MODULE 10

Combination Prevention

10 Combination Prevention

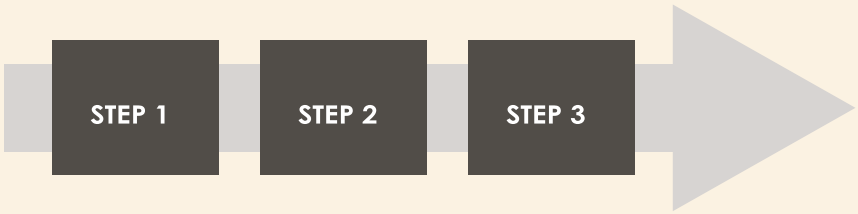
What Is in This Module?

This module was designed to be used in conjunction with the Module 17: Advocacy. It contains an overview of combination prevention; an introduction to and use of an ecological model to help understand combination prevention; and an exercise linking combination prevention to Positive Health, Dignity, and Prevention.

OBJECTIVES	By the end of this module, participants should be able to: ▪ Describe steps to prevention using a Theory of Change model ▪ Illustrate how the Ecological Model helps people understand their relationships with other people in their community and society ▪ Define the structural, biomedical, and behavioural interventions of combination prevention, using examples ▪ Describe how a Cascade of Services is linked to prevention
TIME	2 hours, 50 minutes
ACTIVITY OVERVIEW	**10.1** Goal of Prevention (20 minutes) **10.2** The Ecological Model (1 hour) **10.3** Combination Prevention (45 minutes) **10.4** Key Messages, How to Put this Module into Action, and Wrap-up (45 minutes)
MATERIALS	**Handouts** ▪ Key Messages—Combination Prevention ▪ Putting Learning into Action: How Can I Use What We've Done? Combination Prevention **For PowerPoint Presentation** ▪ PowerPoint: Combination Prevention ▪ Laptop, projector, screen **Other** ▪ Flipchart easel ▪ Flipchart paper ▪ Markers ▪ Pens/pencils ▪ Sticky notes/name tags ▪ Tape

Activity 10.1 Goal of Prevention

OBJECTIVES	By the end of the activity, participants should be able to describe the goals of prevention and explain that it involves a causal chain using a Theory of Change model.
TIME	20 minutes

MATERIALS	**For PowerPoint Presentation** ▪ PowerPoint: Combination Prevention (Slide 2, Goals of Prevention) ▪ Laptop, projector, screen **OR** ▪ Prepared flipcharts ▪ Flipchart easel ▪ Markers ▪ Flipchart paper (blank) ▪ Tape
STEPS	**1.** Begin by asking participants, "What is the goal of prevention?" **2.** Note ideas on a flipchart or whiteboard. **3.** Normally, the end goal of prevention is a decrease in new cases of transmission (decrease in incidence). The goal could, however, go a step further to include a focus on maintaining good health. **4.** Work back from the ultimate goal to develop steps for reaching that goal. Theory of Change defines long-term goals and then maps backwards to identify necessary preconditions.  **5.** When you have completed the steps, discuss how the steps in the process can change depending on conditions, target audience, or other factors. However, this model helps to understand the interlocking pieces of prevention. **6.** Finish the discussion by showing a prepared flipchart or PowerPoint slide on the Goals of Prevention (Slide 2). Talk about how these things might be put into the language of objectives and how project objectives are the elements that people can claim they helped to change in their work (attribution of change).

