HIV Prevention Among Adult Women in Namibia and South Africa

Opportunities for Social and Behavior Change Communication

June 2012
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Research Brief

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This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID), with the research supported by the President’s Emergency Plan for AIDS Relief (PEPFAR) through USAID, under the terms of Agreement No. GPO-A-00-07-00004-00. The contents are the responsibility of the C-Change project, managed by FHI 360, and do not necessarily reflect the views of USAID or the United States Government.
Recommended Citation:

C-Change is a USAID-funded project implemented by FHI 360 and its partners: CARE; Internews; Ohio University; IDEO; Center for Media Studies, India; New Concept, India; Soul City, South Africa; Social Surveys, South Africa; and Straight Talk, Uganda.

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Acknowledgments

C-Change would like to thank Warren Parker for leading the studies and writing the reports. Bamikale Feyisetan, formerly of C-Change/FHI 360, contributed to the development and design of the multi-country research study. Field work was conducted by Survey Warehouse in Namibia and by the Centre for AIDS Development, Research and Evaluation (CADRE) in South Africa.

C-Change Senior Research Specialist Reena Borwankar and C-Change Director Neill McKee contributed to development of the final drafts, and Shanti Conly, Team Leader, HIV Prevention, USAID Office of HIV/AIDS, contributed valuable comments on the conceptual framework for the report. Editing was provided by Hilary Russell.

Key Terms

**HIV-risk behavior** refers to the sexual behaviors and related practices that heighten susceptibility to HIV infection.

**HIV vulnerability** refers to the underlying economic, social, and structural factors that reduce the ability of individuals and communities to avoid HIV infection.

**Social and behavior change communication (SBCC)** is an interactive, researched, and planned process that aims at changing social norms as well as individual behaviors. It involves complementary approaches, drawing on a socio-ecological model to find an effective tipping point for change, either addressing knowledge, skills, and motivation needed; desired modification for social and gender norms; or what would constitute an enabling environment for change. SBCC includes three key strategies: advocacy, social mobilization, and behavior change communication.

**Social mobilization** involves the broad engagement of people in addressing political or social goals with which they identify through self-reliant activities.
Background

In many parts of sub-Saharan Africa, adult women bear the burden of HIV. In Namibia, peak HIV prevalence occurs among women ages 35–39, and very high HIV prevalence occurs among women in the age groups 25–29 and 30–34 (MOHSS 2010). In South Africa, peak HIV prevalence occurs among women ages 25–34 (NDOH 2010). These prevalence increases are illustrative of high incidence among women in their twenties (Barnighausen et al. 2008; de la Torre 2009).

While the factors underpinning HIV vulnerability among women in high-prevalence countries are generally known (UNAIDS 2010), specific reasons for the ongoing pattern of new infections among adult women are not well understood.

Purpose and Methods

Two studies in South Africa and Namibia are part of a larger C-Change study that includes Ethiopia. The overall study is intended to inform strategic responses for addressing HIV prevention through social and behavior change communication (SBCC) among adult women in the region.

Research questions addressed three main areas:

1) How do community members understand HIV vulnerability and risky sexual behaviors that sustain high HIV prevalence among adult women?
2) Are there emerging concepts among community members that provide insight into reducing vulnerability and risk to HIV among adult women?
3) What are the opportunities for SBCC programs to address HIV prevention among adult women?

The study protocol was reviewed and approved by the ethical review boards used by the C-Change project in the United States, the Ministry of Health and Social Services in Namibia, and the Human Sciences Research Council in South Africa.

The qualitative studies employed focus group discussions with men and women ages 20–50 and in-depth interviews with community and traditional leaders, male and female elders, healthcare providers, and staff members of non-governmental organizations. These were conducted in a total of 11 communities the two countries. Data were analyzed thematically and coded using qualitative software.

Study Limitations

Study communities were selected with a view to understanding vulnerability in a range of settings, while at the same time exploring risk factors known to influence vulnerability. At the outset of the study, it was noted that HIV prevalence varied between study communities.

Acknowledging that variations in HIV prevalence are produced by a complex range of factors, contemporary scientific approaches aimed at understanding the heterogeneity of HIV within countries involve drawing together a wide range of epidemiological data drawn from HIV and socio-behavioral surveys as well as qualitative research. Analyses and modeling exercises (e.g., Know your epidemic, Know your response, led by UNAIDS and the World Bank) using these data sources are conducted to provide a sound basis for understanding of HIV incidence and prevalence patterns in a given context.
The present study uses qualitative approaches to understand community perspectives on HIV vulnerability and risk. No data was gathered on sexual behavior at the individual level, and other epidemiological data was not assessed. The study findings are, therefore, unsuited to understanding heterogeneity of HIV between communities, and this is a limitation of the methodology.

