**"Social Isolation and Economic Vulnerability:
Adolescent HIV and Pregnancy Risk Factors in South Africa"**

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## Introduction

Young people making the transition to adulthood in South Africa face a unique set of challenges. Although South Africa is a modernizing constitutional democracy, traditional leadership structures and cultural belief systems remain strong. Young people and women are disempowered by many of these social structures. The effects of South Africa's apartheid history remain, as evidenced by the country's extreme income inequality—black South Africans experience the highest levels of poverty. Overall unemployment rates for black South Africans exceed 30 percent, with young people and women being disproportionately affected. This challenging social and economic environment has also deepened the effect of HIV/AIDS on the population – especially for young women in KwaZulu-Natal. Estimates from the most recent National Antenatal Survey in 2002 show that overall HIV prevalence is not declining. Prevalence is now 26.5 percent nationally and 36.5 percent in KwaZulu-Natal (SA DOH 2003). Moreover, gender-specific indicators for young people show that for every two infected 15-24 year-old males in South Africa, there are ***five*** infected females the same age (UNICEF-UNAIDS-WHO 2002). Adolescent childbearing is also quite high in South Africa: recent census data indicate that 30 percent of females ages 20–24 gave birth before age 20.

Despite these realities, few quantitative studies of adolescent sexual and reproductive health behavior in South Africa have examined social isolation and poverty as determining factors, and fewer still have considered the how these factors interact with gender to influence these behaviors. With data from the "Transitions to Adulthood in the Context of AIDS in South Africa*"* panel study in KwaZulu-Natal, initiated in 1998 and concluding in 2004, we attempt to fill some of these knowledge gaps.

## Theoretical Focus

The motivation for examining social isolation and economic vulnerability as adolescent HIV and pregnancy risk factors is rooted in literature examining the causes and consequences of gender and class inequality.

Relative position within society has been shown to influence not only the ability to access social services of adequate quality and fairly-remunerated stable employment, but also health outcomes. Racial segregation and discrimination are increasingly attributed as factors contributing to morbidity among non-whites in the United States (Acevedo-Garcia et al. 2003). Kennedy, Kawachi, Glass, and Prothrow-Stith (1998) find that *relative* poverty contributes to ill health through factors such as unequal access to education, health care, and economic opportunities, and the psychosocial effects of being "disadvantaged." The poor tend to have less accurate health information, and even with

knowledge often take fewer HIV and STI preventive and treatment actions due to resource and time constraints (World Bank 1998). Barnett and Whiteside (2002) assert that that economic inequality has accelerated the spread of HIV in sub-Saharan Africa through similar avenues.

Traditional leadership structures and cultural belief systems, which remain strong in South Africa have, still disempower young people and women. These two groups are largely excluded from key arenas of decision-making, include local systems of patronage. Hart (1997) (among others) provides evidence that the formation of social networks among those who have traditionally been excluded from long-standing systems of political-economic discourse provides emotional and financial support that carry over to influence conjugal relationships. Understandings of themselves and their relationships with their sexual partners and family can contrast sharply from individuals without such networks.

South Africa has one of the highest levels of economic inequality in the world (UNDP 2003) and historically very unequal access to health, education, and livelihoods opportunities. Evidence shows that economic inequality has worsened since the end of apartheid—reported to be due largely to drops in the real incomes of formerly near-poor black households (Hoogeveen and Ozler 2003; Carter and May 2001).

The relative social and economic vulnerability of black women is manifested in a number of ways, including lack of access to jobs and little control over income and property. In 1999, the official unemployment rate (a lower-bound measure of actual joblessness) stood at 23 percent nationally, 25 percent for black males, 35 percent for black females, and 42 percent for 15-24 year-olds. Moreover, one-half of women (versus only one-fourth of men) who were employed worked in unskilled low-paying jobs, many in the services sector (Statistics South Africa 2001). Among urban households, those headed by females are twice as likely as those headed by males to fall within the bottom half of the income distribution (Statistics South Africa 1998). Being young, female, and African entails being on the low end on the socio-economic continuum in South Africa. The effects of these gendered social and economic inequalities on sexual and reproductive behaviors deserves increased attention.

