HIV/AIDS in South Africa 25 Years On

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Editors

HIV/AIDS in South Africa 25 Years On

Psychosocial Perspectives

Foreword by Edwin Cameron

Springer

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ISBN 978-1-4419-0305-1 e-ISBN 978-1-4419-0306-8
DOI 10.1007/978-1-4419-0306-8
Springer New York Dordrecht Heidelberg London

Library of Congress Control Number: 2009931924

Foreword

AIDS has been one of the defining challenges of our time. On our continent Africa, more so, because its greatest global burden is here, where wealth is least and human systems frailest. And in South Africa most acutely, not just because 5 or 6 million of us are living with HIV and AIDS, but because of the gross political mismanagement of the epidemic, rooted in presidentially instigated AIDS denialism in the early years of this century. Its disabling effects still linger, even as new political purpose is at last bringing order and hope to the epidemic.

No corner of our social effort or investment – from health care to social security, education to the economy, correctional services or the judiciary – escapes AIDS. Amongst the many lessons the epidemic has taught us is that health is only partly the domain of medical science – every aspect of life is subject to, and in turn influences, AIDS.

Hence, no single approach can begin to secure the proper prevention, containment, treatment and care we need. The words "holistic" and "multi-sectoral", though grievously over-used, have practical meaning: that imagination, cohesion and commitment are what we have to start with. Then we need effective knowledge and systems and resources.

But we also need understanding. To deal effectively with an epidemic that threatens the lives of so many demands insight. And for that, we have to confront controversy – indelicately where necessary. It also requires us to innovate, and to confound convention wisely.

This impressive book will, I hope, help us with all of this. It brings together many of the "usual suspects" – those authoritative experts from our region whose clinical and analytical and academic work has placed them at the global forefront of AIDS.

Their common interest here, reflected through their broad range of collaborators, is in psychosocial approaches to the epidemic. Each writes about a fascinating and important aspect. All do so with a view to increasing our understanding, and thus our capacity to do more.

The contributions are generally of high quality; some are innovative; and most are of real interest. The emphases differ. Across chapters, there are differences of opinion. Good.

This book shows how far we have come over the past quarter-century in moving to greater psychosocial understanding of HIV/AIDS in South Africa. It also tells us how far we still have to go.

What is good is that we now have between the covers of one volume a range of authoritative reviews of what we know – and of what we still need to learn.

The editors collected these chapters to provoke debate. The best compliment you could return would be to read the chapters critically, in a spirit of challenge, response and further inquiry.

So I congratulate them and the authors on this impressive compendium of ideas, data, and challenges. This book is quite a landmark in HIV/AIDS scholarship in South Africa.

If it helps us to think more deeply, and to work more effectively in this still dire epidemic, it will have been worth the contributors' effort, and your investment in buying it.

Edwin Cameron
Justice of the Constitutional Court of South Africa
March 2009

Acknowledgments

The contributors to this volume come from a broad range of disciplines and institutions, both in South Africa and internationally. We have attempted to put together a book that reflects a diversity of psychosocial issues and perspectives involved in approaching the HIV/AIDS epidemic in South Africa. We have tried to be as inclusive as possible in addressing various topics, and of course there remain some areas that we did not have the space to include. This has turned out to be a large volume, and we would like to thank all the contributors for putting together their knowledge and thoughts into this book, for thinking about what has been learnt and still needs to be learnt about HIV/AIDS in South Africa, and for doing so within our deadlines. In some cases, authors had to put up with ongoing emails and some difficult requests from the editorial team. We thank all authors for their contributions, without which this book would not be possible.

We would also like to thank Janis Kritizinger for her meticulous final editing and formatting of the manuscript and her attention to detail. As our deadline for submission was approaching, her work on the manuscript was a blessing.

We would also like to thank the team at Springer, especially Bill Tucker and Ian Marvinney for their enthusiasm and support of this project. A special thank you also to Judge Edwin Cameron for his endorsement of the book and agreeing to write the Foreword.

Finally we would like to thank our partners and our families for their patience while we worked on this volume.