Activity 10.2 The Ecological Model

OBJECTIVES	By the end of this activity, participants should be able to: ▪ Use the ecological model to illustrate the three components of combination prevention (biological, behavioural, and structural) ▪ Help to illustrate issues of social mobilisation and building social capital, as well as how they can have influence people's lives and options
TIME	1 hour
MATERIALS	**For PowerPoint Presentation** ▪ PowerPoint: Combination Prevention (Slides 3-4, Ecological Model) ▪ Laptop, projector, screen **OR**

- Prepared flipcharts
- Flipchart easel
- Markers
- Flipchart paper (blank)
- Tape

Other

- Name tags or sticky notes
- Diagram of the Ecological Model (see PowerPoint or Facilitator Notes following the activities)

Special Preparation

- Draw the Ecological Model diagram on the floor (if it wasn't done before) using three circles, each increasingly larger. The circles should be large enough for persons to stand within them and move around. They should also include labels like 'individual,' 'relationship,' 'community,' and 'society.'
- Determine who would serve as key people in the lives of a people living with HIV (directly and indirectly) and write their names or titles on name tags or sticky notes. An example list might include the following people:

1. Mother
2. Brother
3. Partner
4. Friend
5. Doctor
6. Nurse
7. Receptionist
8. Neighbour
9. Pastor
10. Friend in support group
11. Peer navigator
12. Social worker
13. Pharmacist
14. Nongovernmental organisation (NGO) representative
15. Parish counsellor
16. Head of hospital
17. Board member of clinic
18. National representative
19. Ministry of Health National AIDS Programme director
20. Representative in the Country Coordinating Mechanism
21. Chair of JN+

STEPS

1. Ask for a volunteer to be the 'every person' (Jane/John Doe) for the model. They should stand in the middle of the smallest circle. Create a scenario for this person about some difficulty in their life. Discuss how biological and personal factors can influence whether a person is a victim of violence or at risk for HIV. Some of these factors include age, education level, income, use of substances, or history of sexual violence.
2. Place other people around the person inside the second circle, identifying them with

badges or small cards to place on their forehead (mother, brother, partner, or friend).

a. Ask the 'every person': "What kind of influence do each of these people have in your life?" (It doesn't have to be HIV related.)

b. Ask the other participants, "What do we learn from this circle?"

c. Note that the second level explores close relationships and the immediate social circle of an individual.

3. Introduce the concepts of 'social capital' and 'social mobilisation,' and define them (see exercise in Module 17: Advocacy). Say that the group should also think about these issues as the exercise continues.

4. Place people within the third circle, identifying them with badges (doctor, nurse, receptionist, neighbour, pastor, friend in support group, pharmacist, or NGO representative).

a. Ask the 'every person': "What kind of influence do each of these people have in your life?" (It doesn't have to be HIV related.)

b. Ask everyone else the following questions:

i. What do we observe/learn from the people in this circle?

ii. Ask about issues related to prevention, such as stigma and discrimination. "How do stigma and discrimination impede resolution of the problem?"

iii. How do social capital and social mobilisation affect the interactions between the 'every person' and these people?

c. Note that this third circle explores the settings—such as workplace, school, neighbourhood, and local clinic—in which social relationships occur.

5. Place people outside the third circle, identifying them with badges (parish counsellor, head of hospital, board member of clinic, national representative, Ministry of Health National AIDS Programme director, Country Coordinating Mechanism representative, or JN+ chair).

a. Ask the 'every person': "What kind of influence do each of these people have in your life?" (It doesn't have to be HIV related.)

b. Ask everyone else the following questions:

i. What do we learn from the people in this circle?

ii. If these people are not able to be influenced directly by the 'every person,' how could we influence people who could then influence them?

c. This fourth circle looks at the broader social factors that help to create a climate where prevention is encouraged or inhibited.

d. Please note that it is at this level especially that much advocacy occurs, but that some advocacy needs to happen simultaneously at the community level.

6. End the activity by asking, "What were the key lessons learned from this exercise?" Ask one of the participants to explain social capital using the circles, and how to build social capital.

