Women's status and HIV/AIDS risk prevention strategies: A mixed-method evaluation of the effects of Microcredit Participation in Yaoundé, Cameroon

Carolette Norwood, PhD
University of Cincinnati
Department of African/African American Studies

Abstract:

Recently, development scholars and demographers have given important attention to microcredit organization in the "third-world". Burgeoning research suggests that joining microcredit groups can have important impact on poverty reduction, family planning attitudes and practices, as well as women's empowerment status. Recently, however, advocates of microcredit are touting the usefulness of these programs in raising awareness about HIV and AIDS, and as a means of reducing the spread of the HIV virus through prevention education. Using quantitative and qualitative methods, this study assesses the independent effects of microcredit participation on HIV prevention and risk reduction strategies, women's empowerment status and family planning attitudes and practices in Yaoundé, Cameroon. Additionally, this study qualitatively evaluates local meaning and perception of women's empowerment and family planning, the usefulness of microcredit programs, and barriers to HIV prevention.

Background

Microcredit is an old concept and practice that dates back centuries. In French speaking Cameroon, this practice, locally referred to as *tontines*, is said to have originated among the Bamileke ethnic group in the region of Dscheng. It is a traditional, informal banking system that has been practiced since the pre-colonial era.

Today, microcredit programs are strongly embraced by the international community as a solution to abject poverty. Organizations like the World Bank and the United Nations recognize the potential of grass roots banking systems for the extreme poor and most vulnerable. In fact, the United Nations has proclaimed the year 2005, the year of microcredit.

Microlending schemes in developing countries are fairly common. Today, it is estimated that more than 80 million of the world's poorest people benefit from these operations many of which function to provide women (although not exclusively) with supplemental capital usually in the form of a loan for small-scale entrepreneur ventures and personal savings. Using Cameroon, Central Africa as regional case study, this research assesses the impact of microfinance programs on poverty reduction, knowledge and perceptions about HIV and AIDS, women empowerment status and family planning practices in Yaoundé.

Theoretical Framework

In Africa, national rates of HIV and AIDS infections are highest among women. The most recent statistics from the United Nations suggest that in sub-Saharan Africa 52 percent of adults aged 15 to 49 living with HIV are women. In Cameroon, the prevalence rate for adults in the same age group is even greater; per 100 adults aged 15 to 49, fifty-five percent are women living with the HIV virus.

High HIV and AIDS prevalence rates among women can theoretically be explained as an outcome of migratory work patterns among men which presumably increases the odds of extramarital sexual relations, particularly with sex workers but also mistresses; a lack of male circumcision; and low levels of condom use (Caldwell, Caldwell and Quiggin 1989; Caldwell & Caldwell 1993, 1994, 1996; Bongaarts, Reining, Way and Conant 1989; Bongaarts 1996; Goliber 2002). Additionally, rapid rates of urbanization (which are presumed to have direct effects on migratory labor trends that pull mainly men into the cities often without their wives and family); civil unrest, economic distress, and environmental disasters (all which are presume to cause massive

population movements); and poverty, malnutrition and generally low health status (which leaves individuals more vulnerable and less able to stave off infectious diseases) cumulatively explains the rapid spread of the HIV and AIDS pandemic in Africa (Goliber 2002)and perhaps, the disproportionate effects on women.

Outside of heterosexual sex, there are three chief ways the HIV virus is passed on in Africa (Goliber 1997; 2002): 1) through blood transfusion (mostly because of the inability to screen blood), 2) breastfeeding (which accounts for an estimated 1 in 7 HIV infection among children) (Ratzan, Filerman, and LeSar, 2000), and 3) unsterilized needles (Sabaitier 1987).

This study explicitly tests several micro-level (e.g. individual and community level) HIV risk reduction models. Inspired by Meekers and Klein's (2002) study on determinants of condom use among Cameroonian youth, this study will specifically test the following theories: 1) the health belief model, 2) social learning theory and 3) theory of reasoned action. Additionally, I assess: 1) the Aids Risk Reduction Model theory which measures behavioral intentions, risk perception, and self efficacy; 2) the Bandura Social Cognitive theory which evaluates the environment, behavioral capability, expectation, self efficacy, and observational learning; 3) Stages of Change Model that assess precontemplation, contemplation, preparation and action; and 4) Community organization theory which evaluates empowerment, community competence, participant relevance, and issue selection.

