

HIV Prevention Among Adult Women in Namibia

*Opportunities for Social and Behavior
Change Communication*

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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.

Contents

Executive Summary.....	1
1. Background	5
2. Purpose and Approach.....	5
3. Methods.....	5
4. Interpretive Frameworks	7
5. Narratives.....	12
5.1 Life stages and a continuum of vulnerability among adult women.....	13
5.2 Unemployment and employment.....	15
5.3 Multiple and concurrent partnerships	16
5.4 Alcohol consumption	17
5.5 HIV testing and living with HIV.....	18
5.6 Perceptions of HIV prevention communication.....	20
5.7 Engaging with HIV prevention at individual levels.....	21
5.8 Engaging with HIV prevention at community levels	23
6. Conclusions	24
7. Implications for Policy and Programs	26
8. References	28

Tables and Figures

Table 1. Factors affecting the continuum of HIV risk among adult women.....	9
Table 2. Perceptions of HIV and AIDS communication in study communities	10
Table 3. SBCC approaches to counteract adult women’s HIV vulnerability and risk.....	11
Figure 1. C-Change's socio-ecological model for change	7
Figure 2. Factors underpinning sustained high HIV prevalence among adult women.....	8
Figure 3. Factors relevant for the development of SBCC to support HIV prevention	10
Figure 4. A socio-ecological approach to addressing HIV prevention through SBCC	26

Executive Summary

In many parts of sub-Saharan Africa, adult women bear the burden of HIV. In Namibia, peak antenatal HIV prevalence occurs among women ages 35–39, and very high HIV prevalence occurs among women ages 25–29 and 30–34 (MOHSS 2010). Prevalence increases for each age group, reflecting high incidence of new infections among adult women in their late twenties. 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.

This report on research findings in Namibia is part of a larger study by the C-Change project that includes two other focal countries: Ethiopia and South Africa. 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 of enquiry:

- 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?

C-Change's Namibia study employed 43 qualitative focus group discussions (FGDs) with men and women ages 20 and older and 45 in-depth interviews (IDIs) with community stakeholders, leaders, and elders in six communities including cities, smaller towns, and rural communities.

The study protocol was reviewed and approved by Namibia's Ministry of Health and Social Services and the ethical review board used by C-Change in the United States.

Interpretive Models

Data were analyzed thematically and coded using qualitative software. The analysis drew on the socio-ecological model adapted by C-Change, which highlights four overlapping contextual domains—individual, socio-cultural, economic, and environmental—as well as crosscutting issues relevant to SBCC in the context of health.

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. The second model draws on the change elements in C-Change's socio-ecological model: information, motivation, ability to act, and norms. These elements provide an interpretive framework for understanding the utility of SBCC for reducing high HIV prevalence among adult women by focusing on change.

Narratives

The data revealed that study participants had high overall knowledge and understanding of HIV. The study found that common factors underpinning HIV vulnerability across communities 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.

Through exploring the life stages of adult women in Namibia, the study found their vulnerability to HIV continued although their circumstances changed relating to education, unemployment, longer-term sexual partnerships, and marriage. For some, their HIV risk flowed from their own risky behaviors, while the risk practices of male partners affected the vulnerability of monogamous women in stable relationships. Women who had children out of wedlock when in their late teens and early twenties and were abandoned by the fathers continued to be under pressure to meet considerable economic needs, even if these women were employed. Failed relationships and mistrust perpetuated a cycle of partner turnover and incapacity to commit to longer-term, stable, and monogamous relationships.

HIV vulnerability and risk among adult women were perpetuated through economic inequalities. 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 other circumstantial factors. 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 reduced the likelihood of long-term sexual relationships and marriage for adult women, including an emphasis on ongoing education and employment for women and delaying marriage to reduce dependence on men. While these recent 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 to address HIV prevention. These included 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 participants see door-to-door campaigns as overly intrusive. They also expressed concern about some AIDS educators and authority figures, who 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 like male circumcision or treatment as prevention (UNAIDS 2011a).

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. Stepping Stones, Community Conversations, and other communication approaches in southern and eastern Africa provide examples of approaches that 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).

These approaches are already underway in Namibia. Through C-Change, USAID-funded partners have moved away from passive message-transfer to group discussion and reflection to achieve normative and individual changes in behavior (C-Change Namibia 2010). 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.

1. Background

In many parts of sub-Saharan Africa, adult women bear the burden of HIV. In Namibia, peak antenatal HIV prevalence occurs among women ages 35–39 and very high HIV prevalence occurs among women ages 25–29 and 30–34 (MOHSS 2010). In 2010 in Namibia, antenatal HIV prevalence was 6.6 percent for women ages 15–19; 12.5 percent for those 20–24; 22.8 percent for those ages 25–29; and over 29 percent for women in their thirties: 29.6 percent for those ages 30–34 and 29.7 percent for those ages 35–39. These increases in each age range reflect high incidence of new infections among women in their late twenties.

High levels of HIV incidence among adult women has been confirmed in other southern African settings. For example, a study in rural KwaZulu-Natal South Africa found incidence was highest—12.5 percent—among women ages 25–29 and the second highest was 10.4 percent among women ages 30–34 (Bärnighausen et al. 2008).

Namibia’s generalized HIV epidemic follows a hyper-endemic pattern similar to other countries in southern Africa. Drivers of new HIV infections include multiple and concurrent sexual partnerships (MCP), inconsistent condom use, and low rates of male circumcision (SADC 2006; de la Torre et al. 2009). While a general understanding of factors underpinning HIV vulnerability among women in such high prevalence countries are known (UNAIDS 2010), specific reasons for the ongoing pattern of new infections among adult women are not well understood.

2. Purpose and Approach

The study in Namibia is part of a larger C-Change study that includes two other focal countries: Ethiopia and South Africa. The goal is to inform strategic responses for addressing HIV prevention among adult women in the region through social and behavior change communication (SBCC).

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 social and behavior change communication (SBCC) programs to address HIV prevention among adult women?

3. Methods

The study protocol was reviewed and approved by the ethical review boards used by the C-Change project in the United States and the Ministry of Health and Social Services (MOHSS) in Namibia.

The study employed 43 qualitative, single-sex focus group discussions (FGDs) with a total of 112 men and 233 women ages 20–50 and 45 in-depth interviews (IDIs) with community and traditional leaders, male and female elders, health care providers, and staff members of NGOs in six communities. Fieldwork was conducted in March and April 2011 by Survey Warehouse, a Namibian research company.

FGDs included the following categories:

- married or cohabiting women and men, respectively ages 25–34 and 25–50
- unmarried and non-cohabiting women and men, respectively ages 25–34 and 25–50
- unmarried and non-cohabiting women ages 20–24
- employed women ages 25–34
- unemployed women ages 20–35
- migrant workers and work-seekers—women and men, respectively ages 25–34 and 25–50

Criteria for community selection included representation of urban, peri-urban and rural settings and regional distribution. The following communities were selected:

- **Walvis Bay:** a coastal town in the Erongo Region on the western seaboard. Main languages include dialects of Khoekhoe—either Damara or Nama—as well as Oshiwambo and Otjiherero. The main industry is fishing, and there is an emerging mining sector. The antenatal HIV prevalence in the region was 19.6 percent in 2010 (de la Torre et al, 2009; MOHSS 2010). Drivers of HIV include alcohol consumption, MCP, intergenerational sex, sex work, and mobility as a product of migrant work and work-seeking.
- **Keetmanshoop:** a town in the Karas Region, on a major road route. It is the location of a large regional hospital, and sheep farming is one of its major industries. The main language is Nama, a dialect of Khoekhoe. The town’s antenatal prevalence was 11.9 percent (MOHSS 2010).
- **Tsandi:** a rural settlement in the Omusati Region that is surrounded by a region characterized by crop and livestock farming. The main language spoken is the Oshindonga dialect of Oshiwambo. The town has a district hospital and very high antenatal HIV prevalence: 25.5 percent (MOHSS 2010).
- **Engela:** a rural community in the Ohangwena Region, near the northern border with Angola, traversed by travelers and work-seekers. Oshiwambo is the dominant language. Subsistence agriculture is the primary means of livelihood. MCP and sex work contribute to high antenatal HIV prevalence of 22.4 percent (de la Torre et al. 2009; MOHSS 2010).
- **Katima Mulilo:** a town in the northern Caprivi area that lies on a major trucking route. It has a large, open market and one district hospital. The population is mainly Masubia and Mafwe. Mobile populations and sex work are important drivers of HIV in the town, whose antenatal HIV prevalence was the highest in the country: 35.6 percent (MOHSS 2010).
- **Okakarara:** a small town in the Otjozondjupa region whose dominant language is Otjiherero. The economy is primarily agricultural, and the area has relatively low antenatal HIV prevalence: 7.1 percent (MOHSS 2010).