Activity 10.3 Combination Prevention

OBJECTIVES	At the end of the session, participants should be able to name the three components of combination prevention and give two examples of each.
TIME	45 minutes

MATERIALS	**For PowerPoint Presentation** ▪ PowerPoint: Combination Prevention (starting on Slide 5, Combination Prevention) ▪ Laptop, projector, screen **OR** ▪ Prepared flipcharts ▪ Flipchart easel ▪ Markers ▪ Flipchart paper (blank) ▪ Tape ▪ Diagram of the three aspects of combination prevention (see PowerPoint, Slide 5 or Facilitator Notes following the activities)
STEPS	**1.** Make a presentation using prepared flipcharts or the PowerPoint, Combination Prevention. **2.** Discuss the following questions: **a.** How is combination prevention linked to PHDP? **b.** What are some of the ways that people living with HIV can intervene in terms of the following? **I.** Biomedical prevention **II.** Behavioural prevention **III.** Structural prevention **c.** End by saying that advocacy can involve looking at each aspect of prevention.

Activity 10.4 Key Messages, How to Put This Module into Action, and Wrap-up

OBJECTIVES	By the end of this activity, participants should be able to: ▪ Name the three components of combination prevention and illustrate them with examples ▪ Develop a few action steps regarding how they will use this information in their everyday lives
TIME	45 minutes
MATERIALS	**Handouts** ▪ Key Messages—Combination Prevention ▪ Putting Learning into Action—Combination Prevention
STEPS	**Review of Key Messages** **1.** Explain that the group has finished the combination prevention module. Note that this can be presented as a subset of the advocacy module. **2.** Invite participants to share any further comments or reflections that they have at this time. **3.** Explain that the group should conclude this module by reflecting on key take-away messages. **4.** Ask participants to take three minutes to discuss with a partner, "What are your key learnings about connecting to community?" Ask participants to note their responses so they can share

them out loud.

5. After three minutes, ask for responses to people's discussions. Record responses on a large flipchart.
6. Distribute the handout Key Messages: How Can I Use What We've Done? Combination Prevention. Ask one person to read them out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference.

How to Put this Module into Action

1. Distribute the handout Putting Learning into Action: How Can I Use What We've Done? Combination Prevention.
2. Ask people to complete it individually.
3. Ask select people to volunteer to share what they wrote.

Wrap-up

Thank participants for their participation.

Facilitator Notes

THE ECOLOGICAL MODEL

There are a number of different versions of ecological models, but in general, they recognise that successful activities to promote health, including HIV risk reduction, involve not only changing individual behaviours; they also involve advocacy, organisational change, policy development, economic supports, environmental change, and multi-method programs. According to this model, behaviour is determined by the following:

1. Intrapersonal factors—characteristics of the individual such as knowledge, attitudes, behaviour, self-concept, and skills.
2. Interpersonal processes—formal and informal social network and social support systems, including the family, work group, and friendships.
3. Institutional factors—social institutions with organisational characteristics and formal and informal rules and regulations for operation.
4. Community factors—relationships among organisations, institutions, and informal networks within defined boundaries.
5. Public policy—local, state, and national laws and policies.

Interventions are more successful if they intervene within most, if not all, levels of influence. For example, distributing condoms can reduce barriers such as price and convenience, as well as change the social acceptability of carrying condoms.

COMBINATION PREVENTION

I. DEFINITION OF THE PREVENTION AREA

In 2009, *The U.S. President's Emergency Plan for AIDS Relief (PEPFAR): Five Year Strategy* defined combination prevention as its major approach to HIV prevention, stating that

"Successful prevention programs require a combination of evidence-based, mutually reinforcing biomedical, behavioural, and structural interventions."

Also please review this document pre-workshop as it contains the most recent thinking and technical guidance which will likely replace or compliment what is here.[1]

II. EPIDEMIOLOGICAL JUSTIFICATION FOR THE PREVENTION AREA

The goal of combination prevention is to reduce the number of new infections, thus effectively ending the AIDS epidemic as a public threat health threat by implementing a combination of high impact programmes, in key locations and with priority populations. Also, because individuals' HIV prevention needs change over a lifetime, combination approaches help ensure that people have access to the types of interventions that best suit their needs at different times. Practitioners and researchers currently believe that combination approaches result in synergies in which the total effect of a set of carefully chosen interventions is greater than the sum of its parts, with a greater impact on reducing the transmission of HIV. This hypothesis, however, remains to be proven.

