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Policy analysis

"Not on the agenda": A qualitative study of influences on health services use among poor young women who use drugs in Cape Town, South Africa

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ABSTRACT

Background: Poor young women who use alcohol and other drugs (AODs) in Cape Town, South Africa, need access to health services to prevent HIV. Efforts to link young women to services are hampered by limited information on what influences service initiation. We explored perceptions of factors that influence poor AOD-using young women's use of health services.
Methods: We conducted four focus groups with young women (aged 16–21) who used AODs and were recruited from two township communities in Cape Town. We also conducted 14 in-depth interviews with health and social welfare service planners and providers. Discussion topics included young women's use of health services and perceived influences on service use. Qualitative data were analysed using a framework approach.
Results: The findings highlighted structural, contextual, and systemic influences on the use of health services by young women who use AODs. First, young women were absent from the health agenda, which had an impact on the provision of women-specific services. Resource constraints and gender inequality were thought to contribute to this absence. Second, gender inequality and stigma toward young women who used AODs led to their social exclusion from education and employment opportunities and health care. Third, community poverty resulted in the emergence of perverse social capital and social disorder that limited social support for treatment. Fourth, the health care system was unresponsive to the multiple service needs of these young women.
Conclusion: To reach young women who use AODs, interventions need to take cognisance of young women's risk environment and health systems need to adapt to respond better to their needs. For these interventions to be effective, gender must be placed on the policy agenda.

Introduction

Despite decades of investment in HIV prevention and treatment, South Africa has a persistently high rate of HIV incident infections (Shisana et al., 2014). Nearly a third of all new infections are among poor young women aged 15–24, who seroconvert earlier (Shisana et al., 2014) and have up to eight times greater HIV prevalence relative to their male peers (Dellar, Dlamini, & Abdool Karim, 2015). Consequently, preventing HIV infection in this vulnerable group is essential for achieving epidemic control.

Multiple efforts to prevent HIV among this population have been employed; however, these efforts have largely focused on individual behaviour change, such as increasing condom use. More recently, there has been growing acknowledgement that for HIV prevention efforts to succeed, it is critical to understand the physical and social space in which young women's HIV risk

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behaviour occurs and the opportunities that exist within this space for young women to reduce their risk, which taken together are referred to as the risk environment (Rhodes, 1997). In keeping with this risk environment approach, physical and social context (including social disorder, social networks, and social capital) are understood to interact to drive individual risk for HIV and the uptake of opportunities to reduce this risk (Rhodes, 2002, 2009; Tempalski & McQuie, 2009).

South African studies have demonstrated the connection between environment and social conditions and sexual risk behaviour among poor young women. For example, poverty and gender inequality have been identified as drivers of age-disparate and transactional sexual relationships in which young women find it difficult to negotiate condom use (Chapman et al., 2010; Gevers, Jewkes, Mathews, & Flisher, 2012; Jewkes, Dunkle, Nduna, & Shai, 2010). In addition, HIV-related stigma within social networks, limits young women's use of sexual and reproductive health services and has an impact on how young women are treated within these services (Fatti, Shaikh, Eley, Jackson, & Grimwood, 2014; Lince-Deroche, Hargey, Holt, & Shochet, 2015). These dynamics discourage young women's use of health services and the adoption of HIV preventive behaviours (Holt et al., 2012).

While these studies provided insight into the social and structural drivers of HIV risk among poor young women in general, they did not acknowledge the heterogeneity in HIV prevalence found among young South African women. In particular, young women who use alcohol and other drugs (AODs) are missing from policy discussions about how best to reduce the drivers of HIV incidence among young South African women. This is a critical omission because young women who use AODs are likely to be more at risk for HIV infection than young women who do not (Delaney-Moretlwe et al., 2015).