Data Collection and Analysis

Participants for FGDs and IDIs who fit characteristics related to marital and relationship status, employment status, and age and stakeholder criteria were recruited through contacts established in each community at the outset of the study, using a combination of methods.

FGDs were conducted at venues easily accessible to participants, where there was little potential for interruption or excessive noise interference. Each FGD was conducted by a facilitator and an assistant and lasted between 90 minutes and 2 hours. Each IDI was conducted in a suitable private area by a single interviewer.

Participants were briefed on issues of confidentiality and required to sign consent forms prior to participation. Discussions were conducted in languages agreed upon by participants and the facilitator or interviewer. Refreshments and compensation for time were provided.

All discussions and interviews were digitally recorded, translated, and transcribed verbatim. A thematic analysis framework was developed by reading through all transcriptions, and further coding was conducted using the qualitative analysis software HyperResearch 3.

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.

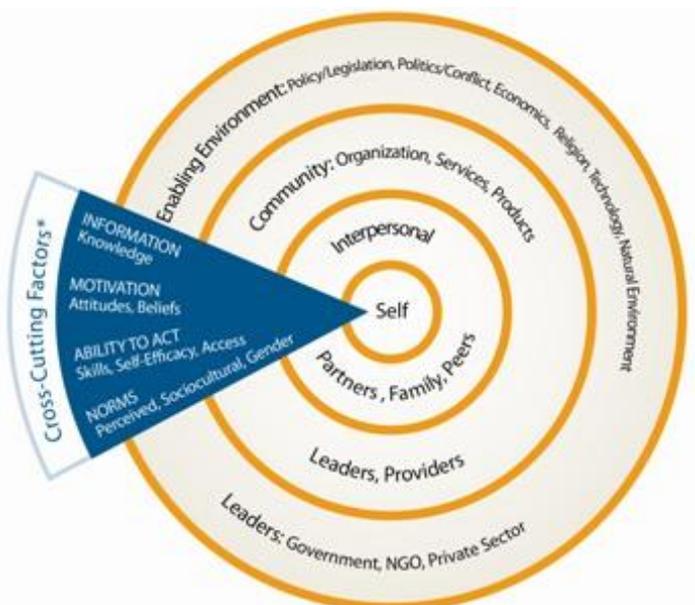
The present study uses qualitative approaches to understand community perspectives on HIV vulnerability and risk. No data was gathered on sexual behavior at the individual level, and other epidemiological data was not assessed. The study findings are, therefore, unsuited to understanding heterogeneity of HIV between communities, and this is a limitation of the methodology.

4. Interpretive Frameworks

Several thousand pages of transcripts emerging from the study were categorized and coded to allow for analysis.

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 by using the socio-ecological model adapted by C-Change (McKee et al. 2010) and developing additional interpretive models to interpret the data. This socio-ecological model highlights overlapping contextual domains as well as crosscutting issues relevant to SBCC in the context of health (Figure 1).

Apart from informing layered, interrelated aspects of individual, socio-cultural, economic, and environmental factors related to HIV risk and vulnerability, the C-Change model informs understanding of cross-cutting elements relevant to SBCC that aims to reduce vulnerability.



*These concepts apply to all levels (people, organizations, and institutions). They were originally developed for the individual level.

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

The data revealed that participants had high overall knowledge and understanding of HIV. The fundamentals of HIV risk and vulnerability were well understood, including as these relate to adult women. Participants revealed a good grasp of HIV in the context of their lives, and they offered a wide range of observations and reflections on communication gaps and possibilities for addressing HIV vulnerability and risk.

The narratives thus had a good fit with the model's change elements of **information, motivation, ability to act, and norms**, as these relate to SBCC for HIV prevention. The data illustrate how knowledge of adult women's HIV vulnerability and risk is related to motivating factors for reducing vulnerability and how, motivating factors are influenced by ability to act, in the context of social norms.

Two interpretive models were developed to further guide the data analysis. The first addresses individual, socio-cultural, economic, and environmental factors underpinning sustained high HIV prevalence among adult women (Figure 2).

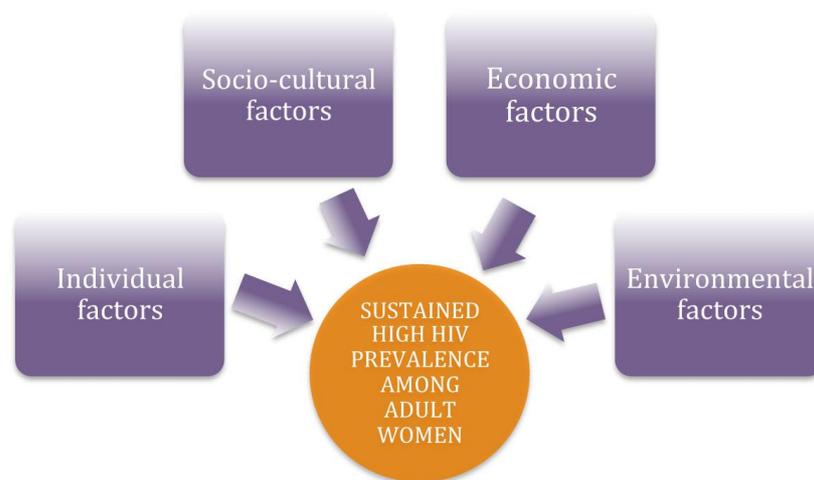


Figure 2. Factors underpinning sustained high HIV prevalence among adult women

Individual factors comprise adult sexual behaviors and relationship practices; psychological factors that contribute to HIV risk; and biological factors.

Socio-cultural factors accentuate risk, including tolerance and acceptance of risky sexual behaviors; relationship practices; and vulnerability to HIV as a product of alcohol consumption and imbalanced gender relations.

Economic factors are largely concentric around poverty and inequality.

Environmental factors include underlying drivers, such as high HIV prevalence in combination with limited relevance of HIV prevention information; the 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.

Table 1 presents a summary of findings in these four domains.

