**HIV/AIDS: Understanding Socio-Cultural Factors and their Influence on Sexual Behaviour and Decision Making in Africa**

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**Introduction**

HIV/AIDS is one of the most widespread and lethal diseases occurring in the world today. During 2007, approximately 33.2 million people were living with HIV and 2.1 million deaths were due to HIV/AIDS. Approximately 26 million of those people living with HIV, and 1.6 million of those deaths, were in Africa alone (UNAIDS 2007). In Europe and North America new drug tests and preventive measures are currently being researched to help stop the transmission and spread of HIV/AIDS. In much of the developing world, however, where HIV/AIDS is a larger problem because of the portion of the population affected, such simple preventive measures (in Western biomedicine) as encouraging condom use are not very successful. This leads to the question of why such preventive strategies, often implemented by developed countries for developing countries, do not work. In order to fully understand the effects of HIV/AIDS in developing countries, particularly in Africa, one must be able to take into account the political, economic, ecological, social, and cultural factors that influence the representations of HIV/AIDS and the ways in which Africans perceive their health outlook. Essential to this understanding, is awareness of the context in which decisions regarding health, health-seeking behaviour, and sexual behaviour are constructed (Falola & Heaton 2007: 8). In this paper, there will be an exploration of the cultural ecology of HIV/AIDS in Africa; an examination of socio-cultural factors and preventive programs that encourage safe sex practices; and how cultural beliefs and social practices influence, and are barriers to, sexual behaviour and the effectiveness of preventive strategies such as condom use. Lastly, an analysis of how anthropological studies of socio-cultural factors can contribute to developing culturally appropriate HIV/AIDS intervention and preventive programs will be presented.

**Cultural Ecology of HIV/AIDS in Africa**

The depiction of Africa as an infectious continent continues to exist today because of the increasing number of HIV/AIDS cases since the early 1980's. Issues regarding economic limitations and financial and political instability are among some of the factors involved in HIV/AIDS prevention; however, it is cultural beliefs and attitudes, which influence sexual behaviour choices, that represent the greatest barriers to preventive strategies, such as increasing condom use (Falola & Heaton 2007: 4, 11-12). High HIV transmission rates continue to exist in many Sub-Saharan African countries despite the increasing rates of condom use. This paradox can be explained by examining the kinds of relationships in which condoms are used and by addressing the issue of inconsistent use, along with various
social and cultural beliefs and attitudes that may influence sexual behaviour (Chen & Hearst 2004: 41, 42). Practicing safe sex is the only means by which most of the world's population in developing countries can protect themselves from HIV/AIDS. As a result, research has largely concentrated on distinguishing barriers to safe sex in the developing world. The most commonly researched topic is the degree to which cultural beliefs and attitudes influence decisions about sex. For example, one topic of interest is how indigenous beliefs and illness representations, such as the cultural belief that AIDS is caused by witchcraft and sorcery, influence decisions regarding sexual behaviour among Sub-Saharan Africans (Barrett et al. 2005: 692). In other words, the question being asked is whether cultural beliefs, attitudes, and practices are influencing people's decision making in sexual situations, specifically with practicing safe sex.

**Socio-cultural Factors and Preventive Strategies Encouraging Condom Use in Africa**

Anthropological research on sexual behaviours and sexual decision making in Africa has contributed to prevention endeavours in three ways. First, anthropologists have presented information on specific cultural and sexual practices related to HIV transmission. Secondly, anthropologists have researched the cultural meanings of sexuality in Africa. Finally, by examining the social and economic contexts in which sexual behaviours are practiced, anthropologists have contributed to a broader understanding of the factors influencing sexual behaviour in Africa (Young 1994: 5).

