Harnessing the Social Capital of Rural Communities for Adolescent and Youth Biosocial HIV Prevention: Exploring Young People's Experiences and Perceptions of a Peer Navigator Intervention in KwaZulu-Natal, South Africa

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BACKGROUND

- HIV-related morbidity and mortality in South Africa is growing among adolescents and young adults aged 15 to 24 years.
- Intersecting socially determined inequalities, namely youth, gender and poverty, have prevented young people from effectively engaging with bio-behavioural HIV prevention
- Community-based peer-to-peer approaches have the potential to sustainably harness social capital ((shared norms and values, trust and social networks)) for HIV prevention.

AIM

To explore experiences and perceptions of a peer-led biosocial HIV prevention intervention – Thetha Nami (Talk to me) in order to **understand how peer support enhances demand and retention to tailored HIV prevention**, including Pre-Exposure Prophylaxis among young people in rural KwaZulu-Natal, South Africa.

STUDY AREA

The Africa Health Research Institute (AHRI) is situated in uMkhanyakude District, KZN, SA. (Fig 1)

Intervention – Thetha Nami
Thetha Nami, was conducted within the study area, iteratively co-created and developed using participatory methods and is delivered by N= 89 community-based peer navigators (17 men, 73 women aged 18-30). Peers are involved in delivering biosocial HIV prevention through peer-to-peer approaches to young people in their locality. They are also responsible for strengthening young people's social capital – helping young people to build a form of strong social networking which shapes individual behaviour through social and cultural influences that discourages risky sexual behaviour and drives social movement for change.

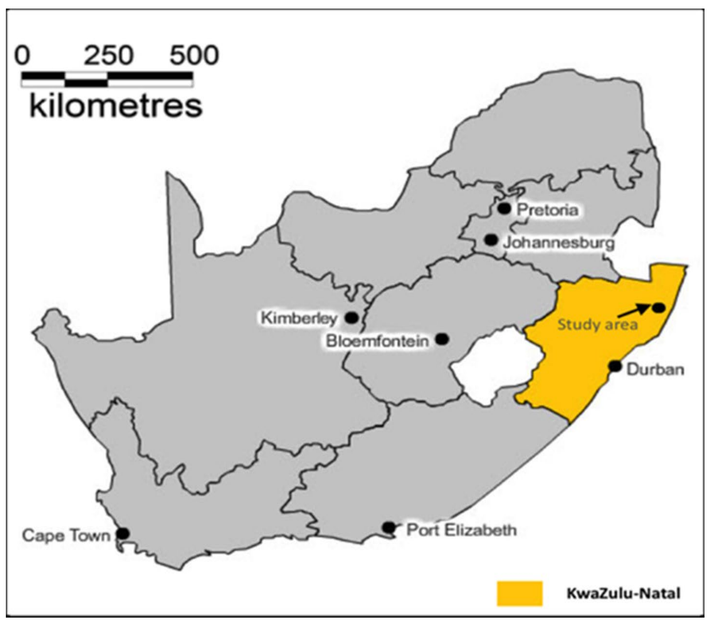

Fig #1 The area is mostly rural and poor, with high youth unemployment (>80%) and an annual HIV incidence of 8% amongst females aged 20–24 and 4% in males aged 25–29.

METHODS

We conducted a process evaluation to assess the acceptability and reach of peer led social mobilization into decentralized sexual and reproductive health (SRH) to deliver universal risk-informed (differentiated) biosocial HIV prevention(2019-2021) We used qualitative methods including semi-structured individual interviews at two time points as shown in Table 1below. Participants were recruited if they resided or worked within intervention communities and if they were willing to provide informed consent to participate in voice-recorded telephonic in-depth interviews (TIDI's).Interviews were done telephonically to adhere to COVID-19 lockdown regulations. TIDI's were transcribed verbatim and translated from IsiZulu to English. Data were analysed using thematic analysis.

2019-2020	Participant Category	No. of interviews (72)
	Young people who received intervention	N=40
	Young people who refused to participate	N=8
	Clinical Staff	N= 6
	Peer navigators	N=10
	Trackers	N=7
2020-2021	Participant Category	No. of interviews (20)
	Young people who received intervention	N=12
	Peer navigators	N=8

Table 1 Participant profile

FINDINGS

We found three overarching themes that underpin different dimensions of social capital within the context of peer-led biosocial HIV prevention and care (Fig 2).

Cultural influences on social support
- Young people described feeling less stigmatised when accessing HIV care and prevention and said the intervention was able to respond to gender and sexual norms as it was delivered by peers who shared similar cultural connections and beliefs rooted in their cultural background.

Community identity
- Resilience within the community was enhanced by "having lived in the area for a long time" and having both participants and peers coming from the same community and sharing similar life experiences. However, due to the COVID-19 lockdown, support was moved to virtual platforms, affecting trust and privacy as some young people preferred face to face support. Coming from the same community also affected openness and the ability to "talk freely" about issues facing young people.

Empowerment through collective action
- Through the intervention, young people were being referred to and connecting to multiple available community resources and this enhanced peer to peer relations and expanded young people's bonding networks.

Once my results came back, she paid me another visit **to tell me that my results were positive, so we spoke at length about that**. Before she told me my results, we started by having a conversation and **she counselled me**. We spoke about life in general and I told her about the type of lifestyle I lead. **She made me feel so comfortable that I felt there was nothing I need to hide** from her because she was so open with me. (IDI, Male, 22 years old)

He wanted to provide another opportunity for me to express myself and speak more freely since we're both males and it was just the two of us. **He also made it clear that he would be able to refer my case to other people if he wasn't able to be of assistance**.... Yes, I felt I was able to open up and nothing was left unsaid. We spoke very broadly. (IDI, Male, 28 years old)

"**It is not bad because it is the community and people I know, and most of them are able to open up sometimes but sometimes it is difficult because some people do not feel free** to open up for someone they do not know.." (IDI, Peer 3, female)

Fig # 2 Example quotations from participants

CONCLUSION

Peer-led interventions have the potential to increase demand and effective use of HIV prevention through enhanced social capital amongst adolescents and youth in rural South Africa. The intervention supported young people at the individual level, however, it was not clear how, when and for whom it enhanced bridging and linked social networks. Moreover, it did not show how social connections were sustained, particularly due to reduced physical contact as a result of COVID-19 lockdown restrictions.

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