The development of a culturally tailored and contextually sensitive behavior change intervention for heterosexual Xhosa-speaking women in the Eastern Cape province, South Africa

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Chapter Seven

General Discussion
Discussion

The majority of South Africans continue to face the consequences of Apartheid and this is especially the case for rural dwellers that are spatially isolated from economic and development resources. Women bear the brunt even more than their male counterparts as they are also confronted with structural, socio-economic and socio-cultural conditions that expose them to adverse health outcomes. Addressing these conditions may be very challenging, as that requires higher level and complex interventions. Health promotion interventions may be used to empower women to be less vulnerable physically and psychologically against adverse health circumstances. The objective of this dissertation is to describe the systematic development and evaluation of a culturally tailored intervention conducted amongst 18-35 year old young women. The intervention was designed to enhance psychological wellbeing and reduce risky sexual behaviors as well as exposure to intimate partner violence (IPV). In this chapter we put the main findings from our research into perspective. We also reflect on methodological issues, public health as well as practice implications. We further make recommendations for future research.

Problem analysis research

Rural resilience and psychological wellbeing

Chapter 2 and 3 describe the problem analysis stage into the development of the intervention. Findings from 7 in-depth focus group discussions (FGDs) with adolescents, young and adult women, provided insights into lived experiences of women who had low levels of education and very few socio-economic prospects. Background literature searches conducted as part of the problem definition showed that there is sufficient data on the prevalence of poverty. Also, that information is available on structural difficulties faced by individuals and families who live in underdeveloped communities. The FGDs were therefore used to gain insight into women’s appraisals of how sustained poverty impacted their wellbeing. In chapter 2, the findings show that living in under-resourced settings comes with continuous distress for women, and that their ability to cope gets constantly challenged by circumstances. Women seemed to understand that resilience was important for sustaining wellbeing. It also emerged that it was important for rural
women to use abiding familial and social network resources to tackle some of the exposing elements or to help with coping. This insight highlighted a need to use a health promotion intervention to focus on addressing women’s coping mechanisms, to use psychological healthcare methods to enhance their mental wellbeing, and therefore ensure sustained wellbeing. There have not been many interventions conducted in South Africa that have had psychological wellbeing as a main outcome. Yet, it is clear that in order to effectively address health problems that arise from living in impoverished settings programs must also incorporate mental wellbeing care strategies. A recent meta-analysis study substantiates the above-mentioned findings. In their study Weiss and colleagues (2016) assessed the effect of having psychological wellbeing as a primary or secondary outcome in behavioral and bio-behavioral interventions. The latter should be understood as interventions that involve addressing both behavioral and biological elements. Studies that were included in the meta-analysis had to be randomized controlled trials (RCTs) that were conducted in a community setting. The RCTs also had to focus on enhancing psychological functioning while excluding participants who presented with psychological or pathological complaints. The findings of the meta-analysis showed that bio-behavioral interventions, which had a psychological wellbeing enhancement component tended to be more effective than those that did not (Weiss, Westerhof & Bohlmeijer, 2016).

Culture and sexual health communication

The study outlined in chapter 3 explored issues associated with young women’s sexual health, particularly how adolescents are equipped at home and how the preparation for young adulthood or lack thereof influenced their behavior in their young adulthood years. It emerged that there was a norm of mothers not being proactive communicators with regards to sexual health and reproductive development. Also, that dictums were used in an attempt to discourage sexual activity or warn against teen pregnancy but the use of the dictums was not accompanied by explanations. Moreover, the findings from the study also suggested that mothers were not able to equip their adolescent daughters with necessary sexual health information because they were ill equipped themselves. The findings suggest that it would be important to integrate a sexual and reproductive health
component into the intended intervention. The component would empower young women on sex matters so that they would be able to protect themselves from risky partnerships. It was clear that it would be important to demonstrate to women that reproductive health is not a taboo subject. An intervention addressing the aforementioned sexual health components may demonstrate to women that they can broach the subject with their daughters in future.

