

Chapter 2

The Sociocultural Aspects of HIV/AIDS in South Africa

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2.1 Introduction

In 2005 the Commission for Africa noted that ‘Tackling HIV and AIDS requires a holistic response that recognises the wider cultural and social context’ (p. 197). Cultural factors that range from beliefs and values regarding courtship, sexual networking, contraceptive use, perspectives on sexual orientation, explanatory models for disease and misfortune and norms for gender and marital relations have all been shown to be factors in the various ways that HIV/AIDS has impacted on African societies (UNESCO, 2002). Increasingly the centrality of culture is being recognised as important to HIV/AIDS prevention, treatment, care and support. With culture having both positive and negative influences on health behaviour, international donors and policy makers are beginning to acknowledge the need for cultural approaches to the AIDS crisis (Nguyen et al., 2008).

The development of cultural approaches to HIV/AIDS presents two major challenges for South Africa. First, the multi-cultural nature of the country means that there is no single sociocultural context in which the HIV/AIDS epidemic is occurring. South Africa is home to a rich tapestry of racial, ethnic, religious and linguistic groups. As a result of colonial history and more recent migration, indigenous Africans have come to live alongside large populations of people with European, Asian and mixed descent, all of whom could lay claim to distinctive cultural practices and spiritual beliefs. Whilst all South Africans are affected by the spread of HIV, the burden of the disease lies with the majority black African population (see Shisana et al., 2005; UNAIDS, 2007). Therefore, this chapter will focus on some sociocultural aspects of life within the majority black African population of South Africa, most of whom speak languages that are classified within the broad linguistic grouping of Bantu languages. This large family of linguistically related ethnic groups span across southern Africa and comprise the bulk of the African people who reside in South Africa today (Hammond-Tooke, 1974).

A second challenge involves the legitimacy of the culture concept. Whilst race was used in apartheid as the rationale for discrimination, notions of culture and cultural differences were legitimised by segregating the country into various ‘homelands’. Within the homelands, the majority black South Africans could presumably

find a space to give free expression to their own culture and language. During this era, language and culture was employed as strategies for cultural preservation and as instruments of resistance to reclaim and reaffirm an African identity (Garuba and Raditlhalo, 2008). A desire to revive and re-dignify African culture and traditional practices, long denigrated through colonial and apartheid processes, has characterised the African Renaissance project of the immediate post-1994 democratic period. Today the cultural terrain remains a highly contested terrain and public debates on culture are often avoided in anticipation of offending personal and political sensitivities. For purposes of this chapter, culture is defined in its most holistic sense following Geertz (1973, cited in Gorringer, 2004) as, 'not only the arts and letters, but also modes of life, fundamental rights of the human being, value systems, and traditions and beliefs that are all suspended in webs of significance that people themselves have spun' (p. 71).

2.2 Contours of the Local Web of Significance

In most African communities of South Africa, Christian influence predominates. Common practices often take the form of religious syncretism whereby people who profess to be Christian and may regularly attend a church and partake in Christian rituals do nonetheless continue to maintain many traditional beliefs and often perform traditional rituals. Such rituals are done mostly to honour dead ancestors and solicit their protection against misfortune. In addition to the formal Christian churches, there are numerous African independent churches that combine aspects of Christian ritual with aspects of traditional culture and religion, and there is currently a growing Christian charismatic movement that extends across the region. Belief in sorcery and witchcraft is deeply rooted and is not uncommon among people who are well educated as well as those who are poor. This seemingly dualistic belief system is visible in peoples' health-seeking behaviours, whereby western biomedicine and modern hospitals and clinics are popular and are widely utilised alongside the services of traditional healers. For the most part, people are able to manage the co-existence of what are essentially logically inconsistent religious traditions (Hopa et al., 1998; Mzimkulu and Simbayi, 2006). While on the whole there is no particular concern with the relationship between the teachings of the Church and traditional religious beliefs, the two religious systems espouse different values with regard to certain behaviours. For example, most African groups are traditionally polygynous and have made allowances for men to continue pursuing women and seeking wives after marriage. While many men today marry monogamously in accordance with Christian rites, many continue polygynous relationships in an informal way through extramarital concurrent partnering.