**Interpretive Models**

A key challenge was to develop a way to present findings in a concise manner that would be useful for policymakers, strategists, and SBCC practitioners. This was addressed applying a socio-ecological model adapted by C-Change (McKee et al. 2000) and developing additional interpretive models.

The socio-ecological model used highlights four overlapping contextual domains—individual, socio-cultural, economic, and environmental—as well as crosscutting change elements relevant to SBCC in the context of health: information, motivation, ability to act, and norms (Figure 1).

Two interpretive models were developed to further guide the data analysis. The first addresses the factors that underpin sustained high HIV prevalence among adult women emerging from the data (Figure 2).

**Figure 1. C-Change’s socio-ecological model for change**

**Figure 2. Factors underpinning sustained high HIV prevalence among adult women**

Based on the study narratives, these include:

- **Individual factors** comprising adult sexual behaviors and relationship practices, psychological factors that contribute to HIV risk, and biological factors
• **Socio-cultural factors**, including tolerance and acceptance of risky sexual behaviors; relationship practices; and vulnerability to HIV as a product of alcohol consumption, sexual violence, and gender relations

• **Economic factors**, which are largely concentric around poverty and economic inequality

• **Environmental factors**, which include underlying drivers such as high HIV prevalence in combination with limited relevance of HIV prevention information; wide availability of alcohol; communication technology that facilitates sexual networking; lack of trust in HIV services; and the lack of involvement of communities and community leaders in the response to HIV and AIDS, including the overall perception that communication about HIV prevention comes from outside sources

The second model (Figure 3) draws on change elements expressed in C-Change’s socio-ecological model. These elements provide an interpretive framework for understanding the utility of SBCC for reducing high HIV prevalence among adult women by focusing on change.

![Figure 3. Factors relevant to the development of SBCC to support HIV prevention](image)

The study narratives provided insight into individual and socio-cultural strategies that can be communicated through SBCC approaches to address HIV vulnerability and risk in relation to these change elements.

- **Information**: Participants highlighted a variety of strategies that could be used to avoid risky sexual partners, violent relationships, and other relationships that accentuate HIV risk. The strategies involve:
  - increasing self-efficacy in relationship choices, including sticking to one’s principles for HIV prevention
  - addressing HIV risk through dialogue with sexual partners about accountability in relation to HIV and by establishing safer, long-term relationships
  - addressing environmental vulnerabilities—for example, avoiding alcohol venues where there is an increased risk of exposure to casual sex or sexual violence

- **Motivation**: This includes the range of factors that psychologically reinforce risk avoidance—for example, setting long-term goals, accepting one’s circumstances, respecting oneself, and having faith.
• **Ability to act:** This includes the range of factors that strengthen and reinforce the capacity of individuals to address HIV prevention, including fostering critical thinking and problem-solving to address HIV prevention at community levels through group interaction; encouraging male involvement at group levels; and promoting and supporting group-level actions to address the vulnerability of adult women.

• **Norms:** This includes the range of socio-cultural norms and values that would be reshaped in support of addressing HIV vulnerability and risk among adult women through individual- and community-level SBCC strategies:
  
  o At the level of relationships, highlighting the importance of greater accountability between sexual partners in relation to HIV risk and increasing dialogue, openness, and trust between sexual partners.
  
  o At a broader social level, promoting recognition that high HIV prevalence and incidence among adult women is an urgent community problem; fostering community-level disapproval of risky sexual relationships that contribute to HIV infection; and promoting recognition that risky sexual relationships have a negative impact on the community as a whole.
  
  o Also at community levels, promoting leadership that includes expectations for exemplary behavior; promoting understanding that ordinary community members can be involved in critical thinking and leadership to develop solutions for HIV prevention; and incorporating greater male involvement in response to HIV prevention.

**Conclusions**

Study participants were well able to describe why and how adult women were vulnerable to HIV and why high levels of HIV prevalence prevailed. Across communities, the study found that common factors underpinning HIV vulnerability were largely related to economic inequality and exposure to alcohol consumption, with gender being a related issue. At the broadest level, adult women faced a continuum of vulnerability to HIV, even if their direct risk behaviors changed over time. Where risk behaviors were reduced, vulnerability to HIV flowed from ongoing relationships with risky male partners.