Table 1. Factors affecting the continuum of HIV risk among adult women

Individual factors that accentuate HIV vulnerability and risk	Risky sexual behaviors and relationship practices of adult men and women	
	<ul style="list-style-type: none"> • Inconsistent or non-use of condoms • Low HIV testing • High or low partner turnover • Concurrent partners or partner has other partners • Single parenting 	<ul style="list-style-type: none"> • Transactional sexual partnerships • Short-term relationships • Casual sex, especially as a product of alcohol consumption • Sex while drunk • Higher-risk sexual partners
	Psychological factors that contribute to HIV risk	
	<ul style="list-style-type: none"> • Lack of satisfaction with circumstances • Lack of individual responsibility • Tolerance of risk • Mistrust /dishonesty • Power/disempowerment 	<ul style="list-style-type: none"> • Desperation, bravado, and fatalism • Loss of control through intoxication • Survival needs • Material wants • Desire to love and be loved • Desire for long-term partnership
	Biological factors	
	<ul style="list-style-type: none"> • Greater biological vulnerability of women to HIV 	
Socio-cultural factors that accentuate HIV vulnerability and risk	<ul style="list-style-type: none"> • Cultural acceptance of late marriage, non-marriage, and extramarital liaisons • Acceptance and tolerance of MCP • Lack of accountability between partners in sexual relationships • Tolerance of infidelity • Tolerance of violence in relationships 	<ul style="list-style-type: none"> • Acceptance of sex as a means of exchange among women and men • Expectations among men for sex in exchange for alcohol • Silence about violence and rape • Acceptance of abandonment of unwed mothers and their children
Economic factors that underpin HIV vulnerability and risk	<ul style="list-style-type: none"> • Poverty • Unemployment or employment • Inequality and relative wealth • Consumerism and materialism • Economic exploitation 	<ul style="list-style-type: none"> • Dependence on others and/or having dependents • Work-related migration and mobility
Environmental factors that frame HIV vulnerability and risk	<ul style="list-style-type: none"> • High HIV prevalence in communities • HIV information of limited relevance to the context of risk • Availability of alcohol central to HIV vulnerability and risk behavior • Communication technology that facilitates sexual networking 	<ul style="list-style-type: none"> • HIV-related services underutilized or not trusted • Communities not involved in policy/strategy environment • Sectoral/community/traditional leadership bypassed in response

Figure 3 shows the second interpretive model used. Drawing on change elements in the socio-ecological model, it provides an interpretive framework for understanding the utility of SBCC for reducing high HIV prevalence among adult women by addressing four domains related to change.

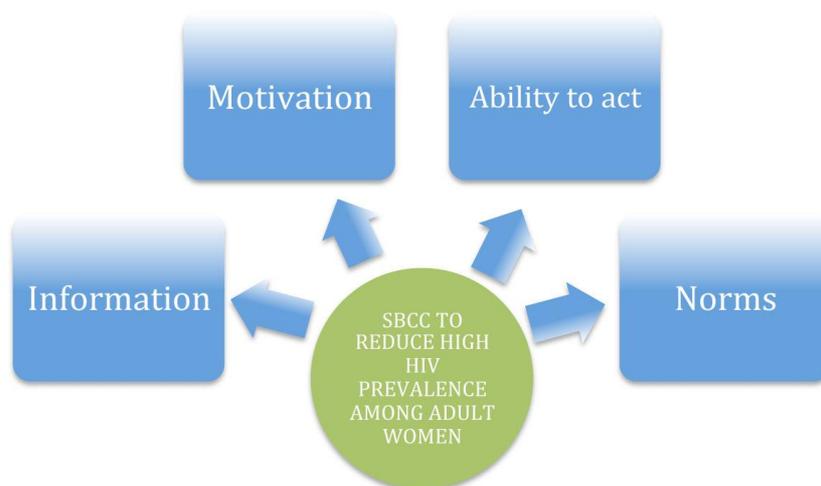


Figure 3. Factors relevant for the development of SBCC to support HIV prevention

Before determining the SBCC approach to support HIV prevention, it is necessary to understand community perspectives on the communication environment. Through-out the narratives, it was abundantly clear that participants have a well-grounded understanding of the complex factors underpinning HIV vulnerability and risk as they relate to HIV prevention. Table 2 summarizes community perceptions of HIV communication that emerged from the data, and in relation to socio-ecological categories for change in Figure 3.

Table 2. Perceptions of HIV and AIDS communication in study communities

Perceptions of study participants	Limitations in information
	<ul style="list-style-type: none"> • Mass media and community-level campaigns provide wide range of information on HIV prevention but lack focus on translating knowledge into action.
	Insufficient motivation
	<ul style="list-style-type: none"> • HIV prevention information is not internalized to the point of action. • Sexual behaviors of some community educators, leaders and authority figures contradict HIV prevention messages.
	Limited ability to act
	<ul style="list-style-type: none"> • Community members have not been engaged at group-level in problem-solving for HIV prevention. • Men have not been engaged or involved in HIV prevention response.
	Unsupportive normative framework
	<ul style="list-style-type: none"> • Traditional, religious, and community leaders have not been adequately engaged in HIV prevention response. • There has been insufficient emphasis on fostering social mobilization to respond to the epidemic.

Study participants were well able to describe why and how adult women were vulnerable to HIV and why high levels of HIV prevalence prevailed. Although there was widespread information about HIV and AIDS, the processes of internalizing HIV risk to the point of action had not been sufficiently addressed. Contradictions in the sexual behaviors of some individuals delivering community-level HIV-prevention information and the perceived HIV-risk practices of some community leaders further diminished the potential for internalizing risk. A central concern expressed was the lack of emphasis on engaging affected communities and community leadership in addressing the epidemic at community level.

Table 3 summarizes participants’ perspectives on SBCC approaches to counteract HIV vulnerability and risk among adult women. The cross-cutting factors of information, motivation, ability to act, and norms inform opportunities to address change processes.

Table 3. SBCC approaches to counteract adult women’s HIV vulnerability and risk

Information	Information relevant to internalizing and acting on HIV vulnerability and risk	
	<ul style="list-style-type: none"> • Avoid risky sexual partners. • Stick to your principles (e.g., consistently use condoms and go for couple testing for HIV). • Establish a long term relationship with a trusted partner who cares about you. 	<ul style="list-style-type: none"> • Discuss risk and accountability in relation to HIV risk with sexual partner (e.g. couple testing, commitment to monogamy). • Avoid risky environments such as alcohol venues.
Motivation	Motivating factors relevant to internalizing and acting on HIV vulnerability and risk	
	<ul style="list-style-type: none"> • Set-long term goals. • Accept your circumstances. 	<ul style="list-style-type: none"> • Respect yourself. • Have faith.
Ability to act	Factors influencing ability to act to reduce HIV vulnerability and risk	
	<ul style="list-style-type: none"> • Encourage support for safer sexual relationships at peer, family and community-levels. • Foster critical thinking and problem-solving to address HIV prevention at community-level through group interaction. 	<ul style="list-style-type: none"> • Foster male involvement in group and community-level responses. • Encourage social mobilization to address the vulnerability of adult women to HIV.
Norms	Orientation of social norms that would reduce HIV vulnerability and risk	
	<ul style="list-style-type: none"> • Promote recognition that high HIV prevalence/incidence among adult women is an urgent community problem. • Promote understanding that ordinary community members can be involved in critical thinking and leadership to develop solutions for HIV prevention. • Support involvement of men and women in an intensified response to HIV. • Promote leadership at community-level including from sectoral/ traditional/ community leaders for HIV prevention. 	<ul style="list-style-type: none"> • Promote recognition that risky sexual relationships have a negative impact on the community as a whole. • Promote dialogue, openness, and trust in relationships. • Foster community-level disapproval of risky sexual relationships that contribute to HIV vulnerability and risk among adult women. • Promote accountability between partners and knowledge of couple HIV status. • Promote accountability to not infect others. • Promote avoidance of risky environments such as alcohol venues.

Participants reported a range of strategies relating to information relevant for internalizing and acting on HIV vulnerability and risk. These included avoiding risky sexual partners; sticking to one's principles about condom use and couple testing; avoiding alcohol venues and other risky environments; discussing HIV risk and accountability with partners; and establishing a long-term relationship with a trusted and caring partner. Internalizing and acting on HIV risk included motivating factors such as setting long-term goals, accepting one's situation, respecting oneself, and having faith.

Factors influencing ability to act to reduce HIV vulnerability and risk included encouraging support for safer sexual relationships at partner, peer, family, and community levels; fostering critical thinking and problem-solving to address HIV prevention at community levels through group interactions; and encouraging social mobilization to address the HIV vulnerability of adult women.

