

HIV Prevention Among Adult Women in South Africa

*Opportunities for Social and Behavior
Change Communication*

June 2012



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By Warren Parker, PhD

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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.

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Executive Summary

In many parts of sub-Saharan Africa, adult women bear the burden of HIV. In South Africa, peak HIV prevalence occurs among women in the 25–34 age group. 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 study in South Africa is part of a larger C-Change study that includes two other focal countries—Ethiopia and Namibia. 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?

The study protocol was reviewed and approved by the ethical review boards used by C-Change in Washington, DC, and the Human Sciences Research Council in South Africa.

The study conducted focus group discussions with men and women ages 20–50 and in-depth interviews with community and traditional leaders, healthcare providers, and staff members of non-governmental organizations across four provinces, in five communities representative of rural, urban, and informal urban settlements.

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 draws on change elements expressed 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

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 as a characteristic of intimate relationships 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 delaying marriage to reduce dependence on men. While 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 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 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 (MCP), 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. Communication approaches such as Stepping Stones and Community Conversations in eastern and southern Africa 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.

1. Background

In many parts of sub-Saharan Africa, the AIDS epidemic is aggravated by social and economic inequalities between women and men. Overall HIV prevalence levels in southern Africa are higher among women than among men, and prevalence peaks among adult women who are in their late 20s and early 30s (Central Statistics Office Botswana 2009; de la Torre et al. 2009). In South Africa in 2010, antenatal HIV prevalence was 37.3 percent among women ages 25–29 and 42.6 percent among women ages 30–34 (National Department of Health 2010). High levels of HIV incidence among women ages 25–34 were confirmed in a study in rural KwaZulu-Natal (Bärnighausen et al. 2008), where the highest incidence—12.5 percent—occurred among women ages 25–29 and the second highest—10.4 percent—occurred among women aged 30–34 (Table 1).

Table 1. HIV incidence among women in Kwazulu-Natal

Women by age cohort	Mean crude HIV incidence rates [per 100 person-years 95% CI]	Mean MI-adjusted HIV incidence rates [per 100 person-years 95% CI]
15–19	3.9 (2.9–5.3)	4.7 (3.6–5.8)
20–24	5.6 (4.0–8.0)	8.8 (6.5–11.1)
25–29	8.0 (4.9–13.0)	12.5 (10.2–14.9)
30–34	3.3 (1.6–6.9)	10.4 (8.4–12.4)
35–39	3.2 (1.7–6.0)	9.2 (7.1–11.2)
40–44	2.0 (1.0–3.9)	7.5 (5.8–9.2)
45–49	1.8 (0.9–3.8)	6.7 (5.0–8.4)
Total	3.8 (3.2–4.6)	7.9 (7.4–8.4)

South Africa has a generalized, high-prevalence HIV epidemic that follows a hyper-endemic pattern similar to other countries in the region. The drivers of new HIV infections include multiple and concurrent partnerships (MCP), inconsistent condom use, and low rates of male circumcision (SADC 2006; de la Torre et al. 2009).

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

2. Purpose and Approach

This study is part of a larger C-Change study that includes two other focal countries—Ethiopia and Namibia. 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 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 HIV risk and vulnerability among adult women?
- 3) What are the opportunities for SBCC programs to address HIV prevention among adult women?

3. Methods

The study employed focus group discussions (FGDs) with men and women ages 20–50. In-depth interviews (IDIs) were conducted with a range of community leaders, traditional leaders, healthcare providers, staff members of non-governmental organizations (NGOs), and male and female elders. The study protocol was reviewed and approved by the ethical review boards used by C-Change in Washington, DC, and the Human Sciences Research Council in South Africa.

Initial fieldwork was conducted between December 2010 and February 2011. A total of 83 women and 47 men participated in 31 single-sex FGDs, while 19 women and 19 men participated in IDIs during the same period. A further round of 10 FGDs was conducted in March 2011 with a total of 74 men and women ages 25–34.

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

Fieldwork was conducted by the Centre for AIDS Development, Research and Evaluation (CADRE), a South African NGO. Study participants representing rural, urban, and urban informal settlements were selected from the following communities:

- **Khayelitsha:** A settlement in the Western Cape, near Cape Town, with modern and informal housing units. The population is poor, unemployment levels are high, and inhabitants are mainly Xhosa speaking. The area has one of the highest levels of HIV prevalence in the province.
- **Robertson:** A small town in the Western Cape that is economically dependent on wine production and fruit farming. It has a mix of racial groups and a fluctuating population of mobile work-seekers. Inhabitants mainly speak Afrikaans.
- **Nongoma:** A small town in KwaZulu-Natal surrounded by rural communities, in a province with the highest HIV prevalence in the country. Residents are poor, live in traditional housing, and are mainly Zulu speaking. The majority of residents are unemployed women, since many men are long-term migrants employed elsewhere.
- **Moretele:** A small town in the platinum-mining area of the North West Province. The district has a high HIV prevalence and high levels of unemployment and poverty. Health services are limited and not readily accessible.
- **Peddie:** A small, rural town in the Eastern Cape. The population is poor with high levels of unemployment. Inhabitants are Xhosa speaking, and HIV prevalence is high.

Data Collection and Analysis

Contacts established in each community at the study's outset enabled the recruitment of FGD and IDI participants who matched characteristics related to marital, relationship, and employment status and the age and stakeholder criteria.

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

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 applying a socio-ecological model and developing additional interpretive models.

The socio-ecological model adapted by C-Change (McKee et al. 2000) was used to interpret the data. It highlights overlapping contextual domains and 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

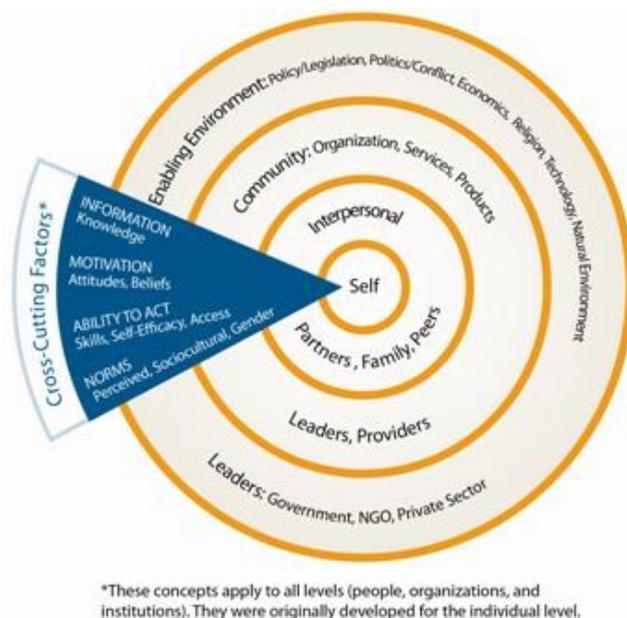


Figure 1. C-Change's socio-ecological model for change

cross-cutting elements relevant to SBCC that aims to reduce vulnerability.

