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ORIGINAL ARTICLE

Inter-linkages Between Culture and Gender in HIV transmission in Zambia

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ABSTRACT

Introduction: The current Zambian adult HIV prevalence stand at 14% with a gender bias of more women (16.1%) living with HIV and AIDS compared to men (12.3%).Hence the aim of this review was to gain an in-depth understanding of the linkages between culture, gender and HIV transmission in Zambia and suggest the best method in best-evidence prevention intervention programs to curb HIV infections due to culturally and gender practices.

Methods: A comprehensive desk review analysis of articles obtained from UNDP, UNAIDS, NAC, ZDHS, and CDC links was conducted. Others sources of data from the Internet after using specific search words such as AIDS and Gender using Google search were also used.

Results: Some of the beliefs and practices of specific African cultures have been seen as accelerating the spread of the virus or at least acting as barriers to prevention of HIV such as initiation ceremony or puberty rites where girl children are taught to be submissive to their husbands in marriage and not refuse sex or sexual encounters from their husbands at any time. Research findings have pointed out that initiation ceremonyis one of the channels for transmission of HIV and STIs because through its teachings, it puts women in a weaker position to negotiate for safer sex.

Conclusion: Interventions should aim at changing people's attitudes and beliefs towards HIV, empowering women and educating men. Evidence based prevention intervention programs such as *Communal Effectance in HIV Prevention and Sister to Sister could be used.*

INTRODUCTION

Zambia demographics

Zambia is a landlocked country with a population of over 14million people with 7,314,734 males and 7,323,771 females. The country is divided into ten provinces, of which three provinces (Lusaka, Southern and Copper-Belt) are predominantly urban while the remaining provinces are predominately rural. The country has more than 70 bantu-speaking ethnic groups of both matrilineal and patrilineal systems of descent. In the 2010census of population and housing the ten largest ethnic groups were Bemba (18%), Tonga (13%), Chewa (7%), Lozi (7%), Nsenga (6%), Tumbuka (4%), Ngoni (4%), Lala (3%), kaonde (3%) and Lunda (north-western) at 3% of the total population.[1]

In 2008 life expectancy at birth was 40 years.[2]The annual population growth rate in 2005 was estimated at 2.7% with projections of a decline to 1.9% by 2015. Similarly by 2015, it is projected that 40% of the population will be under the age of 15 and 37% will be living in urban centres. In 2010, the total fertility rate was 5.9, implying that; on average, each woman aged 15-49 years would approximately have 6 children in her entire reproductive period. In rural and urban areas, the total fertility rate was at 7.0 and 4.6, respectively.[3]

The 2010 Zambiancensus showed that there are a total of 1,947,501 households, of these 1,495,861 and 1,017,907 were rural and urban respectively. Further, 1,150,794 households in rural areas were head by Men and 345,067 by women. While in the urban areas 796,707 households were head by men and 221,200 by women.[3]Adult literacy is estimated to be 68% (60.4% for women and 81.3% for men) with a combined primary secondary and tertiary school enrolment ratio of 60.5%.[2]

HIV and AIDS Scenario in Zambia

Estimates show that, adult HIV prevalence peaked in the mid-1990s at about 16% and has stayed above 14% since then.[4] By 2007 the national adult HIV prevalence was estimated at 14.3% .[5] The epidemic has a gender bias with more women (16.1%) living with HIV and AIDS compared to men (12.3%).[1] However, for women of above

40 years, prevalence is lower than men in the same age bracket. In 2009, an estimated 82,681 adults were infected with HIV (59% women, 41% men) with 226 new adult infections and 25 new paediatric infections occurring each day.[6]

There is an emerging pattern of gender disparity in HIV prevalence with women being more negatively affected. HIV prevalence in women aged 15-49 is significantly higher than in men aged 15-49 (16.1% vs.12.3%). Above 40 years of age, HIV prevalence in women is significantly lower than in men. The female to- male prevalence ratio for young people aged 15–24 dropped from 3.7 in 2001-02 to 1.6 in 2007 (fewer new infections in young women, more in young men).[6]

CULTURE AND GENDER

Culture, Male dominance, violence and HIV

Research has found out that inequalities between males and females are a decisive factor influencing the high rates of HIV in sub-Saharan Africa.[7] Sub-Saharan Africa is the only region in Africa where more women are HIV positive than men; highlighting the vast gender disparities of the epidemic. There are important differences between women and men in the underlying mechanisms of HIV infection and the social and economic consequences of HIV and AIDS. These issues are discussed in this paper to gain a better understanding of the concept of gender.