**Data and Methods**

"Transitions to Adulthood in the Context of AIDS in South Africa" is a representative and longitudinal study of young people based in KwaZulu-Natal, South Africa. Interviews were conducted in two districts in KwaZulu-Natal province, South Africa: Durban Metro and rural Mtunzini Magisterial District. These were purposively chosen for the study site as they represented urban, transitional, and rural areas of the province. A modified multi-stage cluster sampling method was used with enumerator areas (EAs) from the 1996 Census serving as the primary sampling unit. In 1999 interviews were conducted with 3,052 14–22 year-olds residing in 1,974 households. In 2001 these young people were followed up as 16–24 year-olds. In addition, all young people aged 14-24 residing in the sample enumeration areas at that time were newly interviewed—whether

they were included in the Wave 1 survey or not. The full 2001 sample is used for this analysis.

Many aspects of transitions to adulthood were covered in the survey, including schooling, paid and unpaid work, sexual and reproductive health behaviors, HIV/AIDS knowledge and attitudes, childbearing, marriage, and perceptions of social connectedness and safety. The study also includes interviews with heads of youth households, mainly parents, about household demographic composition, living conditions, economic status and shocks, and HIV/AIDS issues.

Social isolation is measured by the sum of a series of questions on social connectedness within one's community: "I have many friends in this community" (1=agree); "Adults in my neighborhood will help other families when they are in trouble" (1=agree); "There is a lot of crime in my neighborhood/community" (1=disagree); "There is lots of violence among youth in this community" (1=disagree); "I would be happier living in a different community" (1=disagree); "People in this neighborhood trust each other" (1=agree). A social connectedness index is constructed by summing the responses above. Relative social isolation is indicated by the quintile into which the particular individual falls within the sample distribution.

Economic vulnerability is measured by relative household wealth. An index of household wealth is constructed by summing the number out of 23 possible consumer durables owned by each household. Although this approach has the disadvantage that relatively inexpensive items are given the same weight as relatively costly items, this measure of economic status has been shown to be a powerful predictor of the impact of economic well-being on demographic and human capital outcomes in developing countries (Bollen, Glanville, and Stecklov 2002). Relative economic vulnerability is measured by the quintile into which the particular household falls within the sample distribution.

For each sexual and reproductive health behavior, appropriate multivariate and multi-level methods will be used to analyze the influence of social isolation and economic vulnerability. Independent explanatory determinants at the individual-, household-, and community-levels include sex, age, population group affiliation, household size, education and sex of the household head, as well as whether the household is rural or urban.

**Preliminary Results**

Our findings indicate that social isolation and economic vulnerability are both associated with higher HIV and pregnancy risk behaviors.

Social isolation is found to be associated with higher risk of early sexual debut among boys and girls. Among girls only, it is correlated with greater risk of coercive or economically-motivated sexual encounters and lower negotiating power in sexual relationships.

Relative poverty is associated with higher risk of early sexual debut for both boys and girls. Among girls only, greater poverty is associated with lower access to media-based family planning messages, higher risk of coercive or economically-motivated sexual encounters, elevated risk of early pregnancy, and lower negotiating power in sexual relationships.

Multivariate work by Hallman (2003) using these data to examine the effects of poverty on sexual and reproductive health behaviors indicates that after controlling for a number of other contextual factors, being poor increases the likelihood of early sexual debut and early pregnancy/parenthood, and decreases the chances of having discussed condom use with most recent sexual partner among both females and males age 14-24. Among females only, poverty raises the risk of experiencing forced sex, exchanging sex for goods or favors, and having multiple sexual partners in the 12 months before the survey. With these same data, Hallman and Grant (2003) demonstrate that poverty is a major determinant of adolescent pregnancy risk in KwaZulu-Natal.

The next step in our analysis will involve examining in greater depth the ways in which social isolation and economic vulnerability interact with each other and the relative contribution of each to adolescent HIV and pregnancy risk behaviors. Multivariate analysis will be undertaken to elucidate the independent effects of various factors on risk behaviors.

**Relevance for Policy and Programs**

Programs and policies aimed at HIV/AIDS prevention among young people in South Africa continue to emphasize the information, education, and communication strategies of behavior change without sufficient attention to the social, economic, and gendered contexts in which these behaviors take place. Furthermore, few programs conduct rigorous evaluations to measure program impact (Focus 2002).

Our emerging research evidence is one element of the groundwork that has been laid for developing with a local partner an evidence-based, well-designed, and rigorously evaluated intervention for young people in KwaZulu-Natal. It will integrate HIV prevention with gender-sensitive elements aimed at addressing young people's social isolation and economic vulnerability. We maintain that lack of attention to these broader contextual circumstances undermines the impact of many current HIV/AIDS prevention and reproductive health programs.