Study of determinants
Condom use self-efficacy and exposure to HIV/AIDS risk

Chapter 4 and 5 describe research that focused on explaining the determinants that influence women’s confidence to exert persistent efforts on safer sexual behaviors, as well as women’s exposure to intimate partner violence (IPV). The research in both chapters formed part of the behavioral analysis for the development of the intervention for young rural women. These studies add to findings from empirical research that focuses on the associations between the three self-determination theory (SDT) needs and health behaviors, and therefore demonstrate that SDT is important in understanding optimal development or human growth and functioning (Gagnè & Deci, 2014; Gaston et. al., 2016; Sanchez-Oliva et. al., 2014).

In chapter 4, important information was gleaned about the association of the three SDT psychological needs with condom use behavior. The research demonstrated that in order for the competence and autonomy needs to be fulfilled or for individuals to internalize the confidence to use condoms (condom use self-efficacy), a number of factors were important. These were, HIV-knowledge and positive life outlook (i.e. not being hopeless and having a positive growth perspective). Further, since relatedness facilitates how individuals process the behavior-change needed, environments that diminish a sense of social security for women, may lead to those women having poor confidence in exerting safe sexual behaviors. For instance in societies where women believe they have a low social status (gender inequality beliefs) their self-efficacy to use condoms will be low or will decrease after a negative reaction of a partner to a first suggestion to use a condom.
In Chapter 5, the psychosocial determinants of intimate partner violence (IPV) associated with the three SDT needs and gender constructs were examined. Research here mainly showed that in sexual relationships where the autonomy need was not satisfied individuals were more likely to be exposed to IPV. Further, the research presented in this chapter suggested that societal norms and beliefs on gender equality also mediated exposure to intimate partner violence.

The findings of the two studies showed that it would be important to incorporate into the intended intervention the concept of self-evaluation, so as to help participants make judgments about their personal decision-making, life choices and progress in a way that would enhance their wellbeing. Literature shows that when individuals can make important self-evaluations, they are able to progress in life. Moreover, when they gain confidence, they also feel secure and in control of their immediate environment (Jiang & Jiang, 2015). Practically this meant that facilitators and participants would have discussions on how an individual makes valuations on their personal development. They would look at the things that have improved in their life and at things that still needed improvement in the future.

The empowerment intervention

The objectives of the intervention evaluated and described in chapter 6 of this thesis were to help women increase their awareness of personal agency especially in sexual relationships. The intervention also targeted poor psychological outcomes such as stress and the management of external stress indicators. A component of the intervention also focused on empowering women with reproductive and sexual health knowledge. This intervention was expected to contribute to empirical studies that have been conducted in hard-to-reach rural community settings. Interventions with similar objectives that have been conducted in other settings in South Africa include the Stepping-stones and SISTA interventions (Jewkes et al., 2008; Wingood et al., 2013). It was also important that the systematic development of the intervention included both literature searches to understand epidemiological and contextual problems, and also to use focus group data. This allowed planners to collaborate on examining the intricacies of the health problems and to gain background information and insight into the behaviors of
the intended participants and their communities. The intervention was grounded on SDT and Social Cognitive Theory (SCT) (Ryan & Deci, 2000; Bandura, 1986; Bartholomew Eldredge et. al., 2016). Both these theories were chosen because they have similar underpinnings; they can be used to explain health problem determinants, and they have been shown to be useful as frameworks for behavior change design.

The findings from the evaluation of the intervention show that there were significant effects in the short-term, especially for the measures of psychological health. After 1-month of the intervention, compared to the control arm, negative self-esteem and the presence of depression symptoms were significantly reduced. Also the young women reported less intimate partner violence exposure (IPV). Stepping-stones, a mixed-gender empowerment intervention also showed an effect on reducing reported intimate partner violence. However, the IPV reports were reduced amongst males and no experiences of violence were reduced amongst females (Jewkes et. al., 2008). Our findings and those of Jewkes and colleagues (2008) show that even though exposure-to or perpetration of IPV is a widespread social problem, when targeted it can be combated or reduced when participants (male or female) are empowered to address its determinants.