For example, 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. In relation to social and behavioral change, the data illustrate how knowledge of adult women's HIV vulnerability and risk is a component related to the motivating factors for reducing HIV vulnerability and preventing HIV. In turn, 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 factors underpinning sustained high HIV prevalence among adult women (Figure 2). Based on the C-Change model's four domains, the model was applied to understand factors influencing sustained high HIV prevalence among adult women: individual factors, socio-cultural factors, economic factors, and environmental factors.

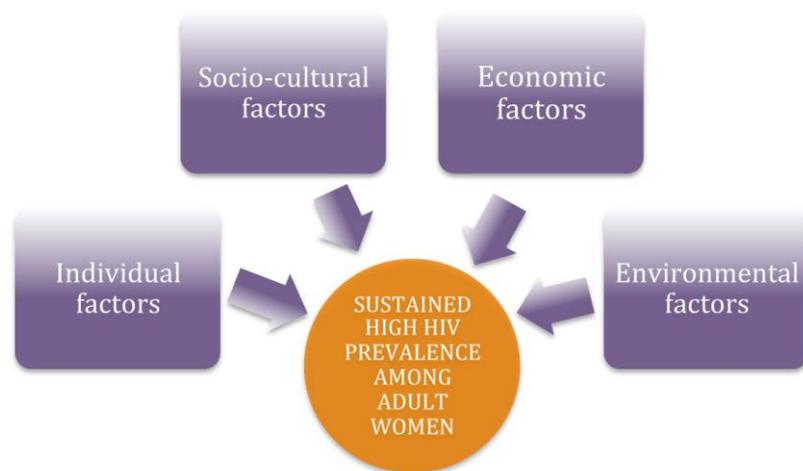


Figure 2. Factors underpinning sustained high HIV prevalence among adult women

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, sexual violence, and 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 2 presents a summary of findings in these four domains.

Table 2. 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 • Acceptance of criminal violence against women among a subset of men (e.g., spiking of drinks, rape) • 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"> • Exploitation of social grants • 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 draws 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.

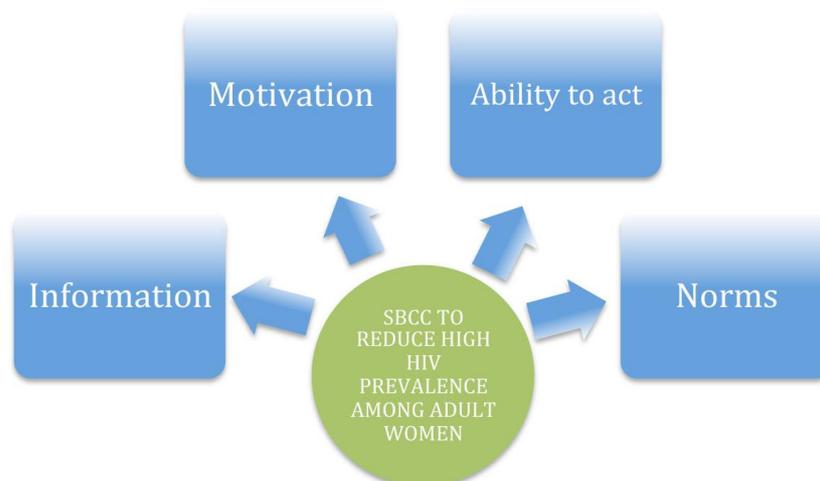


Figure 3. Factors relevant to the development of SBCC to support HIV prevention

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

Table 3. 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 a 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 levels in problem-solving for HIV prevention. • Men are not sufficiently engaged or involved in the HIV-prevention response.
	Unsupportive normative framework
	<ul style="list-style-type: none"> • Traditional, religious, and community leaders have not been adequately engaged in the HIV prevention response. • There has been a lack of 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 4 summarizes perspectives of community members related to 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 4. SBCC approaches to reduce HIV vulnerability and risk among adult women

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; go for couple testing). • Establish a long-term relationship with a partner who cares about you. 	<ul style="list-style-type: none"> • Discuss HIV risk with sexual partner and accountability for HIV risk (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 levels through group interactions. 	<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 and 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 community-level leadership for HIV prevention, including from sectoral/ traditional/community leaders. 	<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.

With regard to information, a range of strategies were relevant for internalizing and acting in relation to HIV vulnerability and risk. These included avoiding risky sexual partners; sticking to one’s principles (e.g., consistently using condoms, accessing couple testing for HIV); avoiding risky environments such as alcohol venues; discussing risk and accountability in

relation to HIV risk with one's sexual partner (e.g., committing to monogamy); and establishing a long-term relationship with a trusted and caring partner.

Processes of 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 South Africa were selected to assess geographic variations in HIV risk and vulnerability among adult women and the potential of differing responses to reduce risk and vulnerability. Some geographic variations were noted. For example, deference to traditional cultural values was more likely to be voiced in rural communities, while geographic mobility was highlighted in settings with industries. In general, however, participants shared a common understanding of factors underpinning HIV vulnerability and risk and perceptions of gaps and opportunities relating to HIV prevention.

Factors underpinning HIV vulnerability across communities were largely related to economic inequality and exposure to alcohol consumption, combined with contextual factors. At the broadest level, the study found that adult women face a continuum of HIV vulnerability, even if their direct risk behaviors change over time. For example, their HIV risk and vulnerability continue as a product of their partners' risk behaviors, even when women move to more stable, long-term partnerships and are faithful to their partners.

HIV vulnerability and risk among adult women were largely linked to economic inequalities that determined relative financial independence. Patterns of MCP addressed a combination of economic "wants" and "needs," underpinned by psychological and socio-cultural factors.

Underlying environmental factors also perpetuated HIV vulnerability and risk among adult women, including the widespread availability of alcohol. Circumstantial factors were relevant, such as the need to care for children abandoned by their fathers, along with contextual factors, such as acceptance of sexual-partner turnover and lack of accountability between sexual partners in relation to HIV infection. Socio-cultural factors were also influential, such as the lack of priority accorded to committed long-term sexual relationships and marriage.

5.1. Multiple and concurrent sexual partnerships

High turnover of sexual partners and MCP were seen as normative for men and women. Although such relationships were not always conducted openly, they were seldom viewed by peers as problematic or abnormal. This is a socio-cultural factor noted in Table 2, while having a concurrent partner who has other sexual partners is an example of individual factors that affect vulnerability and risk.

Participants noted that mobility facilitates MCP. A female participant observed when asked whether women have multiple partners:

Yes we do. Everyone is allowed to have multiple partners. For example, I have four boyfriends....They are not all in the same place. One is in Cape Town, another in Port Elizabeth, one here in Peddie, and one in Johannesburg. It also depends on who is available (Female FGD 20–24, Peddie).