Change processes for HIV vulnerability and risk reduction would be supported by fostering new emphases relevant to social norms that promote:

- more dialogue, openness, and trust between partners in sexual relationships and accountability in relation to knowledge of a partner's HIV status
- recognition that high HIV prevalence and incidence among adult women is an urgent community problem and the negative community impact of risky sexual relationships
- community-level disapproval of risky sexual relationships that contribute to HIV vulnerability and risk among adult women
- avoidance of risky environments such as alcohol venues
- leadership at community-level for HIV prevention, including from sectoral, traditional, and community leaders
- understanding that ordinary community members can be involved in critical thinking and leadership to develop solutions for HIV prevention
- involvement of both men and women in the intensified response to HIV prevention

While these factors are presented sequentially, it is important to note that they occur in parallel to each other and are interdependent: change in any of them influences change in the others.

5. Narratives

A range of cities, smaller towns, and rural communities in Namibia were selected to assess geographic variations in HIV vulnerability and risk among adult women and opportunities for responding to the disease. While some geographic variations were noted between communities—for example, deference to traditional cultural values was more likely to be voiced in rural communities—participants' understanding of factors underpinning HIV vulnerability and risk remained the same, along with perceptions of gaps and opportunities for HIV prevention.

Common factors underpinning HIV vulnerability across communities were largely related to economic inequality and exposure to risk factors such as alcohol consumption. At the broadest level, the narratives indicate that adult women face a continuum of vulnerability to HIV, even if their direct risk behaviors changed over time. For example, although some adult women moved to more stable, long-term sexual partnerships where they were monogamous, HIV risk remained as a product of their partner's risk behaviors.

HIV vulnerability and risk among adult women was largely linked to economic inequalities that determined relative financial independence. Such inequalities were related to patterns

of having multiple and concurrent sexual partnerships to address a combination of economic “wants” and “needs” that were underpinned by economic and psychological factors.

HIV vulnerability and risk among adult women was perpetuated through underlying environmental factors, such as the widespread availability of alcohol, circumstantial factors such as having to care for children abandoned by their fathers, contextual factors such as acceptance of sexual partner turnover and lack of accountability between sexual partners in relation to HIV, and socio-cultural factors such as reduced priority for committed long-term sexual relationships and marriage.

5.1 Life stages and a continuum of vulnerability among adult women

The study explored life stages of women in their late teens, twenties, and thirties to understand the potential influence of age in relation to HIV vulnerability and risk. As these women got older, their circumstances often changed in relation to education, employment, longer-term sexual partnerships, and marriage. Notwithstanding, the women remained on a continuum of HIV risk as a result of the ways that their sexual relationships played out.

For some, their HIV risk flowed from their own risky behaviors, while risk practices of male partners affected the vulnerability of monogamous women in stable relationships. Not all women focused on stable sexual relationships as they aged: some sought the freedom to have multiple partners. As a community health care worker noted, “As you grow older, the chances of freedom are higher” (IDI health care worker, Engela).

In all study communities, there were family and community expectations that young women who had completed their schooling should focus on tertiary education or employment. In both urban and rural communities, it was important that women be independent before considering marriage:

This person should at least finish her secondary education and further her studies or get a decent job. And then, maybe, be responsible, get a boyfriend, be in a stable relationship, and from there on start to think about marriage” (Male FGD 25–34, Keetmanshoop).

Participants said that most parents believed that women should not get married when they were too young (i.e., in their early twenties). Women in their mid-twenties and older who had completed their education and were employed were considered sufficiently independent to explore relationships. It was noted that women at this point became more vulnerable to HIV. They had nobody “controlling them,” were “free to do anything they want,” and had to “catch up with what they missed,” including attending parties, consuming alcohol, and “behaving recklessly.”

As a female participant observed:

When I think of girls between 20 to 24, I think they are still young; they are still staying with their own parents. But those aged 25 to 35, they are already finished with school. They are just roaming around unemployed. Yeah, doing nothing. That’s why they are so affected (Female FGD 25–34, Katima Mulilo).

It was acknowledged that not all women could afford to be educated. Many did not find jobs, and this resulted in ongoing dependence on their parents. Being unemployed or not being in tertiary education was described as being a disappointment to one’s parents. Women who wished to escape dependence on their parents were said to have little option but to seek out monetary and other economic support through sex with men:

Most of these women are under pressure to look after themselves. So they sell themselves so that they can survive (Female FGD 25–34, Okakarara).

Cellphones made it easier to initiate casual sexual relationships. Participants saw their communities as adhering to “modern values” and believed that cultural beliefs and traditions were “dying out.” Modernity included a transition from the more traditional values of parents and family and following peer influences to be in tune with “global styles.” Peer influences were seen to lead to excessive drinking, having sex at a younger age and sex with multiple partners, as well as choosing to cohabit, rather than getting married.

The transition to modernity, including higher levels of education for women, was understood to undermine cultural “protection” of women, thereby increasing HIV risk:

[Previously] people did not question what they were told by their traditions. But now, when you mix tradition and education, that’s when you get people questioning. Why should I not do this? Back in the day, a woman was expected to be home before sunset” (Male FGD 35–50, Tsandi).

Many women were trapped in an ongoing cycle of sexual-partner turnover, a product of difficulties related to developing and sustaining long-term relationships. For example, while having a child was seen as a way to secure a longer-term relationship, being abandoned with a child was said to be a common occurrence.

“Some will just sleep with you, and you will fall pregnant and they will leave,” said one woman (Female FGD 25–34, Keetmanshoop). Another said, “We are very weak, and then at the end of the day you get children and children, and the guys leave us just like that” (Female FGD 20–24, Walvis Bay).

For women who had children in their late teens and early twenties, being abandoned by the fathers of their children was said to be a common experience. Some women also had multiple children from different fathers, each of whom had left. Their prospective new partners were reportedly unlikely to be interested in long-term relationships and to raising children who were not their own. As one woman put it:

No boyfriend is going to raise your kid. He will just drop you like this if you speak about marriage. So you just bear with it if you want to keep him (Female FGD 20–24, Walvis Bay).

The ongoing search for a stable partner in such circumstances was said to be disempowering and self-defeating:

Most women of this age group have become mothers and therefore are looking for men who will support them together with their children. While looking for the best men, we get infected. So the search for a better life plays a role in the increase of HIV infection (Female FGD 25–34, Okakarara).

Being in a relationship that was outside of cohabitation or marriage was seen as a way for women to maintain considerable freedom. In such circumstances, women had the power to make their own decisions and could maintain a degree of independence, but this changed once a woman was in a committed long-term relationship or marriage:

In a casual relationship, the woman has a right. A boyfriend will say that he does not want you to do something, but you can make your own decision. But if you are married, you just have to accept it, whether you like it or not. You might cry, but he will say you have to cook and iron. But in a casual relationship, you are having freedom (Female FGD 25–34, Katima Mulilo).

While cohabiting meant a greater commitment than a casual or non-cohabiting relationship, cohabiting partners were not fully committed to each other. Each partner potentially had other sexual partners, and relationship boundaries were sometimes unclear.

Participants expressed considerable cynicism about marriage, seeing it as an ambiguous construct that was seldom intact or stable. Marital infidelity by either partner was seen as inevitable at some point, a product of the sexual freedoms that preceded the marriage. It was said to be difficult to trust marital partners, since they “know how to do sex” and might seek satisfaction elsewhere.

Where infidelity was suspected or known, a predominant view was that married women could not question their husbands’ fidelity and or suggest condom use. HIV infection was thus seen as inevitable for women:

[The wife] cannot run away because she is under the authority of the man she is married to. If he comes back to you [after other relationships], he won’t initiate to use a condom. He will act as [if] nothing is happening (Female FGD 25–34, Okakarara).