Some of the socio-cultural factors which influence preventive strategies and decrease the use of condoms in developing countries include gender inequality in relationships, toleration of male promiscuity, high value placed on fertility, and patterns of inheritance and land ownership that do not require daughters to remain virgins in order to obtain property and possessions through marriage (Barrett et al. 2005: 692). Socio-cultural barriers to practicing safe sex include a woman's lack of sexual decision-making power, men's dislike of condoms, a denial of HIV/AIDS, the importance placed on family, and the fear that the suggestion to use condoms will elicit suspicion from one's partner and result in social rejection and stigmatization (Meursing 1999: 35). Women are, therefore, at a particular disadvantage regarding safe sex as a result of these cultural practices: gender hierarchies, sexual cleansing, polygyny, the preference for dry sex, and the importance of female fertility increase the chance of HIV transmission. As a result, women are not usually in a position to negotiate condom use (Falola & Heaton 2007: 352, 361). Thus, the relationship between a society's social organization and associated gender inequality, which may affect HIV/AIDS prevention strategies and hamper their efforts to prevent HIV transmission, needs to be understood. A look at the relationship between socio-cultural practices that pertain to women and HIV/AIDS includes the movements of individuals or groups, fertility ideas and practices,
the position of women in society, and traditional protective barriers. In turn, there are a number of socio-economic factors that also appear to have an impact on HIV. These factors include the difficulty that many women face in finding regular employment, which forces them into commercial sex work; a lack of proper education and knowledge on HIV/AIDS and safe sex practices; and social mobility patterns (Lawson 1999: 391, 393, 395-396). Prostitution is a critical risk factor for the transmission of HIV/AIDS, but is often a last resort, and economic survival strategy, for women struggling to take care of children. Commercial sex workers, in turn, are often linked with the employment of men in distant locations; for example, long-distance truck drivers (Morisky et al. 2006: 122). Other socio-cultural factors include the belief that African men are promiscuous and are allowed to have several sexual partners, the legalization of polygamy, and the belief that HIV/AIDS is a punishment from God (Falola & Heaton 2007: 228, Lawson 1999: 394, and Parker et al. 2000: 28).

Cultural beliefs about the representation and causes of HIV/AIDS may also have an effect on sexual behaviour choices and the way that people measure their risk of HIV infection. In fact, since many cultures in Sub-Saharan Africa believe that STD’s and HIV/AIDS are caused by witchcraft or sorcery, safe sex is neither necessary nor perceived as appropriate protection against HIV/AIDS. In addition, if the exchange of bodily fluids is seen as mystical, rather than physical, then the relationship between practicing safe sex and HIV/AIDS prevention is weakened further. Many purification rituals also increase the risk of HIV infection, since they may include practices such as bloodletting and ejaculation. Lastly, Western biomedical messages about prevention, in terms of practicing safe sex and/or abstinence, challenges one of the central cultural beliefs of traditional African cultures that focuses on the life-enhancing forces that are conveyed through fertility and the opportunity for sexual release (Barrett et al. 2005: 697, 698). Examples of additional socio-cultural practices that may be seen as vehicles for HIV transmission include traditional rituals such as circumcision (mixing of blood); religious institutions that promote engaging in sex without condoms; and traditional healers who gave men instructions to sleep with young girls who are virgins in order to cure HIV infections (Falola & Heaton 2007: 369). Thus, the social and cultural factors that influence sexual relationships and decision making in Africa are quite impressive and complex. Some cultural beliefs about sexual practices may be so strong that changing behavioural choices, such as encouraging increased condom use, fail.

The “Condom Barrier”: Examples from Africa
Throughout most of Africa today, condoms are used almost entirely outside of marital relations, and mostly in commercial and causal sex. In many African countries barriers to practicing safe sex are associated with condom use and include some of the following issues; cultural beliefs,
myths, and attitudes; a lack of knowledge about condom use; the belief that condoms contain worms and spread HIV/AIDS; unplanned sex permits no chance to use condoms; sex with condoms is not as pleasurable as sex without; sex without condoms represents the closeness of that relationship and is a sign of young love; condoms give raise to suspicion and distrust; the issue of power relations in which the male is dominant and may refuse to wear condoms; and other local myths about condoms that stop people from using them (Caldwell 1992: 247 and Falola & Heaton 2007: 373-374). Other issues and factors hindering consistent condom use include the cultural value and importance of flesh-to-flesh contact in which condoms are perceived to prevent that intimacy. The use of condoms is believed to be either a statement of other sexual relations or of knowing one is HIV-positive. It is also attributed to fear that condom usage will prevent conception and identify women as being sterile, and therefore linked to a fear of stigma and psychological avoidance and denial. This fear extends to the fear that condoms will stop the sharing and exchange of bodily substances, which have symbolic significance (Caldwell 1999: 247-248, Falola & Heaton 2007: 359, and Meursing 1999: 37). Some men refuse to wear condoms because they claim it is not in their culture to do so; however, traditional healers dispute this argument by saying that some of their forefathers had a type of condom made out of used goat intestines. Refusing to use condoms, then might be more of a lack of knowledge on how to use them, especially in cases where the instructions are in another language and people are embarrassed to ask for help (Falola & Heaton 2007: 228).