The pervasiveness of MCP was further manifested by the ease with which contact telephone numbers were exchanged at parties or at alcohol venues. Mobile phone technology makes it easy for men and women to obtain telephone numbers of prospective sexual partners for later contact. One man stated:

I think they should learn to say no. When I meet a woman, when she agrees to give me her cell phone number, then it's done... The next time I can call her... and then I visit there, I can hug and kiss her and then we are in love (Male FGD 25–34, Nongoma).

Another said: “You give me your phone number and I know you are mine. You are gone. You are finished” (Male FGD 35–44, Robertson). The low-cost cellphone networking site MXit was said to help people find sexual partners. “It just gets easier and easier,” noted one youth leader (Youth leader, IDI, Robertson).

MCP and extramarital liaisons were noted to be common among married and unmarried individuals. Acceptance of these relationships is a socio-cultural factor that contributes to HIV vulnerability and risk.

Married men were able to justify having extramarital relationships:

The one who is the man is able to leave the house and maybe say that he is going to drink with his friends. He will then go and try to find himself a girlfriend on the side, you see, and when he finds a girlfriend she will ask him, “what about the wife that is at home?” And he will say, “a wife is not like a policeman’s hat...” He does not have to wear it all the time (Male FGD 25–34, Peddie).

Women reported that they were not bothered by their boyfriends having other partners, as long as the “other girlfriends” were kept secret from them. Maintaining such discretion was seen as a “sign of respect” for the main partner:

No, it's fine. Women, they tend to pretend, because seriously you can't be that understanding. They pretend to be understanding and say: “There is no man in this world who has one girlfriend, so if he cheats it's okay as long as he respects me, as long

as he does not tell me straight in my face.” ... So actually, they would say if he hides it from you... then you are so superior (Female FGD 25–34, Nongoma).

This statement reflects individual, psychological factors of cynicism, fatalism, and denial, while the linking of relationship secrecy to respect is a socio-cultural factor (Table 2).

Female participants acknowledged several reasons for tolerating an unfaithful boyfriend: the need to be patient in order to keep a man; the need to maintain material or financial benefits accruing from the relationship; the perception that it was inappropriate to question male behavior; and the view that unfaithfulness needed to be accepted as product of “what men are.”

Women also acknowledged that some men pursued short-term relationships with a view to moving on to other partners: *You were just something to him to relax his feet, before he moves on to the next person (Female FGD 25–34, Peddie).*

Women and men who had experienced a cheating partner tended to become cynical about relationships. Perceptions that the principles of monogamy had been eroded contributed to recklessness and ongoing patterns of exposure to HIV risk—an example of an individual, psychological factor that contributes to vulnerability (Table 2):

You are staying with your boyfriend, and both of you are fast with each other and are in love. And then you will be disappointed by your boyfriend. Maybe you go home sometimes and you think “I used to love this person.” And then also you will think, “Hey, I should just do the same as him.” That is why we are also at risk. We attend taverns, and we end up meeting people there and do not even know their HIV status. You end up not looking after yourself because you have been disappointed by the person that you love. So we also in this age group are also very likely to be HIV positive (Female FGD 25–34, Peddie).

Partner infidelity was also said to lead to a sense of mistrust and recklessness—psychosocial factors that may be carried into subsequent relationships with other partners and intrude into the potential of establishing loving and trusting relationships.

Yes, that is a problem, sometimes it gets difficult. Trust... If maybe from your previous relationship your girlfriend cheated on you, then it will not be easy for you to forget what had happened. So you will act in an awkward manner because you don’t trust [your new partner]. If she notices that you don’t trust her, she will be suspicious and nothing will be okay in your relationship because you don’t trust each other (Male FGD, 25–34 Khayelitsha).

This statement also reflects lack of accountability between sexual partners in relation to HIV risk, an individual factor, together with general a lack of accountability in relationships, a socio-cultural factor (Table 2).

Although having a relationship with a high-risk partner raised fears of HIV infection, these were not always acted upon:

At the back of your mind you always wish that the person you are having sex with is not positive. You yearn to say it out loud but get scared. You sit and don’t say anything because you don’t discuss anything about sex (Female FGD 25–34, Khayelitsha).

This tolerance of risk is a psychosocial factor (Table 2). Risk of HIV infection was acknowledged by most people, accompanied by a sense of fatalism. As one woman note:

We live in regret... That’s what we are doing. We are just living our lives regretting (Female FGD 20–24, Robertson).

Although open communication was seen as key to ensuring strong relationships, it was sometimes difficult to maintain balanced expectations or balanced sharing of power within relationships. Additionally, it was not easy to overcome mistrust between partners, particularly in relation to infidelity.

It does not work like that. Trust does not work. It's difficult to trust anyone. I don't trust my girlfriend. That is why I told her we should start using condoms again. Honesty is very important. That is why I told her. I must protect myself and I should also protect her as well. If we do our own things on the side, then we are both at risk (Male FGD 25–34, Robertson).

5.2. Condom use

In all study sites, participants affirmed the role of condoms in preventing HIV transmission and reported that condoms were widely available. Although male condoms were typically used at the outset of most new relationships, often within a relatively short period—ranging from a few days to a few months—their use ceased, when partners developed familiarity and trust.

While cessation of condom use was predominantly rationalized on the basis of partner trust, negative aspects of condoms were highlighted to reinforce the decision—for example, “this thing suffocates me” and “condoms cannot protect you 100 percent.” It was also said that condoms broke, smelled, caused a rash, or made sex less pleasurable. Men who wanted a child also refused to use condoms. Inconsistent or non-use of condoms and lack of responsibility for using them are individual factors that increase HIV vulnerability and risk (Table 2).

Economic dependence was an influential factor for women who engaged in unprotected sex. They rationalized non-use:

[You will not use a condom,] not because you don't want to, but because you just want to protect the relationship. You don't want him to leave you (Female FGD 25–34, Peddie).

Women said they wished or needed to maintain material benefits or money from relationships, and spoke of prioritizing non-barrier contraceptive use because they were more concerned about pregnancy. Those who trusted a new partner and transitioned to unprotected sex tended to disbelieve that their partners could be HIV positive, and some believed they themselves were HIV negative, even when neither had gone for an HIV test.

Denial was also a feature of failure to use a condom when the person's HIV status was stated to be positive. This was largely rationalized on the basis that individuals who do not look as if they are HIV positive, are not HIV positive. Alternately, there was the notion that people who state they are HIV-positive might be lying to avoid having sex:

You may find that I am an honest person, and then I tell my boyfriend the truth about my status. I tell him that I am positive. He then thinks that I am lying and he wants to have sex without a condom. So I think that is denial (Female FGD 25–34, Moretele).

Condom use was spoken of as something not done—and something that should not be done—with a “straight” or main partner or wife. Condoms were supposed to be used with casual partners “to protect the one I love.” Wanting to use a condom with a long-term partner was equated with being a “bad person” (Male FGD 25–34, Nongoma).