Across African communities the nature and implications of marriage, descent and residence are very similar. While local variations do occur in the details of different systems, it is largely to the common features of the systems that attention will be directed. The broad similarities in the manner in which marriage is brought about

arise from the common acceptance of three basic marriage rules that have long been prescribed. These are (1) *polygyny* – a man is allowed to have more than one wife at a time if he chooses; (2) *patrilocality* – a woman is expected to join her husband after marriage, either at his own homestead or at that of his father or brothers; (3) *patriliney with bride wealth* – marriage is legitimised in all these societies with the transfer of bride wealth from the husband's family to the wife's family, which traditionally takes the form of cattle. With this transfer a man and his family obtain considerable jural rights over his wife and children. Children born to a union were and are considered to be children of the father, and descent is traced through males. While various historic and modern pressures continue to undermine these traditional social arrangements, the combination system of polygyny, patrilocality and patriliney with bride wealth continues to have important repercussions and influences on the nature of marital relations and social relations more generally.

In traditional times a woman, upon marriage, was taken to the homestead of her husband's family. Once at her new husband's home, she would normally be installed in her own hut where she was expected to live and sleep with her children. In the event that her husband would acquire additional wives, each new wife was entitled to her own separate hut. As a daughter-in-law, the woman was subject to numerous prescriptions for demonstrating 'respect' that defined the way she was expected to interact with and be subordinate to members of her husband's family. Most older written accounts of married life in the various local communities contain descriptions of the sometimes harsh rules and regulations that young in-marrying wives were expected to follow and obey. Still today women are very aware of cultural prescriptions to show respect by deferring to husbands and in-laws. Full acceptance within a woman's patrilineal home was only complete with the birth of her first born child, and especially when that child was a boy. From then on, culture dictated that a woman's term of address within the home would no longer be a term that translated into 'young wife', but henceforth a term that translated into 'mother-of-so-and-so'. As a mother of a child of a particular home and lineage, a woman was then more fully incorporated and accepted into her husband's family. These prescriptions continue to inform ways of thinking about marriage, motherhood and the role of fertility and children in society.

With patrilineal descent, children born to a married woman are socially considered to be the children of the father. It is important to note that while family life has undergone considerable changes over time, with urbanisation, poverty and the migrant labour system continuing to play major roles in the destabilisation of the family, the cultural *ideals* of behaviours related to patrilineal descent, polygyny, bride-wealth exchange and a patrilocally derived social order remain. These cultural ideals have survived generations of colonial and apartheid history in the region and continue to play significant roles in shaping the attitudes, beliefs and values that people hold in relation to their expectations of family life, parent-child relations, husband-wife relations and gender and sexuality more generally.

The shared heritage of polygyny, patrilocality and patrilineality with bride wealth are characteristic of not only a majority of societies in South Africa but across southern Africa. Taken together as the foundation of traditional social life, these

three elements continue to provide important reference points for people living in this part of the world and form the basis of the fundamentally similar sociocultural institutions and practices that are found in the region.

2.3 From Contours to Practices

The sociocultural context contributes to legitimising and giving meaning to the common assumptions, expectations and values that people hold in relation to their day-to-day activities. Some behaviours found to increase the vulnerability of people to HIV infection in South Africa include practices such as multiple and concurrent sexual partnering, age-disparate and intergenerational sex, dry sex practices, unequal gender power relations, high levels of sexual violence, on-going AIDS-related stigma and denial and a variety of practices relating to cultural rites of passage around puberty, marriage and death. Below is a brief discussion of some of the sociocultural factors that play a role in the spread of HIV/AIDS in South Africa. Some of the issues are also discussed in more detail in later chapters.