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Chapter 1
Introduction and Overview

Poul Rohleder, Leslie Swartz, Seth C. Kalichman, and Leickness C. Simbayi

In June 1981, a rare form of pneumonia, *Pneumocystis Carinii*, was diagnosed in five young homosexual men in Los Angeles in the United States. The diagnoses were reported in the Morbidity and Mortality Weekly Report (MMWR) (Gottlieb et al., 1981). Other reports began to emerge in the United States of other unusual disease presentations, and Acquired Immune Deficiency Syndrome (AIDS) was named a year later. The report in the MMWR was to be the first reported cases of AIDS in the world. In South Africa, the first two reported cases of AIDS were diagnosed in two male homosexuals and documented in 1983 in the South African Medical Journal (Ras et al., 1983). Following on these and other reported cases and the discovery of AIDS, the agent that causes AIDS was officially named in 1986 as the Human Immunodeficiency Virus (HIV).

It has been over 25 years since the first diagnoses of AIDS and HIV in the world, and the disease, reported in just a few isolated cases in the first days, has spiralled into the biggest epidemic in modern history. Since HIV and AIDS were first discovered, an estimated 65 million people worldwide have been infected with HIV and 25 million people are estimated to have died of AIDS (UNAIDS, 2006). The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2008) estimated that there were a total 33 million people living with HIV in 2007, of which 2.7 million were newly infected in 2007.

HIV and AIDS have been researched, written about, discussed and even denied countless times. There are thousands of articles published dealing with a variety of aspects of HIV/AIDS; there are academic and non-academic journals which are dedicated to reporting on HIV/AIDS, and there are hundreds of books focusing on a multitude of issues relating to HIV/AIDS. So the question that is perhaps asked is, why the need for yet another book? And why focus on South Africa?

UNAIDS (2008) reports that although the HIV epidemic seems to be stabilising in many countries, this is not consistent across regions in the world, with many countries showing an increase in incidence in recent years, including "developed" countries such as China, Germany, Russian Federation and the United Kingdom. The UNAIDS (2008) cautions as to the often cyclical and unpredictable nature of infectious disease epidemics, referring to surprising new outbreaks or increases of epidemics, such as that in the Russian Federation. So, while HIV/AIDS has perhaps

P. Rohleder et al. (eds.), *HIV/AIDS in South Africa 25 Years On*,
DOI 10.1007/978-1-4419-0306-8_1,

been the most researched disease in modern history, it remains a significant global issue and impediment to development, and we need to prepare for any future unpredictable developments. South Africa, located in the epicentre of the global epidemic and with its controversial history of HIV health-care policy, remains an important region for trying to understand the many social, psychological, political and medical factors that play a role in HIV/AIDS.

1.1 The HIV/AIDS Epidemic in South Africa

The emerging epidemic in South Africa in the early 1980s affected mostly the white homosexual population, as was the case in the United States and Europe. As South Africa was transforming into a democracy (in 1994) after 40 years of apartheid government, it began to emerge as the epicentre of the world's HIV/AIDS epidemic, with the predominant mode of transmission being among the majority black African heterosexual population.

Sub-Saharan Africa, and southern Africa in particular, is currently the region most affected by HIV/AIDS in the world. This is reflected by the most recent data released by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2008):

- Approximately 67% of adults and 90% of children living with HIV in the world are in sub-Saharan Africa.
- There are approximately 22 million people living with HIV in sub-Saharan Africa.
- Three-quarters (75%) of AIDS-related deaths occurred in sub-Saharan Africa in 2007.
- The epidemic has left orphaned approximately 12 million children under the age of 18 in sub-Saharan Africa.
- Thirty-five percent of people living with HIV in the world live in southern Africa.
- South Africa has an estimated 5.7 million of its citizens living with HIV, thus making it the country with the largest number of people living with HIV in the world.

The South African Department of Health conducts yearly studies surveying the prevalence of HIV infection among pregnant women attending antenatal clinics. The Department of Health (2007) estimated an HIV prevalence rate of 29.1% among pregnant women in 2006. Using this data to extrapolate an estimated prevalence of HIV infection among the general population, the Department of Health approximates that 5.41 million people are living with HIV in South Africa. A survey conducted by a consortium led by the Human Sciences Research Council and commissioned by the Nelson Mandela Foundation (Shisana et al., 2005) estimated that the prevalence of HIV infection in South Africa's general population is 10.8%. The survey further suggests that persons aged 20–40 years are the most affected and that the prevalence rate among women is higher than that of men. In addition, generalised

epidemics are also found among young children aged 2–14 years of age and the elderly aged 50 years and older.