Studies among the population of KwaZulu-Natal in South Africa found little consistency in either opinions of condoms or reported protective behaviour. Common socio-cultural barriers to embracing protective behaviour against HIV/AIDS are critical topics of research implemented to understand why some preventive strategies, especially those encouraging the use of condoms, have been unsuccessful throughout many parts of Africa (Preston-Whyte 1999: 139). South Africa is characterized by a number of high-risk practices, such as: sexual intercourse at an early age, low contraceptive use, multiple partners and sexual networks, weak sexual negotiation skills between males and females, political instability, and barriers to both abstinence, (such as peer pressure and the social and cultural value placed on sexual intercourse) and condom use (Varga 2000: 67-69). The non-use of condoms and the cultural values related to fertility make up what Preston-Whyte (1999: 141) calls the “condom dilemma” (or the “fertility conundrum”). Condoms are steadily increasing in acceptance within causal relationships, but have made little progression into longer-term, monogamous relationships. The issue of trust is vital, since requesting the use of condoms may provoke suspicions. Other issues within the “condom dilemma” include the decrease of sexual pleasure; the fact that some people would just rather not have to use a condom; the
perception that long-term and/or serious partners are risk-free and do not need protection; and the connection condoms have with the treatment of sexually transmitted diseases, which creates negative stereotypes of their use. In turn, negative attitudes towards condoms tend to be reinforced, sometimes by healthcare workers, such as nurses, that object to handing out condoms to young girls at healthcare facilities, coupled with the embarrassment that some girls may feel in asking for protection (Preston-Whyte 1999: 141-143). In South Africa condom use is a particularly difficult and complex issue, with many negative implications, due in part to the manner in which condoms were first brought into the health care system alongside the introduction of HIV/AIDS and because they were seen as an instrument of the apartheid government in order to keep the black population in check. As a result, many people came to identify condoms with HIV transmission and with female infidelity and prostitution (Varga 2000: 68-69).

The “fertility conundrum” may be one of the greatest cultural barriers to HIV protection and the promotion of the use of condoms, especially when women are looking to become pregnant. There is high value placed on both fertility and quick procreation after marriage, in addition to the importance of family and the social maturity and respect that is believed to come with having children. There is also a fear that in using condoms a woman will be labelled as “barren”. The importance placed on fertility is further demonstrated through the notion that a man will not marry a woman unless she has a child with him because this can be perceived as infertility. Another barrier to condom use is the influence of urban and rural myths around the causes and spread of HIV/AIDS. For example, there are local myths that having sex with a virgin is a cure for HIV and that condoms, can come off and get stuck in the female (Preston-Whyte 1999: 143, 147). Thus, one needs to have insight into some of the broader social and cultural contexts that influence sexual decision making and behaviour. Some of these contexts include issues concerning adolescent sexual decision making. Condoms were never initially given out to women and girls, but even though this has changed there is still a disinclination to give condoms to young girls because of the belief that it promotes having sex. In turn, the lack of restrictions against having children outside marriage, coupled with the positive attitudes towards fertility, make the use of contraceptives unimportant for adolescents. This viewpoint is quite the opposite of Western societies in which unwanted pregnancy encourages people to use condoms. Lastly, economic conditions are also major barriers to safe sex behaviours, especially when single unmarried women need to continue having children in order to draw new male protectors (Preston-Whyte 1999: 146-148).

Uganda
In Uganda one of the barriers that restricts and influences people’s sexual behaviour, and helps to account for the very low rate of condom use, is the local churches, which have reacted negatively to the distribution of
condoms as the principal means of prevention. The Church has two arguments; the first is that through promoting the use of condoms one is encouraging greater promiscuity and thereby increasing the spread of AIDS. The second argument is that condoms are defective and have leaks, therefore, they are not reliable and abstinence is the only option (Morisky et al. 2006: 9, 163). Looking at this critically, the first argument may be valid in terms of condoms promoting a sense of immunity from HIV, but condom use itself has yet to be proved to be related to spreading AIDS. The second argument is not as valid because many condoms are not used properly or consistently. People, therefore, need to be educated on how to use condoms in a manner which they understand and can incorporate into their own cultural context.

Another barrier to the use of condoms in Uganda is that condoms are not widely trusted by the population because people believe they are not effective against HIV infection and that they could get stuck in the female and lead to either serious illness or other problems (Morisky et al. 2006: 263-264). Tradition creates barriers to decreasing the spread of HIV/AIDS and changing sexual behaviour. For example, among the Zulu men are expected to father children with different women before being married or it is a sign that they are weak. Therefore, men will often refuse to wear condoms. In turn, because of their subordinated status, women often cannot request the use of condoms or resist having sex, nor can married women stop their husbands from having multiple partners. In addition, many teachers and parents are uncomfortable with discussing sex with their children and some cultural norms may even prevent them from doing so (Morisky et al. 2006: 26, 118-119, 120, 282). Since discussions of sexual behaviour may be taboo, the importance of mass media campaigns promoting safe sex practices is even greater.