2.3.1 *Unprotected Sex with Multiple and Age-Disparate Partners*

Whilst traditional polygyny has declined in many African societies, men in present-day South Africa commonly engage in multiple and concurrent partnerships. This is done as much in the pursuit of social and individual validation as it is done in the pursuit of reproductive success, as male virility is often measured by how many sexual partners one has at any given time. Even though polygyny in contemporary South Africa is not the only norm prescribing husband–wife relations, the cultural heritage of polygyny continues to legitimise sex with multiple and concurrent partners and presents a challenge to HIV prevention. In southern Africa, including South Africa, sex with multiple and concurrent partners in the context of poor and inconsistent male condom usage has been identified as the key behavioural driver of HIV (Mah and Halperin, 2008; SADC, 2006).

Negative attitudes towards condom use in sub-Saharan Africa are often based on cultural factors, for example, the desire for children and female sexual compliance are often ways used by women to achieve economic status (Campbell, 1997; Macphail and Campbell, 2001). The use of condoms is believed to be unnatural, a tool used by men to prevent disease or children (Meyer-Weitz et al., 1998; Ulin, 1992). According to these authors, condom use is seen as a ‘waste’ of sperm and that this conflicts with the emphasis on fertility in African culture (Caldwell et al., 1994; Grieser et al., 2001; Lachenicht, 1993). Such beliefs encourage people to engage in high-risk sexual behaviour and risk HIV infection in order to produce male offspring. Despite such beliefs, studies of condom usage continue to reveal that reported levels of condom use are high in South Africa (Department of Health, 2007, Shisana et al., 2005). Nonetheless, as Versteeg and Murray (2008)

point out, the behaviour of having multiple partners remains risky and the use of condoms can give a false sense of safety if not applied consistently in all sexual encounters.

Among the more worrisome forms of multiple partnering are intergenerational relationships where large age disparities between partners are combined with gender power differentials to make young women's involvement with older men especially risky. Since the older men would likely have been sexually active for many years and therefore more likely to be infected by sexually transmitted infections (STIs) including HIV, the younger women risk being infected by these older partners. Rates of HIV among young South African women in the 15- to 24-year age group is disproportionately high, approximately four times that of young men, and in 2007 accounted for 90% of new infections in that age group (Rehle et al., 2007). A further analysis of the same survey data on the intergenerational relationships showed that having a sexual partner 5 years older poses a high HIV infection risk for youth (Shisana et al., 2005). In addition to poverty that prompts many women to engage in transactional sex, South Africa's rapidly expanding economy is creating new needs and wants amongst young women who often view relationships with older, employed men as a relatively easy way to meet their growing desire for consumer commodities (Leclerc-Madlala, 2008).

2.3.2 Gender Inequalities

The patriarchal social arrangements discussed above ultimately serve to coalesce power and privilege into the hands of men while simultaneously curtailing the autonomy of women. The gender dynamics that result from this system put women in South Africa at greater risk of HIV infection than their male counterparts. These inequalities have serious implications for choices that women are able to make in their lives, and provide a supportive backdrop for gender based violence.

- In the first instance, it affects women's capacity to decide with whom, when and how sexual intercourse takes place (Pettifor et al., 2004). Indeed, such decisions are frequently constrained by coercion and violence in the women's relationships with men (Jewkes and Abrahams, 2000). Young girls are often coerced by older men, including male school teachers, into having their first sexual experience with them (Shell and Zeitlin, 2000).
- Second, women are generally not socialised to initiate sexual activity. This task is normally considered to be part of a man's role (Varga, 1997).
- Third, men perceive themselves to be naturally superior to women and often consider it a cultural right to have multiple partners. Such behaviour is generally equated with notions of normative masculinity (Eaton et al., 2003).
- Finally, women are commonly implicated for bringing HIV into a relationship while their male counterparts are culturally absolved of blame for the disease (Leclerc-Madlala, 2002).