It was also acknowledged that married women who became disillusioned by the inequality in their relationships might seek out other partners. While married women were seen to be less desirable as partners for single men, married men were said to be desirable partners for single women. By comparison to unmarried men, married men were said to be more likely to be caring as well as more capable of providing material support.

Finding a long-term partner was said to be fraught with difficulty, a product of lack of trust:

You don’t trust any man anymore... When you [find a man you like,] maybe you’ll say, “Ah, I got Mr. Right.” But he’s not the one... Will I just stay with this man because I’m tired of changing men? (Female FGD 25–34, Katima Mulilo).

Men were equally cynical about women who had had many partners and found it difficult to commit to longer-term relationships:

I will play along. But at the end of the day, I will not take her, because she has been around and now she brings all that baggage to me. It does not work like that (Male FGD 25–34, Keetmanshoop).

5.2 Unemployment and employment

Sex was viewed as the most immediate “shortcut” to obtaining money and other resources for unemployed women. Relationships of this kind were not based on strong emotional bonding and love:

There is no love. It’s only the money. People will not see who they love; they just go for money (Female FGD 25–325–34, Engela).

The risk of acquiring HIV was acknowledged when economic “needs” and “wants” were allowed to dominate sexual-relationship choices. Where these needs involved survival, risky sex was seen as inevitable. One older woman reflected:

We need money for survival. We need money to buy the daily needs. These are things that we cannot go without, like food and soap. And then when we depend on men to provide this money, we are at risk of HIV. Even if these women do not want to get involved in sexual relationships, they are forced to do so (IDI, older female family member, Engela).

Some participants highlighted the simplicity and practicality of transactional sex:

There is this guy. I will SMS him and tell him that I am alone at home and he can come in his lunch time. Sex does not take hours. It takes only a couple of seconds. And then you do it, and when he goes he gives you money. That is how it goes (Female FGD 25–34, Walvis Bay).

Engaging in sex work was seen by some women as a viable way of securing ongoing income, and, as one observed, once one had traded sex for money, it was difficult to stop:

I decided that I should go and also go do it. I did it... But I saw that if you do this, you do not stop. When you need something, you get a guy. I tried to stop, but then I went back to it. So when you are unemployed, you think this is an option (Female FGD Walvis Bay, 25–34).

Menial work, such as picking up garbage or hawking food, were said to be demeaning and were disregarded as employment options. Choosing transactional sex was deemed to be better than being “laughed at” by one’s peers.

Being employed did not necessarily remove risk. Women engaged in low-paid work in a shop or a bar could potentially engage in transactional sex to meet their additional economic needs. When they worked as bartenders, waitresses, shop assistants, and cashiers, they could meet men who offered money for sex. Women working in hotels could be tempted to earn extra income through sex work because they met relatively wealthy businessmen or male tourists who were on their own. Women who worked as security guards in isolated places and in other unsafe situations were said to be highly vulnerable to HIV.

Female job-seekers also experienced HIV risk, since male managers or employers were said to request sex in exchange for employment:

Wherever you’re going, even the supervisor or the managers are telling you, “No, there is no possibility for you to work here. But there is only one way, one condition; it’s just five minutes” (Female FGD 25–34, Walvis Bay).

Once employed, women might be required to provide sexual favors to keep their jobs or secure promotions.

Women with well-paid jobs were not invulnerable, as men were said to seek them out to cheat them out of their money. A male participant stated, “An employed lady is eyed by everyone; all the guys would go for her” (Male FGD 25–34, Keetmanshoop). While employed women were acknowledged to be educated and less likely to be naïve about such proposals, a number of narratives referred to women who were “sugar mommies” to younger, unemployed men.

Mobile forms of work increased vulnerability to HIV. Men in the uniformed forces and those engaged in fishing, truck and taxi driving, construction, and mining had increased vulnerability to HIV, and poorer women could find opportunities for sex work in locations where mobile work prevailed.

Wives or partners of mobile men were subject to HIV risk when their partners were away and they had relationships with other men and when their potentially infected partners returned home. Women engaged in mobile forms of work were also noted to be more vulnerable—for example, nurses transferred to other towns and woman traders who moved from town to town.

5.3 Multiple and concurrent partnerships

The role of multiple and concurrent partnerships in driving HIV in Namibia was well understood in the study communities. Underlying factors perceived to contribute to this practice included that men had high sex drives and were unable to restrain their sexual desires and that women dressed provocatively and actively sought out sex. Reportedly, neither men nor women restrained themselves when it came to sex:

We are having the same sexual behavior. What should be done is everyone to control his or her feelings (Female FGD 25–34, Engela).

Both men and women were said to enhance their social status through sex. For women, social status was expressed through symbols of economic independence—such as clothing, money, and cellphones—whereas men achieved higher status when they had many sexual partners. Men who had “only one lady” ran the risk of being seen by their peers as “the joke of the group.”

An absence of love in relationships and desire for money were acknowledged as contributing factors for women who had multiple and concurrent partners:

If we love each other we will not cheat on one another. But nowadays we do not love each other. It is all about what is in the pocket (Female FGD 25–34, Keetmanshoop).

Condom use was more likely in casual and new sexual relationships, but could soon fall away when partners trusted each other. With a trusted partner, use of condoms was seen as more inconvenient, and the potential for HIV infection became less of a priority.

In relationships with a transactional component, condom use tended not to be a priority:

You actually just care about the money. We want money, and then we do not use condoms (Female FGD 20–24, Okakarara).

Being unmarried and in a relationship was seen as having much less accountability. People in such relationships could “jump from one relationship to another without being answerable to anyone” (Female FGD 25–34, Okakarara). Men and women acknowledged that people who knew their partners had other partners could rationalize having their own. When there was no formal, committed relationship, having other partners could not be construed as “cheating.”

How long a relationship lasted and reluctance to marry could cause dilemmas that contributed to ongoing and inevitable HIV risks:

Those who are in casual relationships, you do not know how long you will be together. If you keep a lady too long, she will expect marriage. If you do not get married, she will go to the next guy. And the more men you are with, the higher your chances of getting infected (Male FGD 35–50, Engela).

While marriage was noted to involve greater levels of commitment from partners, there was still a risk of exposure to HIV through extramarital relationships. Married men were said to be free to engage in sexual relationships at work and in other social settings—particularly alcohol venues—or in the context of migrant or mobile work.

5.4 Alcohol consumption

In study communities, alcohol consumption was consistently mentioned as a critical risk factor underpinning the ongoing pattern of new HIV infections. Alcohol consumption as a social activity was linked to being unemployed and not having alternative outlets:

People simply have got nothing to do. Like from the age of 25 to 35, they are failures. They are unemployed. The only thing to do is to go drinking and to go running around the streets doing all such things... All they can think of is just drink (Female FGD 25–34, Katima Mulilo).

Alcohol consumption was directly linked to HIV vulnerability and risk for women. Participants said that women became drunk more easily than men and were then more susceptible to agreeing to have sex:

If she is drunk she will have sex with someone she does not know well... When she is sober, she will never just meet someone at the club and have sex with him (Male FGD 25–34, Keetmanshoop).

A “home run” was the expression used when a woman consumed six beers, as this made it very likely that she would accede to sex.

For men as well as women, drinking was said to reduce shyness about making sexual proposals. Being drunk was often used as an excuse for HIV-risk behavior, such as having casual sex or having sex without a condom. Some participants referred to waking up and regretting having had unprotected sex: “The condom is not always used; I once fell victim of having sex while I had a condom in my hand (Male FGD 25–34, Okakarara).

Women reportedly drank alcohol to gain confidence, satisfy peer pressure, and be seen as sociable and attractive to men:

They say, if you do not drink, you are not a person. So you decide to also drink. You drink so that you can also go into a vibe. Then you can get guys (Female FGD 25–34, Walvis Bay).