Culture refers to the ways in which different societies understand their collective system of meaning, as well as their collective ways of valuing and understanding the world which they inhabit.[8]While Gender is a social and cultural construct and is understood as the commonly shared expectations and norms within a society about what is considered appropriate behaviour, characteristics and roles for males and females. It is these gender constructs that have resulted into an imbalance in power between women and men and the curtailing of women's sexual independence thereby expanding male sexual autonomy, which has resulted in an increase in women's *and* men's risk and vulnerability to HIV.[9]

In the context of AIDS, some of the beliefs and practices of specific African cultures have been seen as accelerating the spread of the virus or at least acting as barriers to understanding and preventing the epidemic.[9]Among the cultural practices that are considered to facilitate HIV transmission are male oriented cultural practices and female oriented cultural practices:

Male cultural practices in Zambia that could lead to HIV transmission

Widow inheritance is common in central and Lusaka provinces-a practice where a member of the family of the deceased succeeds and marries or inherits the widow. In many cases the widow is not allowed the opportunity of refusal. Those that refuse face rejection from the husbands' family. The man who marries the widow is at high risk of an HIV infection if the widow's husband died of AIDS.

Male Traditional circumcision that is more prominent in Northern Province involves the sharing of blades and knives, and the initiates having sex with an elderly lady before the wound is completely healed. Use of the same blades or knives can transmit HIV among the initiates.

Unprotected sex with a minor is seen as traditional ritual or treatment for HIV and a remedy for becoming rich and prosperous.

Traditional treatment of infertility by a healer and having sexual intercourse with the woman client is another cultural practice based on such belief.

Polygamy is related to sexual cleansing and wife inheritance in the sense that some polygamous marriages are a result of taking over the wife of a deceased relative. Given the evidence that having many sexual partners increases one's chances of being exposed to HIV, polygamy and extramarital relationships, both of which are culturally tolerated, are important dynamics in trying to understand the HIV/AIDS prevalence in Zambia.[6]

Female cultural practices in Zambia that could lead to HIV transmission:

Sexual cleansing is documented as one of the most deeply - rooted and widespread cultural activities among Zambia's 73 ethnic groups. Sexual cleansing (or a relative of the deceased having sexual intercourse with the surviving partner in a ceremony closely monitored by other relatives) is the common and widely acceptable way of cleansing among most of Zambia's big ethnic groups. There is no requirement for HIV testing prior to the cleansing.[10]This practice has since been criminalized by the penal code Amendment act but is still a source of concern.

Dry sex- described as sexual intercourse with a woman who has a very tight vagina, achieved through the repeated use of local substances and herbs. As with the initiation ritual, the practice of dry sex is meant to consolidate relationships. However, with the advent of HIV/AIDS, concerns have been raised linking it to HIV transmission due to genital ulceration of both male and female organs during sexual intercourse, which in turn facilitates the exchange of blood agents, including HIV.

Premarital unprotected sex is practiced to prove fertility of young girls among some ethnic groups.

Initiation ceremony or puberty rite which is only indirectly related to HIV transmission because it does not directly involve sexual interaction as is the case with some of the other practices already discussed in this section. The process of initiating a girl is significant to the understanding of HIV/AIDS in Zambia as it plays a crucial role in shaping a girl's perception of sex and sexuality. During the initiation the emphasis is on how to please her husband in bed and being submissive to him at all times including making love to him whenever he demands. Concerns have been raised by AIDS information organizations about the values inculcated into a woman with regard to sex and sexuality during this ritual. Many representatives of these organizations believe the emphasis on submissiveness of woman to man and sexual satisfaction partly accounts for the disempowerment of the woman to negotiate for safe sex and also forces her to resort to "dry sex", all in order to please her husband. Traditionally, initiation rituals had some positive values aimed at strengthening marriages. However, the HIV and AIDS reality poses a strong challenge to this cultural practice.[10]

Table 1: Cultural Practices that May Promote HIV Transmission-HIV Prevalence by Province

Cultural practices / province	Ritual cleansing	Spouse inheritance	Polygamy	Initiation ceremonies	Dry sex	HIV Prevalencerates* (2001/2)
Lusaka		✓	✓	✓	✓	22.0%
Central	✓	✓	✓	✓	✓	15.3%
Copper belt	✓		✓	✓	✓	19.9%
Western		✓	✓	✓	✓	13.1%
Southern	✓	✓	✓	✓	✓	17.6%
Luapula	✓		✓	✓	✓	11.2%
Eastern	✓	✓	✓	✓	✓	13.7%
Northwestern	✓		✓	✓	✓	9.2%
Northern	✓	✓	✓	✓	✓	8.3%

*Prevalencerates based onZDHS 2001/2 Report[11]

The above table indicates the prevalence of cultural practices that may promote the transmission of HIV based on the 2001/2 WHO HIV World Report.[11] Lusaka province is the highest with 22% infection rates followed by Copperbelt with 19.9%, Southern province with17.6%, central province with 15.3%, Eastern province with 13.7% and followed by other provinces with smaller infection rates.

This information can be compared with the continued existence and in some cases reduction of the occurrence of the cultural practices in the specific provinces.