Asking a long-term partner to use a condom after discontinuing its use for some time was typically avoided because this raised suspicions. Suggesting condom use to a spouse would immediately suggest infidelity. Violence was also sometimes an outcome of such suspicion:

It happens when you have been sleeping with him without a condom, and all of a sudden you request him to use a condom, then he will beat you up and ask you why after such a long time. Then that is where the problem starts (Female FGD 20–24, Khayelitsha).

Failure to use a condom was seen as inevitable while under the influence of alcohol. In such instances, the need to use one was “forgotten,” even if the condom was “in one’s pocket” or otherwise close to hand. Non-use was also likely if the sexual encounter occurred very quickly—for example, in a tavern toilet or outside area where there was a risk of being discovered.

Lack of responsibility for condom use is an example of an individual factor (Table 2). Sexual cravings and perceived high libido among males seemed to overshadow the rationale for condom use. There was also an expectation that it was up to the woman to raise the topic.

Female condoms were mentioned regularly, and it appeared that these might be used if easily available. There was, however, a widespread misconception that female condoms had to be inserted several hours before sex: an eight-hour period was commonly mentioned. This requirement was seen as impractical and diminished the perceived usefulness of female condoms.¹

5.3. HIV status and testing

Acceptance of HIV testing—an example of an individual factor—was a more common practice among women. Men were said to be more reluctant to test, often relying on their female partners’ results to infer their own status: “As soon as you tell a man to go test with you, they will say, ‘As long as you are negative it means that I am also negative’” (Female FGD 25–34, Moretele). One woman said that men do not want to get tested “until they are sick” (Female FGD 25–34, Peddie).

It was felt that keeping one’s HIV-positive status a secret was a better option than disclosing, since this brought exposure to gossiping and it would be difficult to control who would learn about their status. This fear of stigma and discrimination that constrains disclosure of HIV-positive status is a socio-cultural factor that contributes to vulnerability (Table 2).

Disclosing a positive HIV status to a partner was difficult, and was usually accompanied by denial and blame. Family disclosure was said to be particularly difficult, given the uncertainty about how family members would respond. Negative responses included associating HIV infection with promiscuity and rejection, and with refusals to share utensils. Some traditional families also associated HIV infection with having been bewitched.

There were accounts of family members being accepting and supportive:

I have a friend who discovered that she was HIV positive. She was able to tell me about it because she trusted me, but she wasn’t ready to tell her parents. I pleaded with her to tell them and make them aware of the situation. She never wanted to do so until I told her parents, and they have been very supportive towards her (Female FGD 20–24, Khayelitsha).

¹ This myth is sufficiently widespread to suggest that the usage guideline is misunderstood or people promoting female condoms have been trained incorrectly. Female condoms can be inserted a few minutes prior to penetration and up to eight hours prior to sex.

A number of groups raised the possibility of malicious infection by HIV-positive individuals:

They think that they have to pass the disease on to other people so that they do not die alone (Female FGD 25–34, Peddie); *When you realize you are infected, you tell yourself you just going to spread it* (Male FGD 25–34, Robertson); *They want to destroy your future* (Female FGD 25–34, Khayelitsha).

These statements reflect a sense of fatalism and powerlessness, whereby HIV infection is inevitable because the virus is being actively spread.

5.4. Unemployment and poverty

Economic factors profoundly influence HIV vulnerability and risk. Risk flowed from having money and being employed, as much as it flowed from not having money and being unemployed. As participants explained, having money allowed women and men to have sexual relationships with multiple partners, while being poor led to women having multiple male partners.

Having money or being poor conferred different levels of power in a sexual relationship. Having money allowed for control over when, where, and how sex occurred, while the poor lacked such power. For men, having money meant “never having to sleep alone,” and was directly equated with having access to sex, fun, and happiness:

When I have money, all the girls will come... They know that fun is fun only with money. There is no other fun with something else. You can try to say or do this and that, but without money you will never be able to truly be happy. Yes, I have tried (Male FGD 25–34, Peddie).

Men without money felt distinctly disadvantaged. Besides the possibility of losing their girlfriends to richer men, they also faced the possibility of contracting HIV or another STI from girlfriends in relationships with richer men that made up for what poorer boyfriends could not offer. Being unemployed was seen as stressful, especially if one had skills and qualifications expected to lead to employment. Unemployed men noted that they secured sexual partners by “using tricks and lying” to create the impression that they had money.

For women, unemployment fostered “a way of life” that involved securing financial support through sex:

We are a group of young women... We can't always afford rent, transport, money. We are always looking for something for our children. So... there are boyfriends called “ministers” (Female FGD 25–34, Nongoma).

This statement reflects economic factors—dependence and/or having dependants— that contribute to transactional sex (Table 2). It also reflects the socio-cultural factor that sex is tolerated as a means of exchange.

Men with financial resources were described as “walking automatic-teller machines.” Even when women were aware that such relationships posed a risk for HIV infection, some women were fatalistic: “In most cases, you tend to ignore the [HIV] status of the man, as long you will get something to eat, and money” (Female FGD 25–34, Khayelitsha).

Economic vulnerability was seen to have eroded morality:

It's mostly about survival. So it's not a morality issue anymore at that level. Morality is a luxury in a poverty-stricken environment. Survival is the code (Male religious leader, IDI, Khayelitsha).

Poverty was seen as all-consuming:

That's the problem with poverty. Poverty consumes people's minds, and they can't think of anything else. It's the problem. It complicates the whole issue of AIDS and HIV. And that's why AIDS and HIV is having a field day in societies that are poor (Male religious leader, IDI, Khayelitsha).

Women's vulnerability to HIV was not necessarily removed or reduced by being employed. As one woman observed, satisfaction with one's financial situation was elusive:

In this thing that we call money, you are never satisfied... You even hear stories of people who do shameful things, and then you think that why did they have to do it because they have the money, and I see that maybe they also wanted more money. They do things that women who are not working are doing. You will see that they also want to increase the money that they already have in their purse (Female FGD 25–34, Peddie).

Women seeking jobs could be vulnerable to HIV because of the perception of some male employers that female job-seekers should provide sex to obtain work:

We once went to this shop and said that we are looking for jobs. [The owner] said that he will give the job to us if we are first able to do what he wants us to do and that he will pay R1,500 a month (Female FGD 25–34, Peddie).

Sometimes women agreed to such offers, only to find that they did not lead to employment:

He never even took her CV but he just slept with her. Even today she has not heard from him (Female FGD 25–34, Peddie).

While women might resist such pressures, those who had job applications rejected several times and were without work for long periods might finally agree to having sex to change their economic situations:

When you have stayed at home for a long time, the mind goes wild... and some will end up going to prostitution and others will...sleep with them... [You think], "They will employ me, and I will have money" (Female FGD 25–34, Peddie).

Seasonal work was said to heighten vulnerability to transactional sex. Income streams were interrupted in the off-season, and new relationships were a stopgap measure to gain access to money.

We work for three months during the working season at firms. The whole other nine months we just sit and stare at each other with nothing to do. So then you find guys who come from other places having money and driving nice cars, and then all the girls are impressed and chase after them because of their money (Male FGD 25–34, Robertson).