Prevention programmers have used various models to attempt to identify the drivers of the epidemic, provide a guide on which mix of interventions would have the greatest impact, and give strategic choices on combination prevention approaches.

Others caution against the use of models in making strategic prevention decisions, since models may provide outputs that fail to identify the key behaviours that drive an epidemic and are difficult to fit to local epidemics that are heterogeneous across different locations. Therefore, models are a tool that should always be used in conjunction with other data sources to make programmatic decisions.

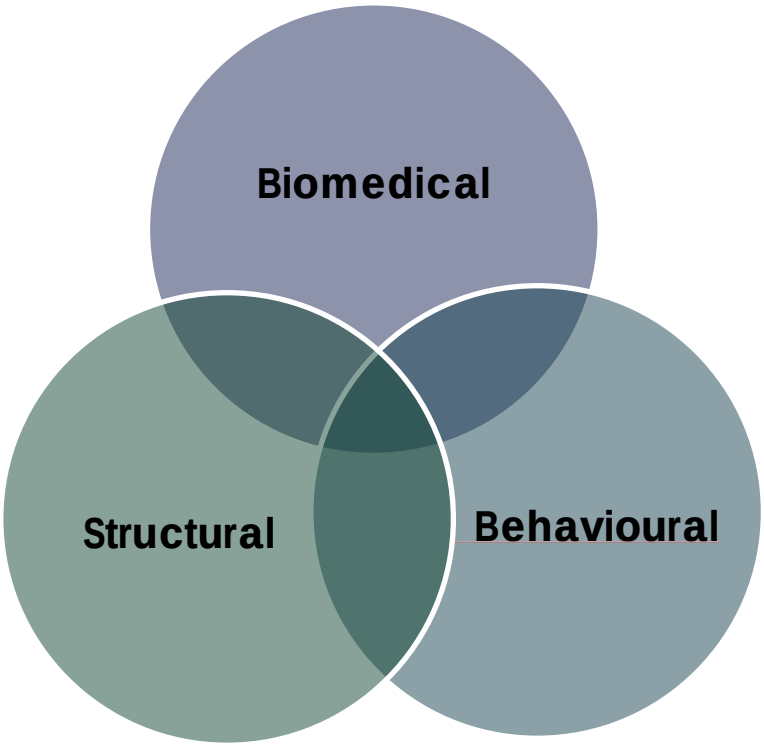
III. CORE PROGRAMMATIC COMPONENTS

In August 2011, PEPFAR issued Guidance for the Prevention of Sexually Transmitted HIV Infections, and recommended a combination approach to prevention that includes three types of mutually reinforcing interventions:

1. Biomedical interventions are those that directly influence the biological systems through which the virus infects a new host, such as blocking infection (e.g., male and female condoms), decreasing infectiousness (e.g., ART as prevention), or reducing acquisition/infection risk.
2. Behavioural interventions include a range of sexual behaviour-change communication programs that use various communication channels (e.g., mass media, community-level, and interpersonal) to disseminate behavioural messages designed to encourage people to reduce behaviours that increase risk of HIV and increase protective behaviours

   (e.g., risks of having multiple partners and benefits of using a condom correctly and consistently). Behavioural interventions also are aimed at increasing the acceptability and demand for biomedical interventions.
3. Structural interventions address the critical social, legal, political, and environmental enablers that contribute to the spread of HIV. PEPFAR uses five categories to describe structural interventions: legal and policy reform, reducing stigma and discrimination against people living with HIV and marginalised groups, gender inequality and gender- based violence, economic empowerment and other multisectoral approaches, and education.

[1] UNAIDS. 2015. *Fast-tracking Combination Prevention: Towards Reducing New HIV Infections to Fewer than 500,000 by 2020.* Geneva: UNAIDS.