Alcohol venues provided women with access to unmarried as well as married men who could be exploited for monetary gain:

We are the ones who, when we see men who are married, we go with them. Just because of money... We are just drinking alcohol and we don't even care whether the virus will infect us or not, as long as we are going to look for money... We like cheating and we are not protecting ourselves (Female FGD 25–34, Engela).

Women reported that drinks were sometimes spiked with “tablets” that caused the drinker not to remember what had happened.

Relationship violence was largely spoken about in conjunction with the influence of alcohol. Misspending household budgets on alcohol also reportedly contributed to arguments and domestic violence. Women were vulnerable to rape and violence when they did not provide sex after asking men to buy them drinks or having drinks purchased for them. In these situations, consent to sex was often inferred: a man buying drinks would expect to “get something” or “get back what he paid for.” “Give alcohol, get sex” was said to be a common expression. Women who failed to follow through could be seen as “playing a man for a fool” and could be at risk of physical violence and rape.

These risks were well known to women:

[We] go to the bar without money. We sit on the counter and look who walks in. And then someone will say they will buy you beer. And then you thank them. And they keep on buying you beer. And then they take you. And they give you the disease. Because he bought her beer, and then she has to pay him with sex (Female FGD 25–34, Katima Mulilo).

A male participant noted that alcohol not only diminished one’s own sense of vulnerability to HIV, but also reduced one’s sense of personal responsibility to avoid infecting others:

I don't even know whether she's also infected or not. Okay, maybe she's not infected. I buy her drinks, everything. She gets drunk, I take her; I'm going to have sex with her, even without a concern that I infect the lady (Male FGD 25–34, Walvis Bay).

5.5 HIV testing and living with HIV

The general view was that men were disinclined to get tested for HIV; a man who knew his partner had tested negative assumed he was negative too. Fatalistic beliefs were also

expressed about knowing one's status. As a male participant put it: "I will never go for HIV test because I believe that once you know your status, you are drawing death nearer" (Male FGD 25–34, Walvis Bay). A female participant said much the same thing:

They say that you should not wake a sleeping dog. This means that they are currently happy with their lives and they believe that they are healthy. Once they get tested, they might get to know that they are not as healthy as they thought and that would worry them. So they do not want to get tested (Female FGD 25–34, Okakarara).

Among both genders, another prominent disincentive to HIV testing was lack of confidentiality among clinic nurses, who were said to warn others that a particular person was HIV positive:

That is why people are scared to go there, because these things have happened. I know of people who have gone there to get tested. And their results came out (Male FGD 25–34, Keetmanshoop).

Such concerns led people to avoid getting tested and choose to "sit back with the disease."

The importance of disclosure and preventing onward HIV transmission was highlighted by participants. Some statements align with the concept of positive health, dignity, and prevention (UNAIDS 2011b):

Teach positive people to take care of others who are not infected. Speak the truth. If a woman or if a man comes to you saying "I love you, I want you to be my [sexual partner]," if you know that you are HIV positive, to save the life of this man [or woman], you tell them about yourself, about your status. If you are HIV positive, tell them to make it as their choice (Female FGD 25–34, Walvis Bay).

While it was noted that it was a good strategy to go for HIV testing at the outset of a relationship, it was far less likely that couple testing could be considered once the relationship had been sustained for a few years. Instead, women tended to go for HIV testing on their own:

When you want to have sex with someone for the first time, you must tell that person that you cannot have sex with them if you do not both go for a test. But after staying with a person for two or three years, it will be difficult to convince him. If you tell him then that you are HIV positive, he will tell you that it is not him (Female FGD 25–34, Katima Mulilo).

The availability of antiretroviral drugs was seen as having changed HIV prevention. Fear of the disease had been "watered down" because it was no longer "a death sentence." This affected perceptions of HIV risk and vulnerability:

The knowledge is there, but the problem is just that we have diluted HIV. We have made it look as if it is okay. You know someone with HIV. It's okay. Even if people know that they are putting themselves at risk, it is okay" (Female FGD 25–34, Engela).

Several participants said that people who knew they were HIV positive became careless and were not concerned about infecting others. Some infected people who did not want to "die alone" were said to contribute to the spread of HIV:

When a person finds out that she is infected, she becomes careless. Saying that she also doesn't know where she got it from, she goes into sexual relationships with whoever comes. She doesn't care to use a condom. That is why they are spreading a lot" (Male FGD 35–50, Engela).

5.6 Perceptions of HIV prevention communication

There was an overall perception that HIV-prevention communication campaigns had reached communities widely, through multiple media and in relevant languages. The broad consensus was that messages were clear and addressed key elements of the disease.

Study participants referenced national campaigns, such as “My future is my choice” and “Break the chain,” along with HIV testing through “New Start” and life skills programs in schools. Sources of information mentioned included Catholic AIDS Action, NawaLife Trust, Total Control of the Epidemic, The Red Cross, Project Hope, UNICEF, Lironga eparu, and local health workers. Information on HIV was observed to be “all over” and available “wherever you go.” It was noted, however, that there was a lack of internalization of vulnerability and risk to HIV, which was described as “ignorance”:

Everybody knows. Even people on the farm... It is the most common topic on the radio. If they say they do not know, they are lying. I must compliment the government. They have done their job well. Even kids know. Even old people know... So we know what we are doing. But it is ignorance (Male FGD 25–34, Keetmanshoop).

Fatalism about HIV infection was noted as a problem among some people, and referred to as “a mentality that is misleading.” Denial was also mentioned in relation to ignorance: “The ignorant are likened to a herd of cattle drinking in a poisoned well. It is as if they are trying their luck” (Male FGD 35–50, Okakarara).

The disease was also said to inadequately contextualized in relation to underlying factors:

We are looking at HIV/AIDS on its own. We are not looking at HIV/AIDS with everything that’s contributing to it. We are not targeting the things that contribute to it. If we can have a system that is going to target poverty, then that message becomes relevant... But somehow it is missing the point (Female FGD 25–34, Engela).

At community levels, non-governmental organizations and some local religious and community leaders were seen as providing overall leadership for the response to the disease:

For example, the Catholic AIDS Action—they are one of the biggest movements in our community when it comes to HIV and AIDS [and] prevention and treatment thereof. Our local pastors and reverends are always on the frontline with this. Like with media campaigns, or with youth activism—they are there, and our local authority councilors as well (Male FGD 25–34, Keetmanshoop).

It was also said, however, that some organizations conducting community-level activities did not always adequately train staff.

Although local leadership was involved in the response in some instances, it was generally felt that traditional leaders—local headmen, local councilors, and other leaders—had not been adequately engaged in the response to HIV and AIDS. They needed to “know where to get AIDS information,” as they had an important role to play in motivating people:

We have not taken in our traditional leaders. We have not taken in our headmen. We have not trained them about HIV. And we did not train them how to speak to people and the information they should give the people. So they have been left out, but they are a very important component in fighting HIV/AIDS (Female FGD 25–34, Engela).

It was also observed that such leaders would be better placed to nuance HIV-prevention information in ways that were more relevant to local contexts, since they were likely to understand the perspectives and concerns of residents in the communities they served.

Contradictions were observed in the personal behaviors of some individuals involved in promoting HIV prevention in communities and others seen as leadership figures, and this led to cynicism. Some health workers, teachers, and pastors, among others, were said to be not setting a good example:

The people are there, but they don't do what is expected of them. You know, a teacher... You are not just a teacher in a classroom. You are a teacher, whether you are at a bar, then you are a teacher and you are seen walking out of the bar with a girl, what does that teach? You are a nurse, but then I see you pregnant out of wedding. The people are there, but then they don't practice what they preach (Male FGD 35–50, Tsandi).