Migrant men were subject to women seeking sexual relationships to secure financial benefits. This reflects economic factors related to labor migration and mobility, as well as individual factors of recklessness and risky sexual behaviors (Table 2).

I worked with guys from other places and their phones rang constantly... You can go stay for six months in Newcastle... When you arrive there the girls are starving and need your money. They will throw themselves at you (Male FGD 25–34, Moretele).

One woman noted with respect to migrant workers:

Young women in our community stick on them like flies. You should see them when the truck with migrant contract workers comes to the village. That is where they [women] stay now. They are all getting men there (Female FGD 25–34, Moretele).

Migrant men also reportedly abandoned mothers of their children, increasing the financial burden on women and perpetuating the cycle of vulnerability to HIV.

By the end of the contract, they leave children and the disease here because [women] have relationships with men they don't know (Female FGD 25–34, Moretele).

5.5. Marriage

While being unmarried was noted to lead to a pattern of multiple and sometimes concurrent sexual partnerships, being married did not necessarily reduce vulnerability to HIV. There was a perception among women that marriage required them to be faithful, while husbands were likely to have other partners:

Marriage has too many risks because a married woman is told to stay at home while the man goes around cheating, and when he comes back to the wife he brings diseases (Female FGD 25–34, Moretele).

“Just because you are married, it doesn’t mean all the nonsense stops,” reported one woman (Female FGD 25–34, Moretele), while another stated that “most of the girls” were “dating married guys,... the most cheating ones” (Female FGD 25–34 Khayelitsha).

Fear of marital infidelity was also a concern among men:

For example, I am working and she is not. So when I go to work I leave her behind in the house because I know that she is my wife. Only to find out that she is seeing other people when I am at work (Male FGD 25–34, Khayelitsha).

Among some women, being unmarried was seen as potentially reducing vulnerability, since an unmarried woman could avoid having to agree to sex with a partner who had other sexual partners: “We are safe in that we can refuse unsafe sex” (Female FGD, Moretele).

Women who were unhappy when their husbands had extramarital affairs might seek other partners in retaliation or as revenge: “Women say that the only medicine for a cheating husband is another man” (Female FGD 25–34, Khayelitsha).

The general belief that infidelity was common in marriage underpinned the perception that unfaithfulness was inevitable—a socio-cultural factor. Women stated this was most hurtful when their partners did this openly. As noted above, keeping other sexual partners a secret was equated with being respectful, and was considered to be more important than infidelity:

He cheats and I cheat as well... The only problem is the unfaithfulness and the manner that he does it in. He is too public with his lovers. People will never be able to tell him about what I do because I don't go back to the same place more than twice (Female FGD 25–34, Moretele).

To justify engaging in extramarital affairs, some men said they sought other partners because of their declining desire to have sex with their wives. Alcohol had a strong influence on marital infidelity among married men, since they met sexually available women when they patronized alcohol venues. Housing arrangements such as tenants in the marital home also opened access to other partners.

5.6. Fertility and children

Women faced contradictory situations with respect to having children. On the one hand, they were expected to demonstrate fertility at a certain age or as a prelude to marriage. On the other, they were abandoned once they became pregnant, and the burden of child-raising fell to the woman and her parents.

As a male HIV activist in Khayelitsha stated: “The role of the father? The father is nowhere to be found.” A male FGD participant added:

You find that these young girls don't know the fathers or the fathers have left, so they need someone else to help support the baby. She then ends up having two or three men (Male FGD 25–50, Moretele).

Sometimes the father would return, albeit briefly, and would be welcomed on the basis that he might provide for the child. As a religious leader in Khayelitsha observed:

Women are tired of being played... But time and time [it is the] child's father who will do as he pleases and come back, and the fact is they need what he can provide.

One woman noted that the father of her child wanted to have another child, though he did not provide for one he had:

We have a child and he is not responsible at all, but at the same time he wants me to have another child (Female FGD 25–34, Nongoma).

Desire for a child is an individual factor, while tolerance for fragmented parental relationships and family breakdown are socio-cultural factors.

Women reported having relationships with multiple partners in order to secure financial support for their children:

You get in a relationship just because you want to feed your children. After having sex, you take what you want and go back to your house and cook for your children (Female FGD 25–34, Khayelitsha).

A number of women referred to social grants as being a motivating factor for having children, as these provided access to cash in a context of severe unemployment. Though the amount was admittedly small, the rewards were still preferable to having no money:

Unemployment is the main problem. It forces us to sleep without a condom so that we can fall pregnant and get social grants (Female FGD 25–34, Peddie).

One community health worker observed that boyfriends of women receiving grants waited outside the community hall on the days that grants were dispensed, expecting that the monies would immediately be shared with them.

5.7. Alcohol, vulnerability, and risk

Excessive alcohol consumption was reported to be common in all communities. It was perceived to be directly related to HIV risk because it fostered casual and unprotected sex. Drinking was widely tolerated and accepted. It was referred to as something one did for entertainment and fun, to relieve boredom and forget one's problems in a context that lacked alternative healthy social activities. Some participants referred to their communities as “Sodom” because they considered that alcohol abuse had caused community members to lose their values.

Spending time at clubs, bars, and shebeens was generally linked to heightened sexual desire, engagement in casual sex, and non-use of condoms: “We all know that a drunk person does not think clearly”, said one female participant, while another said, “when you are drunk you are more reckless” (Female FGD 25–34, Khayelitsha; female FGD 20–24, Peddie). A male participant observed:

You end up doing lots of things that you are going to regret. You forget to use a condom because when you are under the influence of alcohol; you are impatient and you want the girl now. You think you want to get the deed over and done with tonight so that you do not have to see this girl ever again. What draws us to these illnesses is the way we live our lives (Male FGD 25–50, Moretele).

Both genders were careless about condom use after drinking alcohol:

The problem is that both men and women drink. There is no control; no one showing the other one the right way. That is a problem (Male FGD 25–50, Moretele).

One woman observed: “You forget about choices. You end up having sex anyway, without condom” (Female FGD 20–24, Peddie). Some participants suggested that some men who were drunk had sex with women even when they knew the women were HIV positive.

These statements provide examples of individual factors that contribute to vulnerability—recklessness, hasty sexual encounters, and loss of control and inhibitions through alcohol consumption. The wide availability of alcohol provides an example of an environmental factor that is central to vulnerability and risk behavior.

A male participant referred to alcohol as something that “tamed” a woman and made her accessible for sex, including sex without a condom. While male sexual desire was seen as not easily controlled, especially under the influence of alcohol, it was also noted that women who drank alcohol got drunk easily and readily lost their inhibitions or became insensible when drunk:

I give her alcohol and I wait until she is drunk and then I can go sleep with her. She wakes up the following morning and doesn't have a clue as to what happened the previous night (Male FGD 25–34, Robertson).