2.3.3 Stigma, Denial, Exclusion and Discrimination

Rates of denial are still high in South Africa and continue to present an enormous challenge to tackling the epidemic. Cultural manifestations of denial, AIDS-related stigmas and discrimination varies from culture to culture (UNESCO/UNAIDS, 2002). Even so, in many traditional African cultures, illness is attributed to spirits and supernatural forces (Aids Weekly, 2001; van Dyk, 2001), and these beliefs may be associated with stigmatising afflicted persons. Schoepf (1995) argued that the meanings ascribed to heterosexual penetrative sex with ejaculation contribute to the denial of risk. Heterosexual penetrative sex is considered as 'normal and natural', and is invested in cosmological significance, strongly valued by many as the essence of life, beauty and survival of the individual, family and community (Schoepf, 1995). These significations according to Schoepf (1995) contribute to the denial of risk, to stigmatisation of the afflicted and their families and to withdrawal of social support. As elsewhere, HIV/AIDS is widely perceived to be an outcome of sexual excess and low moral character. At the time when those infected really need social support the most, people living with HIV/AIDS who reveal their status are often subjugated to victimisation and discrimination (Rankin et al., 2005; Siyam'kela Project, 2003). This happens everywhere starting from their own homes, within the communities they live in, as well as at work. Consequently, there is a strong culture of silence by people living with HIV/AIDS because of fear of rejection and isolation from both close relatives and the community at large (Johnston, 2001). The stigma is particularly more severe for women than for men (Petros et al., 2006; Skinner and Mfecane, 2004). One of the consequences of the problem of ongoing stigma, exclusion and discrimination of people living with HIV/AIDS is that it forces those who are infected to hide their condition by going 'underground' and to continue engaging in high-risk behaviour (Qwana et al., 2001; Strydom, 2000).

2.3.4 Substance Abuse

South Africa, like most other countries in southern Africa, consumes great quantities of alcohol. Like in other parts of the world, alcohol use has a long history in southern Africa, dating back hundreds of years and spanning social, cultural and economic spectrums (Nielsen et al., 1989). Alcohol has long been used during cultural rituals and ceremonies to celebrate various occasions, ranging from weddings, the birth of children, during initiation, during harvests and after people have passed away. Indeed, such occasions are also used extensively for sexual networking (Pattman, 2001).

It has been estimated that South Africans consume 6 billion litres of alcohol per year (Patta, 2008). There is growing local empirical evidence that suggests a link between substance abuse and HIV infection. A number of studies have advanced the alcohol-risky sex hypothesis and have found some evidence which supports the hypothesis that alcohol intake increases sexual risk-taking behaviour (Fisher et al.,

2007; Kalichman et al., 2007; 2008; Kiene et al., 2008; Morojele et al., 2005). When alcohol or any other illicit drug is consumed in excessive amounts, it has been found to inhibit a person's ability to engage in safer sex practices such as using condoms correctly and consistently. Thus, a person under the influence of alcohol or drugs is highly unlikely to be able to protect him or herself from being infected by HIV when having sexual intercourse with an infected person. With both alcohol and drug use on the increase in South Africa, the HIV infections linked to this route are also bound to increase. In particular, the use of hard drugs such as cocaine, mandrax (especially in the Western Cape Province of South Africa) and dagga among the youth appear to be growing rapidly (Parry et al., 2004).

2.3.5 Dry Sex or Vaginal Douching

Dry sex or vaginal douching is practiced primarily for increasing the sexual pleasure of men (Baleta, 1999; Beksinska et al., 1999). Pleasing men in this way is important to women, either for economic survival as in the case of sex workers (Abdool-Karim et al., 1995), or for maintaining a good marriage, as in the case of a wife meeting the sexual desires of her husband. The combination system of polygyny, patrilocality and patriliney with bride wealth prescribe certain cultural expectations of the 'young wife' that are steeped in norms and values that effectively promote cultural ideals aimed at pleasing her husband. Cultural conceptions of what it means to be a 'young wife' and a woman usually conform to notions of femininity as sexually innocent and inhibited. According to Leclerc-Madlala (2002) and Levin (2005) in the context of cultural influences in modifying vaginal function, this behaviour usually conforms to pervasive patriarchal cultural concepts that 'wet sex' is indicative of female infidelity, uncleanliness, possible infection and moral 'looseness' on the part of the woman.