The HIV crisis in southern Africa is significant. It has been one of the biggest obstacles to redevelopment in South Africa, as the country has tried to bring about transformation with limited resources. An already inadequate public health-care system in South Africa has been faced with the task of improving its infrastructure while having to cope with the increasing demand of the HIV/AIDS epidemic. The health crisis is also compounded by broader political issues. The official response from the South African government has been nothing but controversial, with the government being accused of AIDS denialism and being seen to be resistant to providing anti-retroviral therapy in the treatment of HIV/AIDS (see Chapter 9).

For many in South Africa, then, HIV/AIDS and the battle for effective treatment has been regarded as a "new struggle" following on from the struggle against apartheid (see Chapter 11). Although there has been an increase in access to antiretroviral(ARV) treatment across the globe, UNAIDS (2008) reports that most people in need of treatment in low- and middle-income countries are not receiving them. For many years, the South African government was seen to be actively blocking access to ARVs. A recent calculation of lives lost as a result of the restriction to ARVs on the part of the South African government (under President Thabo Mbeki) conservatively estimates that more than 330,000 people lost their lives and 35,000 babies were born with HIV due to an ARV treatment programme not being implemented timeously in South Africa (Chigwedere et al., 2008). The effect of this has been damaging to HIV prevention efforts in South Africa. It seems timely then to take stock of what has happened, what has been learnt about what works and does not work, so that we may move forward in trying to effectively address the epidemic in South Africa.

1.2 Southern Africa Within the Global HIV/AIDS Epidemic

While southern Africa may be the region most affected by HIV in the world, other regions in the world (for example countries in South and Southeast Asia and Latin America) are also faced with significantly large and, in some cases, growing epidemics.

In Europe and North America, much has been written about the rise in HIV prevalence among the heterosexual population in recent years. In the United Kingdom, for example, a recent report (UK Collaborative Group for HIV and STI Surveillance, 2007) indicates that the prevalence of HIV has increased significantly since 2000, with the number of new diagnosed HIV infections in the United Kingdom rising by almost 300% in the past decade. For many years the prevalence rate of HIV was highest for men who have sex with men. However, there has been an increasing prevalence rate among heterosexual men and women since 1997, and heterosexuals are now reported to be the predominant transmission group in the United Kingdom (UK Collaborative Group for HIV and STI Surveillance, 2007) as well as central

and western Europe (EuroHIV, 2007). In the United States, prevalence rates remain highest for men who have sex with men, but the prevalence rate among heterosexuals especially among African-Americans and indigenous populations has grown over the years (Centers for Diseases Control and Prevention, 2008). The increase in the United Kingdom and Europe has been partly attributed to immigrants (particularly African and Caribbean immigrants) with HIV, either who have arrived in the country already diagnosed HIV-positive or who have been diagnosed here after their arrival (see, for example, Hamers and Downs, 2004). Much has also been made in the UK media about the rise in HIV among the heterosexual population, with the rise in prevalence rates being attributed to African migrants and the so-called health-migrants who are perceived to be coming to the United Kingdom in order to access free HIV treatment.

With this increase in prevalence among the heterosexual population, research attention has been given to African men and women living with HIV in Europe. For example, in the United Kingdom, there have been calls for research on understanding more about the sexual behaviours and sexual relationships of African men and women living in the United Kingdom (for example, Kesby et al., 2003). The issue is complex; statistics do show that large numbers of those living with HIV in Europe are African men and women. However, there is a slippery slope to pathologising African sexuality in an effort to explain this prevalence, in a way that may fuel what can often be regarded as racist beliefs about African sexuality as different, uncivilised and potentially dangerous (Rohleder, 2007; Wellings et al., 2006). As Kesby and colleagues (2003) caution, cognizance needs to be given to factors such as poverty and racism. The epidemic in sub-Saharan Africa also needs to be viewed in the context of global inequalities to health care, and the controversies around the affordable provision of pharmaceuticals and health treatment by the richer nations of the world, or the "Third World" health dependency on "First World" wealth (MacDonald, 2005). UNAIDS (2008) reports that the HIV epidemic, which impacts on family income and ability to earn a livelihood, is likely to push an estimated 6 million households into poverty by the year 2015; a clear impediment to development.