HIV vulnerability and risk among adult women were perpetuated specifically through economic inequality, whether or not it was men or women who were economically advantaged. For example, poorer women might be inclined to exchange sexual favors for economic benefits, while unemployed men sought out employed women for similar benefits. Underlying environmental factors such as the widespread availability of alcohol perpetuated HIV risk, as did circumstantial factors—for example, the need for women to improve their economic circumstances to care for children abandoned by their fathers.

Vulnerability and risk were also perpetrated by socio-cultural factors, such as acceptance of turnover of sexual partners and a lack of accountability between sexual partners in relation to HIV prevention.

A combination of factors has reduced the likelihood of long-term sexual relationships and marriage for adult women, including an emphasis on ongoing education and employment for women and on delaying marriage to reduce dependence on men. While these latter transformations have decreased gendered disempowerment of women, they have not sufficiently diminished adult women’s vulnerability to HIV.
Both male and female participants mentioned personal HIV-prevention strategies with broad application, including acknowledging and internalizing HIV risk and being motivated, through self-respect, self-care, and self-efficacy, to have sexually responsible relationships.

Study findings show that HIV and AIDS communication has reached widely into study communities. The narratives of participants illustrate that they have applied the knowledge acquired about HIV to their contexts, to the extent that they understand HIV vulnerabilities and risks among adult women. The narratives also show that participants are critical of the ways that HIV prevention communication is delivered. Some see door-to-door campaigns as overly intrusive. They also expressed concern that some AIDS educators and authority figures were seen to be engaged in risky sexual practices themselves. Participants also highlighted contradictions in the overly sexualized content of some HIV-prevention messaging.

Perceptions of gaps and opportunities for addressing HIV vulnerability and risk among adult women were voiced in similar ways across communities. Participants emphasized the need to transform HIV knowledge into action through greater levels of community engagement, including involvement in problem-solving. They were confident that by working together they could formulate locally appropriate strategies and solutions, noting that emergent groups—mainly among women—were already doing this.

Male participants voiced concerns about the impact of HIV on the women in their lives and the community in general, highlighting that they had not been adequately drawn into processes for addressing the disease. Participants also noted that traditional and community leaders have not been adequately engaged in the prevention response; and their role in social mobilization is insufficiently emphasized.

**Implications for Policy and Programs**

The past decade has seen a strong reliance on vertically driven, national-level, HIV-prevention programs, nuanced according to epidemiological data and thematic orientations. These include prevention programs that focus on multiple and concurrent partnerships, HIV testing, or biomedical approaches such as male circumcision or treatment as prevention (UNAIDS 2011).

Typically, at community levels, these programs are supported through communication methodologies that largely deliver information passively, with a view to enhancing knowledge about HIV. While generally considered useful, study participants viewed such approaches as problematic for behavior change, since community members are not engaged in critical reflection and problem-solving for HIV prevention.

Instead of vertical, top-down, HIV prevention programming, study participants called for the development and expansion of horizontal systems of response that are led on the ground and incorporate contextually relevant solutions.

Key elements for community participation and social mobilization in HIV-prevention programming through SBCC could potentially include the following:

- collaborative ownership and leadership by implementing agencies, community leaders, and community members
- integration of local knowledge and problem-solving strategies
- contextually appropriate communication focused on translating knowledge into action, supported by promoting new and transformative social norms in relation to HIV vulnerability and risk
- integration and synergy with existing programs and services
• ongoing adaptation, as community-level responses evolve into new formats, and taking into account the evolving epidemic

In sum, these key elements highlight the importance of the “social” in SBCC.

In southern and eastern Africa, communication approaches such as Stepping Stones and Community Conversations have moved away from individually oriented communication in favor of group discussion, reflection, and action to achieve normative and individual changes in behavior (FHI 2010; ACORD 2007). There is clearly potential to widen the scope of such activities (See Kippax 2012). Such approaches offer the potential to bring about a broader social mobilization to address HIV risk and vulnerability and reframe social norms to support HIV prevention.

Plans to monitor and evaluate SBCC programs configured toward this goal would have to define carefully what changes are expected and how they can be measured. There is a need to shift the units of measurement and analysis—from an individual orientation to one that engages community members and leaders in HIV prevention and incorporates an understanding of vulnerability in the context of adult women’s relationships.
References