This practice often involves either cleaning the vagina with a variety of substances, including antiseptics and detergents, or inserting traditional herbs into the vagina and drying it with paper or cotton prior to or after having sexual intercourse (Louria et al., 2000). Some drying and tightening agents are used as 'love potions' to retain the affections of a partner. These practices have implications for the acceptability of HIV prevention strategies such as the use of condoms and vaginal microbicides (Bagnol and Mariano, 2008; Morar et al., 2003). By disturbing the vaginal flora or causing extensive local irritation and inflammation of the vaginal walls, this practice could possibly impact on the female infection with and the spread of HIV (Levin, 2005).

2.3.6 Cultural Practices and Ritual Activity

A host of rituals surrounding the life transitions of birth, puberty, marriage and death have been identified as cultural factors specific to the African continent that are

influencing the spread of HIV (UNECA, 2008). In South Africa, these include the following:

- *Traditional male circumcision.* Circumcision has long been practised in various forms among various ethnic groups. Youth who have reached puberty among the Xhosa, Ndebele, Pedi, South Sotho and Venda partake in initiations, which include circumcision. For the most part, these are conducted by traditional surgeons in deep rural areas under highly unhygienic conditions using the same unsterilised instruments on several of the initiates. In some cases, the newly circumcised young men are encouraged to engage in sex soon after initiation with a woman whom they do not intend to marry. Moreover, according to Vincent (2008), for many initiates circumcision has come to be viewed by many as a permit for sex within a context of gender relations characterised by coercive sex. Considering these wider contextual issues, more scientific evidence is required to ensure that the benefits of circumcision outweigh any potential risks (Byakika-Tusiime, 2008). Even though there has been sufficient evidence of empirical studies conducted in southern Africa of the protective effect of male circumcision against HIV infection (Byakika-Tusiime, 2008; Halperin and Epstein, 2007; Westercamp and Bailey, 2007) many authors warn that male circumcision should be examined and promoted with sensitivity to the specific local cultural contexts (Connolly et al., 2008; Peltzer et al., 2007; Vincent, 2008).
- *Virginity testing.* While this method has been a part of traditional prevention measures to guard against the early onset of sexual behaviour, there has been a resurgence of interest in virginity testing over the past decade to encourage sexual abstinence among young women (Leclerc-Madlala, 2002). Especially popular in Zulu and Swazi communities, virginity testing today is largely conducted by elderly women who often use the same latex glove to insert their fingers into the vaginas of dozens of girls. In order to avoid the social stigma that results from being found to be a non-virgin, girls sometimes engage in unprotected anal sex as a way to retain their virginity while satisfying their boyfriends (McKerrow, 2000). This puts young women at great risk of HIV infection.
- *Fertility and virility testing.* The importance that African culture places on fertility often prompts young women to fall pregnant during their first relationship as a way to prove their fertility before getting married. Wechsberg et al. (2005) argue that this cultural tradition encourages early unprotected sexual activity. Similarly, a major way for a man to prove his virility and potency is by making a woman pregnant (Lesetedi, 1999).
- *Fertility obligations.* Due to social inequality between the sexes and ideas of male superiority, a wife is automatically blamed for infertility and accused of witchcraft as well as being ostracised by society even if it is the husband who is infertile. In some cases, members of the family meet to discuss the problem often without the knowledge of the couple, and encourage a close relative to befriend the wife with the intention of impregnating her and subsequently producing an offspring for the infertile couple (Nxumalo, 1999). Sometimes a sister

or brother is asked to assist an infertile sibling or close relative to have children. In both cases, the large degree of jural rights over a woman that a man's family acquires through the payment of bride wealth gives women little choice in the matter, otherwise facing the risk of being divorced from her husband should she refuse. These fertility obligations encourage the spread of HIV infection among the people involved if one of them is HIV positive.