This also applied to community leaders in some communities: “Most of the leaders are the role models of our community. They are the ones that are actually spreading the disease.” (Female FGD 25–34, Walvis Bay). Some participants also said that the government did not take any action against teachers, policemen, and others who used positions of power to secure sex from girls and women.

5.7 Engaging with HIV prevention at individual levels

Both male and female participants shared personal strategies that could be applied for addressing HIV prevention in relationships. This included acknowledging and internalizing HIV risk, and then being motivated, through self-respect and caring for oneself, to adopt sexually responsible behaviors.

Numerous individual strategies were recommended:

- Set goals for one's relationship:
If a woman has a set of goals, even if she is unemployed, her chances of being infected are less (Male FGD 25–34, Keetmanshoop).
- Focus on one's moral principles:
It also depends on the type of person you are. It has to do with morals and values. Someone can come from a poor family, but they can do other things to get money. They can make and sell things (Female FGD 25–34, Walvis Bay).
- Value oneself:
If I value myself, then I will say no if I do not want to do anything (Female FGD 25–34, Engela).
- Pray and have faith in God:
I only pray, and God provides. If you believe, all will be okay (Female FGD 25–34, Keetmanshoop).
- Focus on the investment in one's education and making educated decisions:
They can advise their children on how to stick to education, to think about their lives, and how to protect themselves by having protected sex (Female FGD 20–24, Okakarara).
- Focus on financial independence:
So if I am [financially] independent, if I rely on myself, I have a voice, you know. I can say no, I don't need you; you can get out because I don't need you (Female FGD 25–34, Engela).
- Avoid wearing provocative clothing:
You must just look after yourself. Look at what you dress like when you go out. You must know what you dress like. You must protect yourself. You must not become a prey to the man (Female FGD 25–34, Keetmanshoop).

- Avoid going to shebeens and bars where there is high risk of casual and unprotected sex: *We should not hang out at shebeens and socialize with men who buy us alcohol. Try to avoid these things. In this way you will save yourself. And you avoid the dangers* (Female FGD 25–34, Keetmanshoop).
- Find a partner with similar interests and values and who is reliable: *You have to communicate and build a relationship...to see whether your interests are the same* (Male FGD 25–34, Keetmanshoop).
I choose a partner; I will have my conditions. And it will be. My partner must be somebody that I can rely on (Male FGD 35–50, Walvis Bay).
- Focus on the need to provide long-term care for children; avoid risky men and needing a man to help support one’s children: *A woman will think of her children. I have to live for my children. If I know that my husband goes out, I should either not sleep with him or I should have safe sex. We should use condoms. Because I think of my children and I am thinking of my future.* (Female FGD 25–34, Keetmanshoop).
- Avoid peers and friends who encourage risky sexual relationships or risky social activities such as alcohol consumption: *They should advise each other... Just to let you know, to let everyone know what’s the danger and what’s the problem* (Female FGD 25–34, Walvis Bay).

Participants recommended the following strategies for couples in sexual relationships:

- Go regularly for couple testing for HIV: *We should go for testing every three months, that’s the only way. If one partner now disagrees on that, maybe we can see that she or he is not committed* (Female FGD 25–34, Walvis Bay).
- Foster openness and honesty in the relationship and discuss and solve problems: *One of the pillars of a long relationship is...trust, then the openness and honesty. I believe that those are some of the factors that can contribute in lasting relationship* (Male FGD 25–34, Walvis Bay).
- Respect each other and avoid silence about important relationship issues, including HIV: *Someone who accepts me for who I am, who respects me, and who has the courage to speak to me openly; we should communicate* (Female FGD 25–34, Keetmanshoop).
Communication is key. We should reassure each other that I am yours and you are mine and we are building this life (Male FGD 25–34, Keetmanshoop).
- Get out of relationships that are unfulfilling, violent, or risky in relation to HIV infection: *Empower the woman to know that if I get out of this relationship, it is better for me to be alone. Or I can find someone else who is going to treasure me more than that* (Female FGD 25–34, Engela).

Strategies for healthy, long-term relationships thus included communicating with one’s partner to ensure mutual trust; sharing values including religious beliefs; supporting, respecting, and caring about each other; facing adversity together; letting the relationship grow; being happy with what you have; and listening to each other. If partners could not adequately address problems, it was felt that counseling should be sought. Children were acknowledged as the “glue” that held marital relationships together, and a stable family life was in best interest of the children.

To avoid HIV risk within marriage, participants said it was necessary to be disciplined, choose stability, build trust, be loyal, be respectful, be in agreement, and avoid infidelity, particularly if there was a history of MCP. People in the community who saw married people as accountable to their spouses frowned upon and discouraged infidelity, but did not apply this kind of accountability to non-marital relationships.

5.8 Engaging with HIV prevention at community levels

The narratives reflect perceived gaps in the response to HIV and a range of concepts related to reinforcing understanding of HIV and HIV-related risk in relationship contexts. Concepts that enhanced personal motivation and ability to act were highlighted, along with group engagement and direct involvement of community members. It was noted, for example, that women were well able to mobilize and motivate other women to address issues that directly affected them, and many women were already doing so:

There are women like this and... they can have even more measures to put in place [on] how to prevent the spreading of HIV and AIDS (IDI traditional leader, Engela).

Men noted that men's groups could be formed to address HIV prevention, and men were keen to participate:

But men are not involved. It is only the women who go to these groups. But as a group, we should start campaigning, and then we attract more men. And then we can even go to other areas (Male FGD 35–50, Engela).

A community leader observed that male groups of this kind could productively engage with women's groups toward solutions:

When there is a group, a men's group, then we can sit and talk man-to-man and say, "Guys, these are the things which you must do and not do." The pros and cons. And the women also; they can feel free to ask questions and they can give information to one another. So, they can help each other (IDI community leader, Keetmanshoop).

The involvement of elders and parents in open dialogues was also encouraged. Existing committees (such as development committees) could also be mobilized:

We also have the development committee in the communities. They should get involved with this so that they can teach people in the community (Female FGD 25–34, Katima Mulilo).

Some participants referred to having already formed groups— for example, as part of church activities—that were working hard to address HIV prevention. As one participant observed, it was necessary to engage people directly in response rather than offering information through top-down processes:

At the end of the day, if you want to help people, you have to talk to people who are affected. Rather than sitting in the offices and boardrooms, they should focus on the grassroots. Then you will know what the perfect solution would be (Male FGD 25–34, Keetmanshoop).

Strengthening networks of people was seen as important, and provision of visible support materials like T-shirts would promote group identity and help identify community members as part of a group involved in the response to HIV and AIDS.

6. Conclusions

A key research objective of this study is to understand HIV vulnerability and risk that sustains high HIV prevalence among adult women. The issue is considered from the perspectives of adult women as well as of adult men, community stakeholders, elders, and leaders in rural, urban, and informal urban settings that experience high HIV prevalence, and in contexts representative of many communities in Namibia.

Findings emerging on a range of issues exhibited marked similarities between communities. There were similar understandings of HIV vulnerability and risk, including the variety of factors that increased HIV prevalence among adult women. Narratives also exhibited similar points of view in relation to identifying gaps and opportunities for intensifying HIV prevention to address high HIV prevalence among adult women.

Broadly speaking, the findings show that the factors underpinning HIV vulnerability are closely related to economic inequality, with contextual factors such as availability of alcohol at social venues exacerbating risk. Gendered power dimensions also had bearing on HIV vulnerability and risk, but could not easily be disentangled from other factors. Though gender inequality has been reduced and socio-cultural values considerably transformed relating to more equitable marital relationships and women's education and employment, women's vulnerabilities related to HIV have not been reduced or removed as a consequence.

The data were considered through the lens of C-Change's socio-ecological model, which recognizes the interconnections between the self, partners, peers, and family members; the community context—resources, services, and leadership structures—and the broader environmental context that includes overarching economic, political, and cultural systems.