The PEPFAR guidance goes into further detail on which core interventions (i.e., prevention of mother-to-child transmission, voluntary medical male circumcision programs, condom programs, and programs for most-at-risk populations and people living with HIV) should be prioritised and implemented based on UNAIDS' 'Four Knows.' The Four Knows bases selection and scale of interventions on epidemiological evidence, country context, knowledge of other donor programs, and national strategies. Additionally, prevention strategies should be assessed through impact evaluations.

To achieve this, programmers should perform a gap analysis in their countries to determine which key drivers, geographical locations, and range of interventions are lacking, and then include those in their prevention portfolio to try to create synergy among them. To implement the interventions that would be most effective in the country's context, the questions to ask when making prevention portfolio decisions are, "How much, when, and where?"

IV. CURRENT STATUS OF IMPLEMENTATION EXPERIENCE

Although the term 'combination prevention' is relatively new, the concept itself is not. Countries experiencing HIV epidemics routinely implement complex packages of prevention interventions; yet the scale, intensity, and quality of these interventions is often insufficient. Furthermore, only a minority of programs include interventions designed to address structural drivers of the epidemic. Complex and successful programs have existed for some time in concentrated epidemics, where service packages include biomedical, behavioural, and structural interventions; however, these approaches remain under-implemented and under-evaluated. Often, prevention portfolios are not adequately focused on the populations and the behaviours that actually drive the epidemic, nor are they sufficiently well implemented in the locations where the risk behaviours are most likely to occur. Interventions need to be chosen based on the complexity of behaviours within populations as well as how social and cultural norms influence sexual and health-seeking behaviours. Current combination prevention programs are building on lessons learned and improving strategies to increase their impact on the epidemic.

A number of countries—such as South Africa, Botswana, India, Namibia, Uganda, and the Ukraine—are implementing combination prevention packages. Combination prevention is a portfolio approach for a given geographic area—whether at the national, state, district, or community level. It is not an individual implementing a partner-level approach, but involves a number of partners who contribute towards a combination prevention approach. For example, in South Africa, several studies have demonstrated a reduction in HIV incidence mostly due

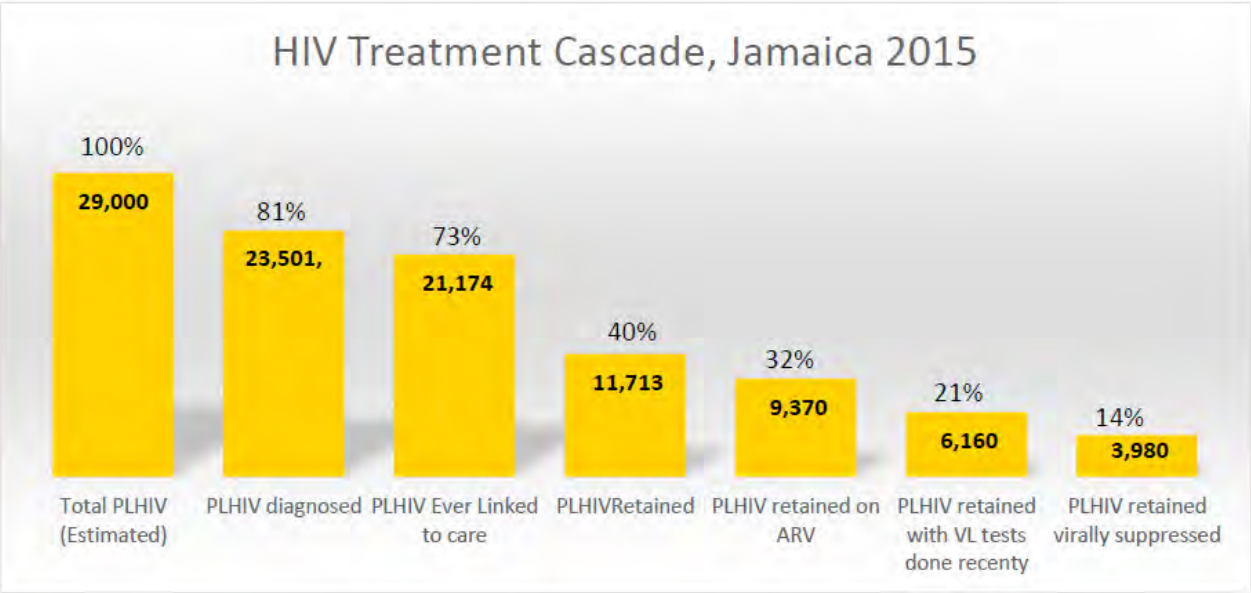
to increased condom use among youth and to antiretroviral treatment. The decline in incidence coincides with the increase of prevention interventions in the country such as increased distribution and availability of condoms, school-based HIV life skills programs, and a large mass media serial program that depicted how positive and negative behaviours can affect health outcomes.