For some women, drinking alcohol was a way of overcoming nervousness so that they could engage in conversation with a man, accepting that this would lead to sex: *Sometimes you also like this guy and you decide that you need something to help you get rid of the shyness. Then you drink and you are not shy anymore. That is when you will be able to approach then guy and talk about your feelings for him (Female FGD 20–24, Peddie).* Drinking to overcome shyness was also mentioned by men.

It was also noted in all study communities that women were expected to have sex with men who bought them drinks or provided transport to drinking establishments. This was clearly a common and severe risk for women who drank at public venues. Such obligations were seen as normative. One male participant said that a woman for whom he had bought drinks didn't have any choice, but another said, “She can escape when she sees that the drinks are getting finished” (Male FGD 25–34, Khayelitsha).

Men described women who did not pay for drinks as “drinking your money.” One said, “If you are going to buy her a beer, that beer must come back. With one beer you must gain” (Male FGD 35–44, Khayelitsha). This expectation was well understood by women, and statements reflect individual factors of bravado and recklessness that contributed to their vulnerability and risk:

What happens is that you go out looking your best, knowing that you are going to the shebeen. At that time you are aware of the fact that you do not have even a cent in your pocket and you decide that you will get a man to buy you drinks. When you get to the shebeen and you know the implications. You leave your home or your house knowing very well what is likely to happen (Female VCT counselor, IDI, Khayelitsha).

Failure to accede to the expectation to provide sex sometimes had dire consequences:

I had a friend who was in this situation. We were together and we had been drinking in the shebeen. She got herself a man that could buy her drinks. Later on in the evening he requested sex with her. She refused. The buyer and his friends dragged her to a nearby college and raped her and killed her (Female FGD 20–24, Khayelitsha).

Mention was also made of men who spiked drinks (including with eye drops or brake fluid) to make women oblivious:

And so now a person does not even know now where they are or where they slept, and so they will end up finding themselves wherever they are taken, and then they will find themselves there in the morning not even knowing what was happening or happened to them during the night (Female FGD 25–34, Peddie).

Women who were cautious about the risk of having their drinks spiked mentioned keeping a watchful eye over their drinking glasses: “Always your glass must be clean. If you go to the toilet, take your glass with you” (Female FGD 25–34, Robertson).

The surroundings of drinking establishments were considered extremely unsafe, with rapes occurring even in the toilets. There were accounts of women under the influence of alcohol who had sex with multiple men, and scenarios that suggested that group rape was common. Women were offered assistance to go home, then were taken to locations where they were raped by groups of men. In one community, this was referred to as “belt sex”:

Belt sex is for those girls that think they are clever. A girl will use me to buy her drinks and dodges me at a tavern, and the following day uses a different guy and then moves to the next. So when all of the guys she has used come together, they talk and they plan their revenge to get their share. They drug her and take her to an isolated place, and they all remove their belts and have sex with her (Male FGD 25–50, Moretele).

These statements suggest a range of socio-cultural factors affecting vulnerability: acceptance of criminality and silence about violence, rape, and gender violence.

5.8. Violence

Physical abuse did not appear to be a common feature of most relationships, though its occurrence was acknowledged. It was said to be restrained by fear of legal recourse, which made men more inclined toward emotional abuse: “I think that emotional abuse is the one that happens more than physical abuse because men are scared to go to jail” (Female FGD 25–34, Khayelitsha).

Where violence did occur, women who wanted to maintain their relationships were said to be acquiescent:

The men, if they are cheating, they become violent and aggressive, so that they will just leave the room... and then he will come back in the morning... You just thank God he is back (Female FGD 25–34, Robertson).

Some women kept violence they experienced secret because they feared derision: “She will be ridiculed, and then everyone will know her plight” (Female FGD, 20–24, Nongoma). Other women lived in hope that the situation would change:

She lives in the hope that he will change. She is not trying any help for him to change, but she keeps on saying, “He will, he will change for the better” (Female FGD 20–24, Nongoma).

Family members did not necessarily accept this violence: “If your mom knows that your boyfriend is beating you up, she tells you that you may leave that boyfriend” (Female FGD

20–24, Khayelitsha). This kind of support for safer sexual relationships increases ability to act to reduce vulnerability.

Rape was acknowledged as a risk to women of all ages—an increased risk when women were drunk, walked in unsafe areas, or had to walk to work. Perceived disincentives to reporting rape were noted. Younger women who lived with their parents could not admit they had been raped after being out drinking:

When rape actually happens, when you come back, you fail to report them for the fact that you can't actually report to your parents that you were out all night while they didn't know (Female FGD 25–34, Nongoma).

A woman who had been raped while drunk would not readily report the case:

So maybe that person was also drunk when you forced her [to have sex], so the following day she will not want to go and open a case because she thinks that the police won't believe her because she was also drunk (Male FGD 25–34, Khayelitsha).

Another perception was that reporting rape might contribute to a woman being “blacklisted” and avoided by prospective boyfriends. This silence about violence and rape is a socio-cultural factor that increases vulnerability and HIV risk.

6. Emerging concepts for HIV prevention

Study findings indicate that community members are able to discern and unpack the factors underpinning HIV vulnerability and risk. Findings also illustrate a continuum of risk and vulnerability for adult women, who appear to be bound to it as a product of their preceding circumstances. For example, having a child out of wedlock produces a continuum of risk, since single mothers face the need to negotiate their way through unemployment and seek stable partners to care for themselves and their children. Women who find partners may find their vulnerability is perpetuated as a result of potential HIV risk flowing from their partners. Whether women are unemployed or employed, scenarios of risk repeat themselves through exposure to risky sexual relationships.

6.1. Individual strategies

Notwithstanding these findings, a number of participants referred to individual strategies that moderated or mitigated HIV risk. Fear of HIV sometimes overshadowed tolerance of infidelity and HIV risk, and relationships could be severed, even long-term ones:

I had a relationship for nine years, but I heard that my boyfriend was cheating with an older woman... His friends were saying to me: “No, relax, he is just there to get the money. He is going to come to you to spend the money.” I said, “No, I am sorry, he can just stay there. I don't want him. What about AIDS?” Then I broke up with him just like that. I didn't care about the love... I mean what a relief. I just thank God (Female FGD 25–34, Khayelitsha).

Similarly, in spite of the perceived acceptability of MCP among some men, fear of HIV led some men to value monogamy:

Most girls wear short skirts. When she walks, she attracts you as a male to go to her. These are one of the ways that HIV can be passed on. We should only have one partner. And when you have one partner, you must wait until you get married. Try to go to church and read the Bible (Male FGD 25–50, Robertson).

The statement also reflects the motivation of having faith and respecting oneself. For some participants, a longer-term view of their personal future required sacrifices, including being abstinent and coping with derision from peers. One woman noted it was possible to prioritize other interests—motivation that entails setting long-term goals and accepting the situation:

I have a strategy. For instance, right now I have been single for nine months... I know what I want in life for me to get to point B. I have to do this, even though my friends always say I'm holding on to the past because now I'm not dating... I'm nursing myself. I have told myself I have to get my degree first, then I will see about boyfriends after that (Female FGD 20–24, Peddie).