What is clear is that although southern Africa, and South Africa particularly, faces context-specific issues that impact on the epidemic, concerns and issues about HIV/AIDS in South Africa are global concerns. What happens here has an impact on the rest of the world. Similarly, the local context is profoundly affected by global political issues, including the politics of gender, and the policies of neoliberalism (Susser, 2009). To look at HIV/AIDS in South Africa is also to look at aspects of ways in which a globalised world operates.

1.3 Rationale for this Book

Since the onset of HIV and AIDS, much has been researched and written on the subject internationally and in South Africa, from a variety of disciplines and points of view. As it was realised that preventing HIV infection is not as easy as just educating

people about the risk for HIV and promoting a change in risky sexual behaviours, research began to focus on the various psychosocial factors that were fuelling the growing epidemic. Psychosocial issues around HIV transmission and prevention in South Africa, and internationally, have influenced social science research in this area. Likewise, social science research has influenced how we think about and approach the HIV epidemic, and indeed other health issues. Social science research has allowed us to learn of the various cultural, social, political and psychological factors that were not always considered in biomedical research. UNAIDS (2008) argues that important for moving forward is the need to address issues such as stigma and discrimination, gender inequality and the prevention of new infections. These are all issues that social science research can help understand and address. The ethics of HIV prevention and treatment, and of research into HIV and AIDS, are complicated and highly contested, furthermore (Rennie et al., 2009; Van Niekerk and Kopelman, 2006), and social scientists have a contribution to make to ethical debates.

After over 25 years of the known epidemic in South Africa, it may be useful to consolidate what has been learnt by social science researchers about conducting research and interventions on HIV/AIDS in the context of South Africa. Much has been learnt about the epidemic during this time, about the issues of HIV in social science research, within the socio-political complexities of South Africa. The epidemic is dominating social science research in South Africa, in areas such as health research and anthropology. Furthermore, with the magnitude of the epidemic in South Africa, there has been a large amount of interdisciplinary and international collaborations in social science research in HIV/AIDS.

However, much of this research and the lessons learnt remains fragmented. Literature is published in a variety of academic and popular journals, books and other forms of media. In putting together the lessons learnt about various psychosocial aspects of the HIV epidemic into one volume, this book aims to provide a valuable resource for future researchers and academics, and those who are interested in learning more about the various psychological, social and political aspects of HIV and AIDS in South Africa.

Because South Africa is at the epicentre of the HIV/AIDS epidemic, South African concerns are global concerns, and lessons learnt in South Africa are lessons for the international community. South Africa offers a particularly useful site for consideration of the value of psychosocial approaches to HIV/AIDS, combining as it does a sophisticated research infrastructure with good international connections with all the psychosocial problems and challenges associated with widespread poverty and development challenges.

1.3.1 Overview of the Book

The book takes a look at various psychological and social issues related to the epidemic, contextualising it to the South African experience. The book focuses on what

has been learnt by social sciences, as well as lessons learnt in collaborative multi-disciplinary and international research. The book will also look at emerging areas of research in South Africa with regard to the continuing epidemic. In looking at these areas, the book also aims to try and understand and get a sense of what has worked and not worked in research and interventions.

The various chapters in the book will

- review some of the international and national literature related to specific topics, including the authors' own work;
- identify the main issues and key debates related to the various topics, in the context of South Africa;
- where relevant, chapters will identify successes and challenges and lessons learnt in conducting research in the South African context. In some cases this will also look at international or multi-disciplinary collaborations; and identify any possible areas of future research.

The book is divided into four broad sections, focusing on different aspects of the epidemic, and focus areas of research.

Part I will be concerned with psychosocial issues relating to HIV transmission in South Africa. This section starts with a chapter (Chapter 2) on the social–cultural context of the epidemic in South Africa. This provides a context in which many of the further chapters are read and highlights some of the key social–cultural issues that are discussed more in depth in future chapters. Sexual relationships are key in the ongoing transmission of HIV, and Chapters 3 and 4 will go on to look at the role that gender plays in the transmission of HIV. This is a very broad field, and the separate chapters focus on HIV and women (Chapter 3) and HIV and masculinity (Chapter 4). As reports by the UNAIDS indicate, youth and children are significantly affected by the epidemic, and Chapters 5 and 6 explore youth and infants and children, respectively. Chapter 7 looks at dynamics of poverty and HIV/AIDS, critically looking at whether poverty is a determinant or a consequence of HIV/AIDS. The final chapter in this section (Chapter 8) looks at the role that social stigma plays in maintaining the HIV epidemic, and the issues around considering stigma in research and in interventions.