- *Post-partum sex and breastfeeding taboos.* In many African communities, post-partum sex was traditionally discouraged between the husband and wife for sometimes up to a year or until the child has been weaned from breastfeeding. Sexual activity during this period was seen as polluting the blood of the nursing mother and thus detrimental to the health of the child. The association of sexual taboos with childhood health conditions is widespread among African societies in South Africa and continues to be a factor in men's involvements with women outside of marriage. During confinement and breastfeeding, men are often expected to seek other women to satisfy themselves sexually.
- *Death rites.* There are two main customs that continue to be practised to varying degrees in South Africa. The first is the *levirate*. This refers to a situation whereby when one of the two partners in a marriage dies, a brother or sister of the dead partner inherits the remaining spouse. In South Africa, patrilineal descent dictates that it is usually the woman who will be 'inherited' by one of her dead husband's male relatives. The second is known as the *sororate*. As noted above, in order to ensure that the relationship developed by the two families at marriage produces some offspring and does not dissolve, a widower or sometimes a husband of a barren woman marries his wife's sister. In cases where one partner in the new relationship may be infected with HIV, this increases the chance of the new partner will also become infected.
- *Indigenous healing practices.* In most African countries and indeed throughout the world, modern (i.e., western) and traditional (i.e., indigenous) healing systems co-exist side by side (Hopa et al., 1998). Even though the western system is dominant in terms of both official status and scientific acceptability, the traditional counterpart is more widely accessible as well as being used due to pervasive traditional health beliefs. People who live in rural areas, which generally have poor western medical services, depend mainly on the services of traditional healers. Consequently, a majority of the people, estimated to be about 80% of the South African population, consult with traditional healers for treatments of most ailments (UNAIDS, 2006). There are two main indigenous healing practices that are thought to contribute to the spread of HIV in South Africa. First, the use of unsterilised sharp instruments, such as knives, blades, spears, animal horns, quills and thorns, as surgical tools when treating patients is problematic. Second, and more importantly, healers sometimes have sex with their clients as a way to cure a number of ailments, including infertility and depression. Some healers also recommend that their clients have sex with virgins as part of their treatment regime for illnesses such as STI and HIV infection. Both practices enhance the chances of acquiring HIV.

2.4 Conclusion

In South Africa, many customary and contemporary influences have combined to result in present-day practices, beliefs, norms and values that play significant roles in impeding the adoption of safer sex practices. Some elements of culture have changed through time while some have persisted, others have mutated and still others have disappeared while the ideals and values that they reflect continue to shape the way people think and feel about certain behaviours. New elements of culture have also arisen and have been added to the milieu in which sexual decision making, amongst other things, is taking place. Foreign media densification along with a host of more recent globalising and modernising processes are adding their own shaping influences to the sociocultural environment in which the HIV/AIDS epidemic is occurring.

Making HIV prevention more effective in South Africa will require approaches that are better attuned to the cultural specificities of the people concerned. This in turn will require a deeper understanding of the role of culture in the production and management of disease. Culture is far more than a collection of easily identified and measured beliefs and practices; it is about that which gives meaning and purpose to human life. Taking a cultural approach to the problem of HIV/AIDS means taking into account the particularities of the sociocultural domain at each stage of the intervention process, from conceptualisation and design of policies and programmes to evaluation of outcomes and impacts. Thus far, there has been little evidence of any serious attempt to do this either at the level of HIV policy making or programming in South Africa. There remains a need to engage more directly with the sociocultural factors that make our local communities so exceptionally vulnerable to this disease.

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