Our intervention had no long-term effects (after 6-months follow-up) on the measured outcome variables, except for the presence of depression symptoms, which was reduced. It is noteworthy that the young women were able to maintain their psychological resilience in the long-term. The fact that no long-term effects were observed on women’s exposure to IPV is also interesting. It could be that women entered into new relationships where their sense of social security was reduced and therefore required them re-assert themselves or extricate themselves from violence. It would have been helpful to have qualitative evaluation data to test the above assertion, or to better understand the lack of long-term effect on this particular measure.

Further, the intervention was unsuccessful in changing the motivation of women to enact safer sexual behaviors, both in the short-term and in the long term. This is particularly interesting since SISTA another empowerment intervention in South Africa from which the sexual health component was adapted showed an effect on reducing risky sexual behaviors (Wingood et al., 2013). The SISTA intervention may have been more effective in reducing the aforementioned behaviors because they had a voluntary HIV-
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testing component, which may have caused participants to personalize their vulnerability to HIV. Finding no effect for intention to use condoms and condom use self-efficacy measures in our intervention may have to do with a number of factors. Firstly, even if women may have realized the importance of condom use after the intervention, entrenched patriarchal norms or gender-power inequalities within sexual relationships may have served as a hindrance for women to enact healthier sexual behaviors. Secondly, it may be that women have tried to initiate condom use but may have had refusals by their sexual partners which may have caused their condom use self-efficacy levels to drop, thus possibly making it an issue of persistence in order to realize behavior change.

The lack of effect on HIV-knowledge may have to do with how the message about this topic was delivered. The intervention message stressed more on how HIV is contracted, while it did not directly address myths about how individuals could avoid contracting HIV, and myths about available non-medical cures. In retrospect, addressing myths surrounding HIV contraction can help participants learn that they can’t avoid safe sexual behaviors for what has not been scientifically proven to work. Further, it may be important for facilitators to develop measures of testing whether accurate information relating to infection, prevention and curing HIV/AIDS are clearly addressed. Also testing whether or not accurate information has been received can help participants fill any biomedical or health promotion gaps that may be apparent, within reason. In terms of this finding, when our study is compared to the SISTA intervention, the latter showed to have an effect on increasing HIV knowledge in the intervention arm (Wingood et. al., 2013). The effect could possibility also be attributed to the HIV-testing component, which may have helped echo the information on safe sexual behaviors and general HIV-knowledge. Prior to testing it is standard that clients are given pre-and-post-test counseling.

Reflections on methodology
Using Intervention Mapping for intervention planning

The work conducted in this thesis describes how the Intervention Mapping (IM) framework was used for the planning and the development of a new intervention; with small incorporations of an existing intervention, which was conducted in South Africa. Chapter 2 and 3 describe the outcome of step 1 where IM was applied, this step resulted
in the development of a logic model of the problem and the identification of key determinants to target in the intervention. Stakeholders played an important role in step 1 (Logic Model of the Problem), their involvement started with meetings that were held with the Provincial Traditional Legislature (Eastern Cape House of Traditional Leaders; ECHTL). The objective of the meetings was to gain entry into the communities, and to also get different perspectives of the problem, as well as social and cultural roles in worsening or lessening the problem. Further, the researchers identified a network of local traditional leaders, mostly women, who already had development projects within their rural communities. The local leaders formed part of the participatory planning team, however due to funding constraints, the network of leaders could not be involved full-time in the process. This limitation was addressed by updating the traditional leaders on the progress at regular time intervals. The planning team used Step 2 (Programme Outcomes and Objectives) to outline what should be addressed to promote healthy sexual behaviors as well as psychological wellbeing. However, the scientific team took a decision to only follow the core tasks of this step because of time constraints. Therefore, a list of the determinants that were considered a priority based on the needs of the community and what the literature showed to be a health burden was compiled. Chapter 4 and 5 describe some of the selected determinants and illustrate the use of theory to explain how the determinants affect wellbeing. For the remainder of the framework, a careful step-wise approach was followed to complete the tasks and develop an intervention program. The team felt that the expertise of the principal investigator was important for steps 3 to 5 (Programme Design and Programme Production) to be successful. Also, the expertise of a senior researcher who had extensively worked in similar communities (i.e. in a peri-urban and a rural setting) was used to help with the practical messages and the language used within the curriculum. In addition, the component of sexual health that was adapted from SISTA was formatted to follow a similar structure to the rest of the lessons in the intervention program. In the new intervention the sexual health topic was introduced in a form of a group discussion, and then followed with parts that provided health information.