Part II will be concerned with HIV/AIDS prevention and treatment issues and projects in South Africa – what has been done, what has been learnt and some new directions in these fields. South Africa provides an interesting context in this regard, having a controversial political history in its governmental response to the epidemic. Some of this context is explored in different chapters. Chapter 9 is a critical analysis of AIDS denialism on the part of the South African government under the leadership of Thabo Mbeki. This chapter is complemented by Chapter 10, which looks at local-level responses to HIV/AIDS, focusing on the organisation, coordination and effectiveness of local-level responses, and a chapter on the history of social movements in HIV (Chapter 11). Chapter 11 looks at various social movements developed to address various crises of HIV/AIDS, for example, the combating of stigma and the provision of support for those affected. This chapter also looks at

the development of social movements in response to the politics of HIV treatment and the South African government's reluctance for many years in providing of antiretroviral (ARV) treatment to HIV-positive individuals. Chapter 12 focuses on voluntary counselling and testing (VCT) in the care and treatment of HIV and uses a case study to explore the scaling up of VCT services. A large focus of the prevention of HIV infection has been around preventing the vertical transmission of HIV from mother to child, which is discussed in Chapter 13, looking at various psychological factors as well as particular issues involved in mother-to-child transmission (MTCT) programmes. In Chapter 14, structural interventions for HIV are discussed, looking particularly at the important issue of nutrition and food security and its link to HIV/AIDS. The last two chapters in this section look at community-level responses to managing HIV/AIDS, looking particularly at how communities can be supported in responding to the epidemic (Chapter 15) and the role of religion and spirituality, and religious-institution-based responses to the epidemic (Chapter 16).

Part III is a short section but has as its focus persons living with HIV/AIDS. In the first chapter (Chapter 17), a narrative voice is given to the experience of living with HIV, using words of HIV-positive persons themselves. This provides an important personal voice to people who are otherwise objects of research. In Chapter 18, consideration is given to the importance of positive prevention – prevention interventions for persons living with HIV.

Part IV, the final section to the book, will explore some of the new agendas for research that are being developed in South Africa on issues relating to HIV/AIDS. These might not be exactly "new" concerns, but are areas that have been identified as possibly under-researched or as emerging issues for research. Chapter 19 is from a collaboration of international authors looking at how HIV/AIDS affects persons with disabilities, a population vulnerable to HIV infection that has been largely overlooked. Chapter 20 looks at the issue of HIV/AIDS and prisons in South Africa. Prisons have been identified as having higher HIV-positive populations than the general population, yet, in South Africa, there is little known or researched about HIV/AIDS in prisons. The next two chapters provide a social science perspective on new and future biomedical interventions. In Chapter 21, the authors look at the issue of male circumcision and recent findings that suggest circumcision helps prevent the transmission of HIV. As in many other areas of HIV research, the issue of male circumcision is complex for social scientists, and the chapter in this book forms part of a broader debate about how we should act on this new and important evidence (Connolly et al., 2008; Eaton and Kalichman, 2007; Kalichman et al., 2007). Chapter 22 focuses on the development of an HIV/AIDS vaccine, and issues around recruitment and participation in HIV vaccine and microbicides trials. In the final chapter of the book, Chapter 23, the authors look at HIV and mental health, looking both at mental disorders as possible risk factors for HIV and at the mental health consequences of having HIV/AIDS.

The book has attempted to reflect the diversity of perspectives, by including authors from various disciplines, such as psychology, anthropology, economics, social work, public health and medicine. We have also invited authors from different parts of the world, in the hope of capturing some of the collaborations between

international and local researchers and voices from the social sciences. While the book is wide in scope, it can never cover everything, and important issues, while touched on in some cases, cannot be fully explored. Much still needs to be learnt, and we hope that this book can serve as a starting point for the development of future research and interventions.

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Part I
Psychosocial Issues

Chapter 2
The Sociocultural Aspects of HIV/AIDS in South Africa

Suzanne Leclerc-Madlala, Leickness C. Simbayi, and Allanise Cloete

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

P. Rohleder et al. (eds.), *HIV/AIDS in South Africa 25 Years On*,
DOI 10.1007/978-1-4419-0306-8_2, © Springer Science+Business Media, LLC 2009

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 Gorringe, 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 coexistence 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) *patriliny 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 patriliny 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)