Additionally, two psychometric scales of social support will be assessed in regards to Microcredit membership, namely the Multidimensional Scale of Perceived Social Support (MSPSS) and the Multidimensional support scale (MDSS).

Lastly, this study also broadly addresses those persistent theoretical debates concerning population and development, especially, women, population and development.

Research Design

This study will use mixed-method -*quantitative and qualitative* - research technique to assess the independent effects of membership in a tontine group. This study is cross-sectional and the quantitative and qualitative data are collected simultaneously at one period in time. Moreover, methodological priority is not biased toward either approach.

Quantitative

Much of the demographic literature to date on women and microcredit focuses almost entirely on Asia and Latin America. With Sub-Saharan Africa as a central focus, this project will impart a significant contribution to the burgeoning dialogue on the usefulness and limitations of microcredit for women and their families.

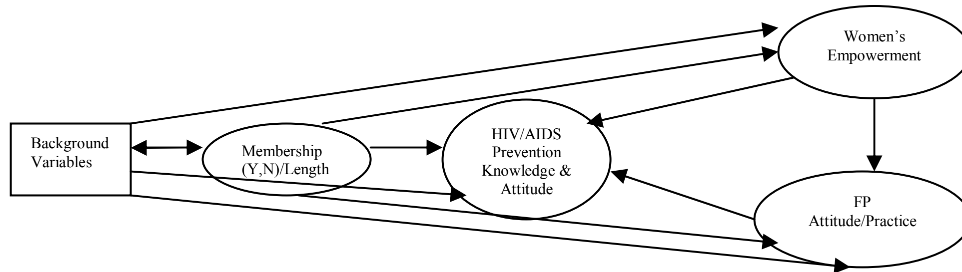
The link between microcredit and women status and family planning practices is unclear. Prior literature suggests that membership in microcredit groups enhances both women status and contraceptive use [***see*** Schuler, Hashemi and Riley (1997, 563); Steel, Amin and Nave (2001, 262); Amin, Yiping and Ahemd (1996, 158); Amin, R., R.B. Hill and Y. Li. (1995, 93); Amin, Sajeda and A.R. Pebly (1994, 121); Schuler and Hashemi (1994, 65); Steel, Amin and Nave (1998,3)]. Yet, other studies caution that women's status and family planning practices maybe elevated prior to membership. In other words, women who join microcredit groups are already empowered prior to membership, have lower fertility and a higher propensity to use contraceptives (Steele, Amin and Nave 2001). A recent study on microcredit in rural Ghana, likewise finds no significant difference between members and non-members in attitudes and practices in family planning, and that empowerment status increases with duration in a microcredit group (Norwood 2004).

Most recently, microfinance has been linked to HIV prevention education. International organizations like the United Nations, the World Bank and the Microcredit Summit are now discussing ways microcredit participation can increase knowledge and awareness of HIV, and perhaps positively influence behavior to reduce risk.

Barriers to HIV prevention among women, in particular, are often linked to issues of financial and personal empowerment. A recent study in Tanzania finds that the most salient barriers to HIV-1 testing and disclosure are firmly linked to conventional measurement of women's empowerment

such as decision-making autonomy and patterns of communication between partners (S. Maman et al., 2001).

Predicated on prior research findings and the theoretic-al assumptions linking microfinance participation to HIV risk reduction strategies, this study will test the following hypotheses (see research model below):



- First, membership (or membership length) in a tontine enhances 1) women's empowerment status, 2)family planning attitudes and practices and 3) HIV/AIDS prevention knowledge (behavioral intentions, risk perception, self efficacy, precontemplation, contemplation, preparation and action);
- Second, women's empowerment status has a direct and indirect effects on HIV/AIDS prevention knowledge (behavioral intentions, risk perception, self efficacy, precontemplation, contemplation, preparation and action) and a direct effect on family planning attitudes and practices;
- Third, family planning attitudes and practices have independent and direct effects on HIV/AIDS prevention knowledge (behavioral intentions, risk perception, self efficacy, precontemplation, contemplation, preparation and action);
- Fourth, background variables such as age, number of children, daily earned income, personal wealth (scaled), level of education completed and age at first marriage influences 1) membership and membership length, 2) women's empowerment status, 3) family planning attitudes and practices and 4) HIV/AIDS prevention knowledge (behavioral intentions, risk perception, self efficacy, precontemplation, contemplation, preparation and action)