Malawi

In Malawi, the condom is often considered an “intruder” in the marriage because of three critical issues and beliefs. First, the rate of condom use within marital relations is low because of its symbolic nature and the fact that condoms impede the natural sexual act that is linked with marriage. It is believed that if condoms are used the marriage is not a real marriage. Second, there is only ever discussion of using condoms in the context of preventing HIV/AIDS in extramarital, causal relationships. Finally, the thought of talking about condom use for preventing HIV/AIDS in marriage is like bringing an intruder into the domestic space. Thus, changes in attitudes about condom use and sexual behaviour are only happening outside of marriage (Chimbiri 2007: 1102, 1113). During the late 1960’s the Malawi government banned family planning and condoms were proposed by healthcare workers as a method for HIV/AIDS prevention outside marriage (particularly in commercial sex work) and only as a back-up contraceptive method within marriage. At the community, state, and international levels condom use is rejected on a moral foundation through religious beliefs. At the individual and couple levels there are
social issues related to condom use, which include a decrease in sexual pleasure and the full "sweetness" of flesh-on-flesh contact; the harmful effects on users; ineffectiveness of condoms; and the belief that condoms can increase the risk of transmission of HIV/AIDS and TB. The most important issue, however, is that condom use is a symbol of the type of relationship and that by bringing condoms into a serious relationship, one is thereby indicating that the relationship may not be exclusive and that there is a fear of becoming infected with HIV/AIDS or other sexually transmitted diseases (Chimbiri 2007: 1103, 1104, 1112).

**South Africa**

Since condoms tend to be generally permitted in causal sex relationships, an examination of socio-cultural and economic factors associated with condom use among South African commercial sex workers will further exemplify socio-cultural barriers to preventive strategies and the "condom dilemma", as well as illustrate the contrast between condom use in professional versus private sex situations, the issues of financial strain, the negative symbolism of condoms, and the small effect that HIV/AIDS has had on condom use because HIV/AIDS is a minor threat when viewed against pressing practical and economic concerns (Varga 1997: 74). The commercial sex industry has long been associated with disease, and research commonly targets commercial sex workers as a high risk group for sexually transmitted diseases. Key reasons for commercial sex workers to have unprotected sex include limited access to condoms, financial incentive of more money for sex without condoms, clients' refusal to use a condom coupled with physical abuse and a low self-perceived risk for HIV infection. Other cultural barriers to condom use include the value of personhood and social unity through the mixing of bodily fluids; the belief that condoms take away male control in a relationship; and the idea that condoms reflect a females status as untrustworthy, uncommitted, and dirty through being promiscuous and a possible carrier of HIV/AIDS. Among commercial sex workers, sex with clients is seen as dirty and impersonal, and therefore in need of condoms; while personal partners are seen as clean and trustworthy and not in need of condoms. Thus, the barriers to condom use with clients are practical and environmental factors, while the barriers to condom use with personal partners are deep-rooted socio-cultural and ideological factors (Varga 1997: 75, 77, 79, 82, 83).

**Botswana**

The rapid transmission of HIV/AIDS in Botswana has been due to three main factors: the position of women in society, particularly their lack of power in negotiating sexual relationships; cultural attitudes to fertility, especially the cultural belief that single women have to have a child in order to prove that they are fertile and to clean out their womb so they are not deemed unclean; and social migration patterns that spread HIV/AIDS into isolated rural areas. Botswana is different from other African countries in that there is a high rate of internal migration because most households have
traditionally retained several homes which they move between. These factors, which influence the spread of HIV/AIDS and represent barriers to preventive strategies, have developed within the individual context of Botswana’s cultural setting and socio-economic development. Other factors involved with the transmission of HIV/AIDS include the denial of any such disease, for example, there is no word in Setswana for “AIDS”; cultural opinions and behaviour concerning sex as a commodity for sale; the occurrence of other sexually transmitted diseases which are considered to aid in the transmission of HIV; and an increase in the number of casual sex partners (MacDonald 1996: 1325, 1327-1329, 1331, 1332). Misconceptions and myths about condoms and HIV/AIDS in Namibia is another example of socio-cultural factors, which influence condom use and make up the “condom barrier”. Even when male or female condoms are widely available, condom use is not consistent or universal. Myths and cultural beliefs about sexually transmitted diseases and HIV/AIDS include the belief that HIV is not related to sex; AIDS is a punishment from God; those infected with AIDS purposefully spread the disease so that they do not die alone; and the denial that AIDS is present within one’s family. Myths about condoms include the belief that men put holes in condoms and they are not safe; condoms cause disease; those who are already infected with HIV do not need to protect themselves by using condoms or practicing safe sex; condoms handed out by the government are of low quality; and sex with a condom is not real sex (Mufune 2005: 676, 679-682, 685).