In South Africa, the link between AOD use and risk for HIV infection has been well established (Kalichman, Simbayi, Kaufman, Cain, & Jooste, 2007; Parry & Pithey, 2006). AOD use among young women is associated with multiple, syndemic risks for HIV (Pitpitan et al., 2013). AOD use impairs judgment and decision-making and this has been shown to lead to higher rates of inconsistent condom use (Kalichman, Simbayi, & Cain, 2010; Parry & Pithey, 2006; Wechsberg et al., 2010). Further, women who use AODs report trading sex in exchange for AODs or money to buy AODs, or they may use AODs to cope with sex trading (Parry et al., 2008; Wechsberg et al., 2010; Wechsberg, Luseno, Lam, Parry, & Morojele, 2006), which in itself increases risk of exposure to HIV (Dunkle et al., 2004; Parry et al., 2008). Young women who use AODs are also at increased risk for gender-based violence relative to young women who do not use AODs (Pitpitan et al., 2012; Rosenberg et al., 2015), which decreases the likelihood of condom use (Wechsberg et al., 2010).

These earlier findings suggest that efforts to reduce HIV incidence among young South African women are only likely to be effective if young women who use AODs are provided with comprehensive services—including access to sexual and reproductive health, mental health support, and AOD treatment services—that help them reduce these risks (Sawyer-Kurian, Browne, Carney, Petersen, & Wechsberg, 2011; Wechsberg et al., 2010). Even though South Africa has a relatively well-developed AOD treatment system, comprising both residential and community-based outpatient services that offer a mix of evidence-based behavioural treatment approaches, less than 10% of poor women with AOD use disorders ever seek treatment, despite a high proportion desiring treatment (Myers, Kline, Doherty, Carney, & Wechsberg, 2014). Additionally, young women who use AODs rarely engage with other health services (Flisher et al., 2012; Luseno, Wechsberg, Kline, & Ellerson, 2010). While individual barriers to the uptake of these services have been identified (e.g., Myers et al., 2014), there is little understanding of how the risk environment of this marginalised population influences health service utilisation. This lack of information may hamper efforts to link these young women to health services, which ultimately may undermine efforts to achieve an HIV-free generation in South Africa.

As a first step to addressing this gap, we use qualitative data to explore how the risk environment of poor young women who use AODs in Cape Town informs access to and use of health services. In this study, we included the perspectives of young women who use AODs as well as the perspectives of service providers. The overall aim is to identify structural and contextual factors that should be targeted when developing interventions to improve linkage to health care for this most-at-risk population.

Methods

Study design and setting

As part of a larger study to adapt an evidence-based woman-focused HIV prevention intervention (Wechsberg et al., 2014) for a younger population, we conducted focus group discussions (FGDs) with young, AOD-using women from two peri-urban township communities in Cape Town, South Africa. More than 40% of residents in each of these communities are unemployed, with close to 70% having a monthly household income of less than ZAR 3000 (~USD 300) (Statistics South Africa, 2013). We also conducted in-depth interviews (IDIs) with health and social welfare service planners and providers.

Participants and recruitment procedures

We conducted two FGDs (each comprising 6 participants) with Black African women and two FGDs (comprising 4 and 7 participants, respectively) with Coloured (of mixed race ancestry) women. Outreach workers approached potential participants in settings frequented by young women and described the study before requesting verbal permission to screen them for study eligibility. To be eligible, young women had to be between 16 and 21 years old, live in one of the target communities, report dropping out of school for at least 6 months, report using at least two drugs (including alcohol) weekly over the past 3 months, and report unprotected sex in the past 3 months.

We conducted 14 IDIs with service planners and providers. We generated a list of relevant health and social welfare departments and purposively selected key informants (KIs) from these departments to interview, guided by recommendations from our Community Collaborative Board. To be eligible for inclusion, KIs had to be responsible for planning or delivering AOD, HIV, or other relevant services in our target communities. Project staff contacted these potential participants, described the study, and asked if they would be willing to be interviewed. If a KI was willing to participate, an appointment was made for an interview.

Procedures

All FGDs and IDIs were conducted between September and November 2014. Prior to the start of the FGDs, participants were rescreened to confirm eligibility and were asked to provide written informed consent. FGDs took place in a private room at our study site and followed a semi-structured guide comprising a series of open-ended questions (with probes) about the impact of AOD use on young women's lives and the influences on help-seeking for these problems. Each FGD was facilitated by the U.S. principal investigator and a South African co-investigator, both of whom are experienced in conducting FGDs and one of whom is a trained