Another woman observed, “It is about preserving yourself,” adding that it was necessary to be assertive about the goal of avoiding HIV infection and stick to principles (Female FGD 25–34, Peddie). Even participants with multiple partners or unfaithful partners noted opportunities to address risk by being abstinent or insisting on HIV testing:

I made a decision of testing every six months. I made this decision after I had an affair with another guy and I noticed that this guy was also seeing other girls and the girls were getting sick. One of them was admitted to hospital. So, I decided to abstain or the guy must do an HIV test (Female FGD 20–24, Peddie).

Community members sometimes became involved in curbing unfaithful relationships and invoked the authority of community leaders:

The community once reported a woman who they said steals other women's husbands. The case was heard and the woman did not deny the allegation. We spoke to her and asked her why she did such a thing, especially since she has a husband of her own. Her husband was also crying about the wife's infidelity. So the community played a role in addressing that and the case was solved (Male FGD 25–50, Moretele).

This is an example of how community members can promote recognition that risky sexual relationships have a negative impact on the whole community. Another possibility suggested was for parents, those in stable relationships, or friends to engage couples in discussions about HIV risks and strategies for HIV prevention and promote healthy relationships.

Another suggested strategy was to appreciate one's limited resources and constrained overall situation:

She must just love herself as a woman, and she must be proud to just be herself (Male FGD 25–34, Peddie).

If people accept where God has chosen them to be, HIV would be less. If you would just appreciate what you have and do not want something that you cannot have, then I would say your risk of HIV would decrease (Male FGD 25–34, Robertson).

While participants noted that condom use was difficult to sustain in ongoing relationships, they noted the possibility of remaining cautious and insisting on condom use:

If your partner does not want to use a condom let him go, because it is clear that he wants to bring you a disease when he does not want to use a condom. Even if he tells you that he loves you, no. He must love you with a condom; no stress (Female FGD 25–34, Robertson).

Among strategies for sustaining condom use, one male participant referred to a process of “making one's principles” at the outset:

If you say from the first day you will use a condom until you check your status, stick to that. You don't come to a stage where you say tomorrow you will not use a condom.

You must give yourself a principle or bring yourself on the safe side from the beginning (Male FGD 35–44, Khayelitsha).

A similar point was made by a female participant:

You should be the first to follow your own rules. If you are weak about the rules you laid down, the boy will know that you do not have a firm standing ground (Female FGD 20–24, Nongoma).

While women with children born out of wedlock were acknowledged to be vulnerable to an ongoing pattern of unsatisfactory short-term relationships, some single mothers had been able to resist going along that path:

I have got two kids, and I know it's not nice to raise children as a single parent. But what I have learnt is if you are going to go to someone for his money, then you will end up being a prostitute or doing such things. Love is there. If this boyfriend you have loves you, he will know what to do. He will make a plan for you because he loves you (Female FGD 25–34, Robertson).

Some single mothers tended to be more wary in later relationships because they had learned that men could not be trusted.

When the lady has a child, she is not behaving in that very same way like the one who doesn't have a child. So, when you compare them, the one who has a child becomes more serious because the guy that she was dating before did something very bad to her (Male FGD 25–34, Nongoma).

Another male participant said that a woman who had children with different fathers was likely to be cynical about relationships: “She has been exposed to many people with different stories” (Male FGD 25–34, Nongoma).

6.2. Community-level opportunities for SBCC programs

Communication delivered through mass media from HIV and AIDS programs was widely noted as the source of information about HIV prevention. There was spontaneous mention of most national mass media campaigns, as well as exposure to community-level communication: group discussions, workshops, pamphlets and posters, door-to-door campaigns, and events organized by a range of organizations.

Constraints observed in exposure to these mass media campaigns included limited broadcast times and differences in literacy levels, language preferences, abilities, and levels of interest in the content. One participant noted:

I think it depends on how much you want the information, because there is a lot of information out there. It depends on the individual's seriousness of the issue and in life (Male FGD 25–34, Khayelitsha).

The general view was that people heard and understood messages being delivered, but did not want to act on them. This failure to act was perceived as ignorance: “People have all the knowledge that they need; it is just ignorance” (NGO director, IDI, Moretele).

There was also a perception that HIV communication reached people unevenly. For example, older people were being ignored by campaigns, so parents and elders did not adequately understand the disease. There was also a need to bring about action through leadership, rather than simply conveying information:

The other thing is that some people keep the information to themselves when they have it. We need mobilization (Male FGD 25–50, Moretele).

Concerns were voiced about the contradictions between the highly sexualized content of television programs and HIV-prevention messaging. Somewhat similar concerns were expressed about the delivery of HIV-prevention information at community level:

The very same people who educate are the ones who misbehave...They are the ones who excel in sexual misbehavior more than the ordinary people (Female FGD 20–24, Nongoma).

Some participants saw door-to-door campaigns as effective, while others said people were “fed up” and avoided such visits. Sporadic interventions that focused on HIV prevention during special days or periods such as the Soccer World Cup were not seen as useful, given that the epidemic was seen as an ongoing social problem.

The potential of churches emphasizing HIV and AIDS issues through the leadership of pastors and ministers was noted.. One religious leader said:

The church is a huge NGO... and these are people who meet every week, some of them twice, thrice a week. You have, you know, an audience there, you have human resource, and then over and above that we have this moral obligation as a church (Male religious leader, IDI, Khayelitsha).

When discussing preferences for addressing HIV and AIDS at community levels, participants referred to interactive activities such as workshops, where people could discuss and learn about HIV and explore viable opportunities to engage with the disease effectively:

That togetherness, that calling of communities together, can make people aware of what is happening (Female FGD 25–34, Nongoma).

The approach was also raised in the context of leadership for such community engagement:

If I was maybe a leader or someone in authority, I would start these things of getting together, get together of women. Like, as we are sitting here, we are sharing our ideas one from one another... talking together, one and the same (Female FGD 25–34, Nongoma)

Instead of gossiping, we should be discussing things that can build us instead, like having some constructive discussions with regard to women’s health (Female FGD 25–34, Khayelitsha).

This kind of action could promote understanding that ordinary community members can be involved in critical thinking to develop solutions and can lead the response to HIV and AIDS. It also suggests there has been insufficient engagement of communities in problem-solving HIV prevention issues.

Funeral clubs and savings clubs run by women were also seen as a possible conduit for discussing and passing on information about HIV if leaders of such organizations were trained to discuss the disease. Another suggestion was the holding of regular community-led discussions and debates on HIV.

Participants noted that support groups and related processes of providing information about HIV focused on people who were HIV positive, but the same resources were not extended to people who were HIV negative:

That’s what we are complaining about, that people should not [have to] get the HIV first in order to get the information about it (Male FGD 25–50, Nongoma).