Zambia
Lastly, an example from Zambia presents a critical look at how the fact that research is often focused on cultural barriers that are seen as increasing the spread of HIV/AIDS is actually placing the blame for the spread of AIDS on African cultural practices. The major problems associated with HIV/AIDS prevention strategies involve the negotiation of safe sex rather than the cultural barriers such as polygamy, sexual cleansing, dry sex, circumcision, and beliefs in witchcraft. These cultural practices may be responsible for hastening the spread of HIV/AIDS, but they are not as important to preventive strategies as other more basic underlying issues such as the economic position of women, the lack of knowledge and communication between males and females, an association of condoms with mistrust and infidelity, and the lack of privacy in access to condoms (Gausset 2001: 509-510, 512-515). This argument is legitimate in many ways, but it fails to recognize that an anthropological study of the socio-cultural factors that influence preventive strategies is required in order to understand the social and cultural context in which sexual decisions are made, so that future intervention and development programs can be culturally appropriate and help encourage sexual behaviour choices that are geared towards practicing safe sex and not towards changing cultural practices themselves.
Conclusion

Ignoring the cultural beliefs and attitudes that African societies have about HIV/AIDS is counterproductive to the development of culturally appropriate and effective HIV/AIDS prevention programs (Barrett et al. 2005: 698). There is a need for HIV intervention and preventive programs, including condom distribution, to be designed around the intended population and locally specific needs. In addition, there needs to be a change in sexual behaviour choices, without changing cultural practices and beliefs, in order to stop the transmission and spread of HIV/AIDS. Preston-Whyte notes that: "...imported and inappropriate intervention programs may be, in themselves, barriers to behavioural change, in that by their very irrelevance to local concerns, they may promote negative reactions to the intended prevention message" (1999: 140).

Thus, preventive programs should try to make sexual behaviour and practices safer in a way that is culturally appropriate to people. Changing a society's behaviour, however, can be very complex. Given the situation of HIV/AIDS in Africa, along with the various socio-cultural factors, there needs to be increased promotion for condom use among high risk groups, more precise measurements of the effects and success of condom promotion, more research on how to best incorporate condom promotion with other preventive strategies and safe sex practices, encouraging condoms to be used in all sexual relations and not just casual ones, and a decrease in the number of sexual partners per person (Chen & Hearst 2004: 39).

To "outsiders" the sexual behaviour and decision making of societies in Africa may appear irrational, but from their own perspective their behaviour is both rational and appropriate given the circumstances. Therefore, what must be understood when implementing preventive strategies and programs, such as free condom distribution, is the cultural and situational contexts, the local influences on behaviour, the socio-cultural influences and barriers on behaviour, and the importance of local indigenous cultural practices and systems (Preston-Whyte 1999: 152-153). As a result, there is a need for research directed at recognizing contextual socio-cultural factors, beliefs, and practices that influence sexual behaviour choices and the distribution of HIV/AIDS in Africa. Such information may contribute to understanding the forces influencing people's decisions to use or not use condoms, and may be a step towards developing appropriate and successful HIV/AIDS interventions. An anthropological approach, therefore, offers a valuable perspective in developing solutions to HIV/AIDS intervention and preventive strategies, by understanding the socio-cultural responses to HIV/AIDS, including how societies conceptualize it, its symptoms, and its treatment, and the possible influence of socio-cultural factors upon sexual behaviour. In addition, anthropology can help one understand why people behave the way they do, and not just what people know and do with regards to sexual behaviour (Lawson 1999: 396 and Varga 1997: 78). By
offering an ecological viewpoint on human behaviour and decision making, anthropological research is important in determining the factors that influence sexual behaviour and in proposing ways to encourage positive changes. Such work can make significant contributions to all stages of HIV/AIDS intervention programs and preventive strategies (Varga 2000: 69).

References