The intervention was developed for implementation. Therefore, it was important to include measures of monitoring and evaluation. This was done through evaluating reports
of sessions that were compiled by the facilitators. Because the intervention only had four sessions, the planning team agreed that it was important to attempt to get the participants to receive a complete dose. This was challenging since the intervention was implemented in a rural community setting. The facilitators encountered problems where participants missed sessions and often had to schedule time for catch-up sessions. Participants often missed sessions because they had to attend to other life demands. The other reason behind requiring participants to attend catch-up sessions was that it was important for the participants to process the elements of the interventions in a step-wise manner without having components of information missing. Also, exposing participants to all components of the intervention allowed the group to evolve together.

Other methodological issues

The strength of this dissertation is the fact that the intervention was developed in a systematic manner, thus allowing a learning process of the successes and limitations that come with undertaking work of this magnitude. In reflecting on the methodology used in the thesis we will start with the qualitative research. It is important for researchers to ensure that when they conduct qualitative studies they have a way of ensuring validity and reliability of their results (Noble & Smith, 2015). First in terms of sampling, the strength of this work (chapter 2 and 3) was that a sample was selected from a cross-section of adolescents, young and adult rural women. Also the discussion groups were comprised of 6-12 members at a time. The data collection was concluded once saturation was reached; meaning that there was no new information arising. In addition, the groups were set-up in such a way that participants of similar age were grouped together, so that age and seniority was not a barrier to open communication. Further, to ensure sufficient depth, post-focus-group discussions were held by the researchers; the team comprised of the principal investigator, an experienced professor in qualitative research and two other junior researchers. Regarding the analyses, the lead researcher consulted the principal investigator, an experienced qualitative researcher and two other senior professors on the data findings as a way of reducing researcher bias. However, the analysis could have benefited from analysis triangulation, where at least two other researchers conducted
independent analysis of the data. This therefore was a limitation of the analysis of the qualitative research.

In terms of the quantitative research conducted in this thesis, a strength was the fact that behavioral and psychosocial measures in the questionnaires (baseline, 1-month follow up and 6 months follow up) such as exposure to violence, condom use frequency and gender-power constructs were assessed using at least two different set of scales or question items. Thus ensuring that reliable responses from participants were obtained, especially since these were sensitive topics and most likely to be answered according to perceptions of social desirability. Even though, a strong overview of the SDT theoretical framework was provided in chapter 4 and 5, upon reflection the three SDT may not have been adequately operationalized. The weakness particularly lies in not ensuring that where the same constructs are used they are mapped onto the same psychological needs in both chapters (4 and 5). However, further research of which theoretical concepts fit into which psychological needs is required. This is to refine the list of existing social cognition or psychosocial constructs that best describe the three SDT needs. Another limitation of the quantitative research was the fact that the effect evaluation of the intervention was designed to be a quasi-experimental study. However, the design was the most optimal for this intervention because of the spread of the target population, which could have increased the likelihood of contaminating the sample. Another limitation was that even though the criteria for participation were strict and informed by the problem analysis step, the sample was small (N = 240), and may have resulted in reduced statistical power to obtain statistically significant differences between the intervention and control group on the main outcome measures.

Implications of this intervention development process for practice

The studies conducted for this dissertation demonstrate the development and implementation of a community-based empowerment intervention. Rural communities are an important health care setting, especially in terms of acting on the UNIFEM and World Health Organization call made about three decades ago, which states that “individuals have a right to the enjoyment of the highest attainable standard of physical and mental health. That health is all encompassing and not just the absence of disease”. Also, that “Health is determined by the structural environment, social space, politics, and
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biology”. Further that “Inequality prevents women from attaining the highest levels of health” (WHO, 2008). Health promotion efforts in rural communities can also contribute to the body of knowledge, which shows what is feasible and what are the difficulties that are likely to be encountered in terms of implementation.