Another participant suggested the option of providing HIV counseling without HIV testing:

I have this idea of my own. The government should provide counseling... for people to come and be advised and find out about HIV, how it affects people, how you get infected with HIV and what it does and all those things, without even testing (Male FGD 25–34, Nongoma).

Proactively addressing HIV at community level was seen as a necessary first step. In this context, a female community leader added:

People do not need to disclose their status, but the questions will show that people have different problems related to the issues (Female community leader, IDI, Khayelitsha).

A perceived advantage of such support groups would be that people could be advised about their particular problems and get solutions.

Although workshops and HIV training provided by external groups were valued, study participants noted there was seldom follow-up to ascertain whether those trained were doing anything with their new knowledge and skills.

It was also noted that some people only attend workshops when food is available—“People will be together and be happy and listen if there is food” (Female FGD 25–34, Robertson). It was also noted that men were more likely to attend when there were other giveaways, such as calendars, caps, or T-shirts.

Although there was a consensus on the need to stimulate and conduct community-level conversations about HIV and AIDS, a concern commonly voiced was that it was difficult to get men to participate in such activities. However, not all men were unresponsive:

I would say, men let us try to defeat ourselves; men let us try to cooperate with women (Male FGD 35–44, Peddie).

Others noted the need to avoid having multiple partners:

We need to advise each other to slow down. We are the ones that have the power to have as many women as we like... We can stop this (Male FGD 25–34, Nongoma).

Men also noted that women should be proud of themselves and learn to love themselves and their bodies to avoid exposure to HIV vulnerability and risk.

Coming together in a group as men was seen as a means to address the problem of HIV. This illustrates that men have not been adequately engaged and involved in the response:

We are sick and tired of our sisters being infected... We tend to forget that if we get the HIV, it's for life ... But if the ten of us can join us and we call other men and we say okay, come, we have a support group, whether you are infected or not. Maybe we get a name. We say okay, we are fighting for HIV in this community. Maybe it can make a difference (Male FGD 35–44, Robertson).

In one community there were plans to form diverse support groups: “one for sick people and another one just for people with other problems, and then hopefully another one with just men in it” (Male FGD 25–50, Moretele). Groups might start out small:

We started very small and we are growing the group. I started with one person. She was my friend... She brought her friend and there were two. They brought another man, so there were three of them. So it grows and grows, and when there were ten and I said I am going out now... do the job. And they do the job... They are doing very well (Male preacher, IDI, Robertson).

A religious leader described how groups of men had been mobilized in a similar way through playing pool and referred to the potential of social media for horizontal communication:

Two Sundays ago, there were young people who were capturing footage using their phone while I was preaching, and later on we discovered that they are in fact a group of young people who have decided to take information and feed it on MXit to other young people (Male religious leader, IDI, Khayelitsha).

A male participant observed: “I believe that each and every one of us is a leader.” Recognizing this and leading a response to HIV was preferable to waiting for others to lead.

Encouraging leadership was seen as a necessary and important component of awareness campaigns. Facilitation of community groups was an important function. As a religious leader observed:

I think that is what is lacking, my sister. Giving people the platform to say what they think. Yes, I think that they are not involving the community in the decision-making, and that might be the cause of the problem (Male religious leader, IDI, Moretele).

Traditional leaders were noted as having the potential to educate about HIV, but were seen as generally not well informed about the disease and would need support before they could educate others. Adding this component would help to bolster the perceived authority of the communication by health workers and others in the community.

7. 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 perspective of adult women and adult men, including community stakeholders, and elders and leaders in a range of communities in rural, urban, and informal urban settings. As such, the views are representative of perspectives of people in communities where HIV is highly prevalent, in contexts representative of many communities in South Africa.

Although perspectives were explored in different communities, findings that emerged on the range of issues explored 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 gender-related socio-cultural values considerably transformed relating to more equitable marital relationships and women’s education and employment have been, women’s vulnerabilities related to HIV have not been reduced or removed as a consequence.

The data collected 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 explored 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. The narratives of participants clearly illustrate 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 were critical of the ways that HIV prevention communication is delivered. They highlighted concerns about the sexualized nature of some HIV-prevention communication and intrusive door-to-door campaigns, as well as the behavior of some HIV educators that were 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 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 promote increased self-efficacy in making relationship choices, including sticking to one’s principles for HIV prevention; addressing HIV risk in through dialogue with sexual partners about accountability in relation to HIV, and establishing safer, long-term relationships. A further element of

self-efficacy includes 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 level through group interaction; fostering male involvement at group level; 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.
 - For example, at the level of relationships, this would include highlighting the importance of greater accountability between sexual partners in relation to HIV risk and increasing dialogue, openness, and trust between partners in sexual relationships.
 - At a broader social level, this would include 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.
 - A related element of fostering social response involves promoting leadership at community levels and expectations for exemplary behavior among leaders; 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 earlier, these elements interact with each other and occur in parallel, rather than in sequence, and they are mutually reinforcing. The change processes envisaged are illustrated in Figure 4, where SBCC 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.

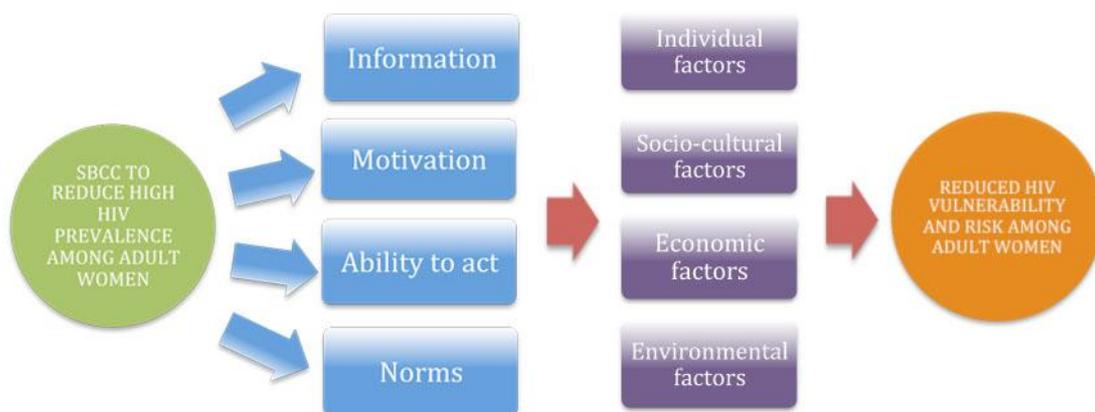


Figure 4. A socio-ecological approach to addressing HIV prevention through SBCC

8. 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).

Communication approaches such as Stepping Stones and Community Conversations have moved away from this passive message-transfer, toward group discussion and reflection that aim to achieve normative and individual changes in behavior (ACORD 2007; FHI 2010). There is clearly potential to widen the scope of such activities (see Kippax 2012). Emerging approaches that foster group responses to 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 evaluation of SBCC that is 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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