Africa) Developing future aspirations (S. Africa: *loveLife*)
Legal	100% condom use in brothels (Thailand, Dominican Republic) Legalisation of harm reduction approach to drug injecting (UK, Australia)	
Educational		Cash incentives for girls to stay in school (S. Africa) Allowing young mothers to return to school (Tanzania) Investing in pre-schools for cognitive development (UK, USA)
Political leadership	National-level mobilization (Uganda) Local authority prioritization of HIV prevention (Australia) Sex worker intervention (India: *Avahan* - India AIDS Initiative)	
Modifying gender norms		Challenging traditional masculine norms (Brazil: *Program H*) Community mediation (Africa: *Stepping Stones*) Radio edutainment (Tanzania: *Fataki*) Magazine (Tanzania: *Femina*)
Religious organisations		
Community empowerment / solidarity	Sex worker organization (India: *Sonagachi*, Dominican Republic) Sex worker intervention (India: *Avahan* - India AIDS Initiative)	
Parents		Modifying parent practices (Kenya: *Families Matter*, Tanzania: *Mema kwa Jamii*)
Health services	Provision of clean injecting equipment (UK, Australia) Sex worker clinics (Congo, Ivory Coast)	
Traditional healers		Training on HIV/AIDS and encouraging referrals (Uganda, Zambia)

There are several other underlying factors that broader preventative approaches might tackle. While many individual-level interventions are delivered in schools, few programmes have attempted to modify the school environment itself as a way of tackling HIV 'upstream'. Pre-service teacher training could encourage the development of critical thinking, more supportive, less authoritarian, teacher-pupil relationships that boost pupils' self-esteem and engagement in school, or change dominant gender norms. There might be further initiatives to stop educational establishments tolerating sexual abuse by teachers, and the broader principles of 'health promoting schools' could be adapted for developing countries.

Religious organisations provide extensive networks that reach into almost all communities. In so far as sexual health promotion messages are compatible with religious teaching, there is great potential for preachers to reinforce healthier norms of behaviour in churches or mosques. This is already being done, particularly by imams in West Africa and Pentacostalist preachers elsewhere, but there is scope for greater use of religious institutions.

Issues of evaluation

The choice of possible interventions should not be determined by ease of evaluation, but by evidence of what seems most promising. However, it is essential to evaluate new interventions as rigorously as possible. There are several interrelated reasons why evaluating broader interventions is more challenging than individual-level interventions.

- Rigorous trials usually involve prescribing an intervention to a particular population, but broader interventions often require a participatory approach, making this difficult.

- The mechanisms by which structural factors influence health are often difficult to clarify, and the causal chains are often long, multilayered and non-linear. This makes it more difficult to attribute any change in outcomes to the intervention. It requires the collection of more detailed process data to understand the impact of the intervention along the chain, and often a longer duration before the effects of the intervention can be demonstrated.

- Since they are highly context-dependent, structural interventions do not work in the same way in all societies. Indeed, what can be beneficial in one area can be negative in another; in Kenya and Zimbabwe microcredit schemes were found to exacerbate women's sexual risk-taking since they needed to repay loans.

- It is difficult to find funding for the kind of large-scale, long-term evaluations necessary to clarify attribution.

Several of these factors make it more difficult to conduct randomized trials of broader preventative interventions. In such cases evaluation should not be abandoned, but more complex designs are necessary. Contribution analysis offers a valuable approach to identifying what contribution a specific programme has to the outcomes in the context of several other possible influences. Although attribution is never as definitive as can be achieved through a well-designed trial, it is better to assemble strong evidence to establish the most probable contribution different factors make to one's outcomes, than only to speculate.

This research brief was written by Daniel Wight and Pieter Remes (MRC Social & Public Health Sciences Unit, Glasgow, UK; National Institute for Medical Research, Mwanza, Tanzania). It is based on research funded by the UK Department for International Development (DFID). The views expressed are not necessarily those of DFID.

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