Although it was important for this intervention to target individuals who had dropped out of school in order to help them be less vulnerable to adverse health outcomes. The planners were aware that linguistic challenges and poor perception of health concepts could serve as barriers to the effective transfer of health messages. Therefore, attention was also paid to ensuring that the lessons were simple enough without diluting the core message. Another issue was that because the intervention also targeted young women who were unemployed or under-employed, the women tended to be impermanent rural dwellers. This therefore posed serious challenges to the retention of participants, especially in the intervention arm. After the intervention, especially after 6-months, the research team had to make an effort to track the participants who were in the nearby towns, as they had completed all the intervention sessions. For further practice purposes this too has to be accounted for when power issues are considered. Further, to extend the ecological approach to addressing health problems in rural communities, health promotion researchers can facilitate the dissemination of key health messages from an intervention by helping participants formulate action campaigns. Topics such as intimate partner violence are sensitive and urgent; therefore prevention messages about these topics need to be spread as far and wide as much as possible. Collaborations between the researchers, participants and stakeholders can help communities become more open about these problems.

Recommendations for future research

In considering contextual factors that facilitate women’s health and wellbeing, we have outlined that access to socio-economic and structural resources is crucial. The background studies for this thesis, however, highlight that for rural communities this ideology is currently impossible. Instead young women are forced to live under impoverished conditions that cause them to be vulnerable to risky sexual and violent behavior. Therefore, since we were designing an empowerment intervention it would
have been beneficial to integrate a component where women were equipped with practical ways on how to free themselves from poverty. Examples of these ways could have been steps on self up-skilling, adult education and how to source government funding for small business enterprises. The lack of component in the intervention, therefore serves as a limitation. However, we recommend that such a component be considered in future empowerment interventions.

In terms of having a well-designed intervention, planners have to apply relevant and potentially effective theoretical frameworks, and they also have to use effective assessment measures (cf. Bartholomew Eldredge et al., 2016). Regarding relevant theoretical frameworks it may be beneficial for future research to go beyond using SDT constructs, which only explain how undermining the three psychological needs exposes people to illhealth. This particularly concerns sexual health behavior, it may be important for future research to consider incorporating human rights based approaches (explicitly). The human rights based approach advocates for programs to include an element where the stakeholders discuss the importance of the identification of individual rights and freedoms (Health Policy Makers, 2014). This consideration would be very important for rural young women, especially how they are to exercise their sexual and reproductive health rights (SRHR) as well as their entitlements.

Concerning well-designed assessment measures, this intervention only used a quantitative effect evaluation; future research may consider also conducting a qualitative evaluation. This would allow a nuanced and a rich understanding of the effect or lack thereof. Such an evaluation may be important for a rural setting were there may be linguistic challenges as it would allow participants to express their valuations using their own understanding.

Since this was an empowerment intervention it may have also been beneficial to include an arm in the intervention that would have facilitated the formation of mentorship groups. The research team would train the mentorship groups or facilitators and the groups would in turn mentor their peers. Further the trained mentees could be included in the planning team (for implementation) to help tailor the intervention to the needs of the community. The above-mentioned process would create effective collaborations but would also impart some skills that the young people can use should similar projects arise in the communities.
Concluding remarks

This thesis has provided, through using a systematic approach insights into the development, implementation and evaluation of an empowerment intervention, which targeted young rural women. In the absence of primary healthcare services, empowerment based programmes can be implemented in rural settings to improve the wellbeing of rural residents. However, to effectively promote healthier sexual behaviors programmes would need to explicitly address environmental gender-power issues from a rights-based perspective as well. This cannot be overlooked or neglected as young women continue to be disproportionately affected by adverse outcomes that come with risky sexual behavior. Further, incorporating a rights-based approach in future interventions may teach women, especially rural women that they reserve the rights to their own bodies, and that they are not the property of males, whether it is their immediate sexual partner or any other male in society.