The emerging interpretive frameworks allowed findings to be organized in a way that informs strategic direction, including approaches to SBCC. At the most general level, the HIV vulnerability and risks that adult women experience are related to a combination of individual, socio-cultural, economic, and environmental factors. Such vulnerability relates to risk-behaviors of women as well as risk-behaviors of men with whom they have sexual relationships. Even when women enter more stable relationships such as long-term sexual partnerships or marriage, they remain vulnerable to HIV infection through the sexual behaviors and practices of their male partners. As a consequence, a continuum of vulnerability and risk to HIV infection sustains high HIV prevalence among adult women.

Many of the specific factors identified as contributing to HIV vulnerability and risk among adult women have been examined in the literature (Parker 2010). However, this study has further informed understanding the nuances of HIV vulnerability and risk and explored points of resistance with the potential to reduce vulnerability and risk. The findings help to shape understanding of strategic approaches to address new infections among adult women, including through SBCC.

HIV and AIDS communication has clearly reached widely into the study communities. Participants' narratives clearly illustrate that the knowledge they have acquired about HIV has been applied to their contexts, to the extent that they are well able to understand HIV vulnerabilities and risks among adult women.

Participants also critically engaged with the ways that HIV prevention communication is delivered. They highlighted concerns about the sexualized nature of some HIV-prevention communication, intrusive door-to-door campaigns, and behaviors of some HIV educators seen to contradict HIV-prevention messages conveyed.

Another concern expressed was the orientation of resources and support to only certain categories of group engagement—for example, resources that were available for support groups for people living with HIV, but not for support groups of community members concerned about HIV prevention. This highlighted the fact that there has been little emphasis on moving beyond individual-focused efforts in knowledge delivery toward engaging groups of people in communities in analysis and problem-solving to reduce HIV vulnerability and promote prevention.

Participants were confident that by working together they could formulate locally appropriate strategies and solutions, and they said that emergent groups—mainly of women—were already doing so. Also woven through the narratives are the voices of men concerned about HIV prevention and the impact of the virus on the women in their lives and the community in general. It is clear that these men feel alienated from the prevention response, and they offered insights into potential benefits of engaging groups of men to address it. Similarly, in some instances, traditional and community leaders have not been extensively engaged in the prevention response, and there has not been sufficient emphasis on fostering social mobilization to address the disease.

In considering strategic SBCC approaches, various elements are aligned with cross-cutting change elements in C-Change’s socio-ecological model at the levels of information, motivation, ability to act, and norms (Figure 1). The narratives provide insight into individual and socio-cultural strategies that can be communicated through SBCC approaches to address HIV vulnerability and risk. These approaches, detailed in Table 4, are summarized here:

- **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 making 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 on HIV prevention through group interactions at community levels, fostering 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 to reduce HIV vulnerability and risk among adult women.
 - 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 them.
 - 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.

- 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.

As noted, these elements are mutually reinforcing: they interact with each other and occur in parallel, rather than in sequence. The change processes envisaged involves addressing socio-ecological aspects of HIV response and strengthening the potential to address contextual factors that perpetuate HIV vulnerability and risk among adult women (Figure 4).

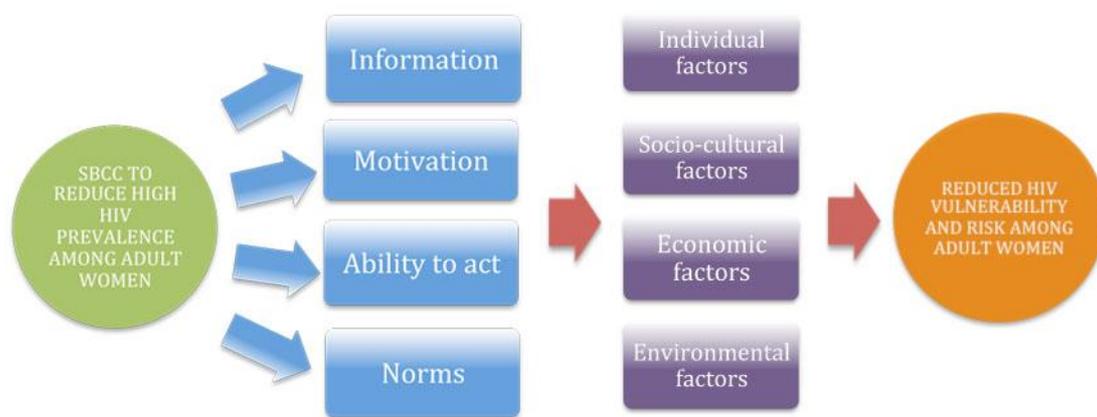


Figure 4. A socio-ecological approach to addressing HIV prevention through SBCC

7. Implications for Policy and Programs

Over the past decade, there has been a strong reliance on vertically driven, national-level HIV prevention programs. These have been nuanced according to epidemiological data and thematic orientations—for example, focusing on MCP or HIV testing or, more recently, on biomedical approaches such as male circumcision and treatment as prevention (UNAIDS 2011a).

Complementary communication support has typically been provided at community levels, through methodologies that largely deliver information passively to enhance knowledge about HIV. While generally considered useful for knowledge change, study participants viewed such approaches as problematic for bringing about sustained behavior change, since community members are not engaged in critical reflection and problem-solving for HIV prevention.

While the broad data illustrate the apparently intractable nature of the economic and socio-cultural circumstances that perpetuate HIV vulnerability and risk, many individual strategies and ideas were put forward that address HIV prevention and group engagement. The need to foster leadership among ordinary community members was recognized, along with the need to engage with already established leadership systems and structures. Importantly, study participants did not call for marked changes in the structural conditions of their lives

or improvements or expansion of existing HIV prevention services. Instead, they called for meaningful involvement in addressing the epidemic and support to a response appropriately nuanced to the contexts of their lives.

The concern of study participants is to develop and expand horizontal systems of response that incorporate contextually relevant solutions and are led on the ground, instead of HIV prevention programming delivered vertically and from the top down. It is clear that it would be beneficial for community members to work together to address HIV prevention through group dialogue and group engagement, and participants were keen to lead such processes. By jointly seeking solutions and advising each other to change the prevailing patterns of risky sexual behavior, men and women could craft new processes for HIV risk reduction.

Community-level stakeholders, such as religious, traditional, or community leaders, are noted to have a role to play in framing, stimulating, and supporting community-level discussion and problem solving.

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

- collaborative ownership and leadership by implementing agencies, community leaders, and community members
- integration of local knowledge, including 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

In sum, these principles highlight the importance of the “social” in SBCC, and they can readily be brought about through existing approaches and models that cultivate participatory engagement and critical thinking. Such models already exist – for example, various approaches to community dialogues or sequential workshops such as the Stepping Stones model (FHI 2010; ACORD 2007).

Approaches such as Stepping Stones and Community Conversations have moved away from passive message-transfer, toward group discussion and reflection that aim to achieve normative and individual changes in behavior (ACORD 2007; FHI 2010). Through C-Change, such emphases are also underway in Namibia, where USAID-funded partners now emphasize group discussion and reflection to achieve normative and individual changes in behavior (C-Change Namibia 2010). There is clearly potential to widen the scope of such activities (see Kippax 2012).

Emerging approaches that foster group responses to address violence against women in South Africa illustrate the potential of bringing about broader social mobilization to address HIV vulnerability and risk and a reframing of social norms to support HIV prevention (Parker et al. 2011).

Approaches to monitoring and evaluating SBCC configured toward this goal would have to define carefully what changes are expected and how these can be measured. Clearly, there is a need to shift the units of measurement and analysis from an individual orientation to one that incorporates the engagement of community members and leaders in HIV prevention and an understanding of adult women’s vulnerability in the context of relationships.

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