SOCIAL MOBILISATION

Social mobilisation is a process that engages and motivates a wide range of partners and allies at national and local levels to raise awareness of and demand for a particular development objective through face-to-face dialogue. Members of institutions, community networks, civic and religious groups, and others work in a coordinated way to reach specific groups of people for dialogue with planned messages. In other words, social mobilisation seeks to facilitate change through a range of players engaged in interrelated and complementary efforts.[2]

CASCADE OF SERVICES

The HIV and AIDS, sometimes called the HIV, cascade is a model that delineates the sequential steps or stages of care that people living with HIV go through: from initial diagnosis and engagement in care to the goal of viral suppression (see HIV Treatment Cascade, Jamaica 2015). This model is often used to visually depict the number of people living with HIV who are accessing treatment and care. The model also helps to highlight and flag at each step in the cascade where individuals may 'drop off ' of the cascade. Each step along this cascade is critical in order to lower the viral load in individuals, to reduce infection, transmission and decrease HIV related morbidity and mortality. This visualization of data along the steps of care for a person living with HIV is essential for programmatic reviews, identifying bottlenecks and leaks in the response and for displaying progress made at facility, regional or country level.



Source: Ministry of Health, Jamaica. 2016. *Jamaica's HIV Treatment Cascades 2014-2015*. Kingston, Jamaica: Ministry of Health.

Another useful cascade is that which depicts the full journey of people within the context of HIV and moves to into that of someone living with HIV. There are several touchpoints, steps and sub steps that can be expanded at an individual level which are often worth exploring with developing a plan of self-care. In Jamaica there are several health facility staff and community support people who serve as touchpoints of care and support for the success of a client along the cascade with the ultimate goal of improved HIV outcomes and resilience. These include peer navigators, contact investigators, adherence counsellors, social workers, nurses, and pharmacists some of who are openly living with HIV.

[2] Retrieved from http://www.unicef.org/cbsc/index_42347.html.

Handout:
Key Messages—Combination Prevention

The Ecological Model shows that behaviour is determined by the following:

- Intrapersonal factors
- Interpersonal factors
- Institutional factors
- Community factors
- Public policy

The goal of prevention involves a series of steps that ultimately result in reducing the risk of transmitting HIV. Combination prevention involves biomedical, behavioural, and structural interventions.

Other Messages

_____

_____

_____

Handout: Putting Learning into Action:
How Can I Use What We've Done?

COMBINATION PREVENTION

1. How can I use information from this module in my own personal life? Please list.

_____
_____
_____
_____

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)

_____
_____
_____
_____

a. With whom would I want to share? Please list.

_____
_____
_____
_____

b. For each person or group with whom I would like to share, please consider:

PERSON 1 OR GROUP 1: _____

1. What do I want to share?

2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

PERSON 2 OR GROUP 2: _____

1. What do I want to share?

2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

PERSON 3 OR GROUP 3: _____

1. What do I want to share?

2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3 What additional support or information do I want? How can I get it?