The population of interest are men and women tontine members and non-members, age 19 years and older. The anticipated sample size is 300; 100 Active tontine members (e.g. those currently participating or those who have participated within the last 12 months); 100 Inactive tontine members (e.g. those who have participated since one year, but no longer than 5 years ago), 100 Non-members (e.g. never engaged members of tontines and or those who have not been active for more than 5 years ago). Non-probability purposive sampling will be used to select tontine groups, while random stratified sampling techniques will be used to select individual members. Inactive and non-members will be selected via snowball sampling.

A 213-item survey will be administered to the entire sample. The questions inquire about the respondent's demographic characteristics such as age, marital status, personal wealth/savings, number of children ever born and highest level of education completed. The survey also asks about the perceived value of tontine membership, the respondent's knowledge and perceptions of HIV and AIDS, the respondent's behavioral intentions to reduce risk to HIV/AIDS, attitudes about violence against women, personal decision making, reproductive autonomy and family planning attitudes and practices.

Difference in means test by membership status will be used to analyzed using non-parametric Chi square tests for categorical variables and parametric T-test for continuous variables. Bivariate correlation tests will assess if variables are significantly related to one another. The independent effects of multiple variables will be evaluated by logistic and ordinary least squares regression. Lastly, factor analyses will be used for scale development.

Qualitative

The qualitative part of this study is concerned with understanding why women who are aware of HIV and AIDS, and know ways to reduce transmission, "*choose*" not to change sexual behaviors that may increase their susceptibility to HIV and AIDS. The idea of "choice" is firmly linked to issues of empowerment. In this context, women are often unable to negotiate the terms of their sexual relations within or outside of marriage, so understanding the limitations of "choice" is an important component of the qualitative part of this research. Furthermore, this part of the study will explore local meaning of women's empowerment and perceptions of and practice with family planning.

These data will be collected by in-depth interviews. I will do 15 in-depth interviews with about 10 women and 5 men. Non-probability snowball sampling will be used to select interviewees. The estimated length of the interviews is one to five hours.

Interviewees will be probed about their experiences in the tontine and its usefulness for themselves and their families. Details will be gathered about their experiences with and knowledge of HIV and Aids. I am especially interested in understanding why do some individuals decide to have a HIV and AIDS test. The closed ended survey specifically asks respondents if they have taken an HIV and AIDS test. The in-depth interview will especially elaborate on this experience both for those who have been tested and for those who have not. Understanding why some people elect to do the HIV and AIDS test can have important implications for understanding why people who have knowledge about HIV and knows ways to protect themselves from the HIV virus, still make no effort to modify risk in their sexual relationships.

In-depth interviews will be used to get participants to elaborate on their attitudes and practices with family planning and to explain local meaning of empowerment. The close-ended survey will ask respondents about their experiences with family planning and whether or not they approve of it. The in-depth interviews will allow respondents to explain in greater detail about their experience with contraceptives. For instance, how are contraceptives perceived in their communities? What, if any, are the stigmas associated with family planning. Additionally, what is the relationship, if any, between violence against women and reproductive autonomy? What does it mean to say that women have reproductive autonomy or personal empowerment and how is women's empowerment defined in their communities, in their tontines, and for themselves personally.

Guba and Lincoln's (1985) criteria for assessing the strength of qualitative research (e.g. Internal and external validity and reliability) will be used. Namely, "creditability" will be assessed as a substitute for internal validity, "transferability" for external validity, "dependability" as a proxy for reliability and "confirmability" as an alternative to objectivity.

Data gathered in the qualitative in-depth interview stage will be analyzed by open coding and pattern analyses. These data will be used to identify major thematic outcomes regarding experience with and knowledge of HIV and AIDS, local attitudes toward and practices with family planning and local meaning of women's empowerment. The themes that emerge from these data will be cross-verified with select respondents. The overarching intent of the qualitative interviews is to expand on and compliment findings from the quantitative survey data.

Conclusion

The conclusion is tentative. I will be collecting these data this summer and would like present my findings at the Fifth African Population Conference in Arusha, Tanzania this winter.