Table 2: Cultural practices in four selected provinces in a study conducted in 2012 by Gender studies department at the University of Zambia[12]

Cultural practices / province	Ritual cleansing	Spouse inheritance	Polygamy	Initiation ceremonies	HIV prevalence rates* (2007)
Western		✓	✓	✓	15%
Southern		✓	✓	✓	15%
Eastern		✓	✓	✓	10%
Northwestern			✓	✓	7%

*Prevalence rates based on the ZDHS 2007 Report[1].

While some customary practices undermine gender equality, others promote gender equality. Those that enhance gender equality include selection of traditional leadership and decision making; especially at household level. Customary practices that contribute to undermining gender equality include initiation ceremonies, early marriage, forced marriage, arranged marriage, as well as polygyny. Other customary practices such as widow and property inheritance, sexual cleansing as well as elopement also undermine gender equality[12]. It was found[12] that in southern, Eastern and North-western provinces the cultural practice of ritual cleansing had been drastically reduced or phased out. A consideration of the 2007 ZDHS report[1] on the incidence of infection rates in the three provinces attests to the fact that the three provinces experienced reduced infection rates. Southern province's infection rate was 15% in 2007 compared to 17.6% in 2001 a reduction of 2.6%. Eastern province's infection rate was 10% in 2007 compared to 13.7% in 2001 a reduction of 3.7%. North Western province's infection rate was 7% in 2007 compared to 9.2% in 2001 a reduction of 2.2%.

The only aberration was western province which even in 2001 was reported to have no incidence of sexual ritual

cleansing and was again reported to have no incidence of sexual ritual cleansing in the 2012 study but whose 2007 ZDHS report show an increment in the incidence from 13.1% to 15% an increase of 2.1%.

It could be argued that southern, Eastern and North Western provinces among other factors experienced a reduction in HIV infection rates because of the drastic reduction or phasing out of the sexual ritual cleansing and modification of the cultural practices in the provinces.

The increase in the incidence rates in Western province is more difficult to explain but since the practice was nonexistent even in the 2001 study it can be speculated that the increase could have been driven by other factors such as urbanisation.

It should be noted and emphasised that it is almost impossible to totally eliminate the incidence of adverse cultural practices but that their rate of practice can be reduced or minimised. The percentages given above should be interpreted in this vein rather than interpreting them as a complete eradication.

Gender based violence and HIV

Some cultural practices and norms for instance that a woman should not refuse sex or that a man can demand for sex at any time lead to gender and sexual violence. In 2005 it was reported that about 15.1% of females experienced forced sex. In 2005, approximately 17.7% of urban females and 13.7% of rural females reported forced sex. Forced sex was most commonly reported among the 20-24 year age group.[5]It was further reported that most perpetrators of forced sex were husbands or live-in partners, (67.5%). Other reported perpetrators were boyfriends (25.0%), male relatives(5.8%), former husbands/boyfriends (2.5%) and strangers (1.7%).[1] As aforementioned because many women are socialized to accept, tolerate, and rationalize such experiences and to remain silent about them and men are taught to demand and not negotiate for sex refusing sex, inquiring about other partners, or suggesting condom use have all been described as triggers for intimate partner violence: yet all are intimately connected to the behavioural cornerstones of HIV prevention.[13] Such physical violence has resulted in women seeking solace and sex from additional partners, while maintaining a relationship with their steady partner .[13] Having multiple partners was the most consistent risk factor for domestic physical violence across eight countries analysed, including Zambia.[14]

FINDING A SOLUTION

Given the complexity of some of the highlighted cultural practices, intervention efforts should always be culturally specific and sensitive, and they should include a collaborative approach wherever possible. Local adaptation is a necessary component of any HIV prevention intervention. Hence it's important to understand a society's belief about how HIV is spread, and how it can be prevented. Factors such as individual beliefs, personal identify and morality, illness, life and death should always be considered because such beliefs will determine whether HIV and AIDS are seen as transgressions and retribution, or chance and risk. If HIV is seen as inevitable, such fatalism may make prevention very difficult. If it is seen as a result of witchcraft, breaking sexual taboos or poverty, then prevention and care strategies are less likely to be adopted or have an impact. Therefore, factors such as blame, stigma, shame and discrimination, especially gender based discrimination stem up because of the particular beliefs held by individuals in a community and also inhibit effective prevention and care.

Gausset[9],furtherasserts that the fight on HIV and AIDS should not focus on fighting cultural practices but rather adapt our discourse so that it can be understood in local terms. He further suggests that it is important to first understand why some of these cultural practices exist and why they are difficult to abandon overnight.

Therefore from the foregoing it is important that interventions that are established aim at changing people's attitudes and beliefs towards HIV, its causes, transmission and treatment. The intervention should also aim at empowering women and educating men to curb gender related HIV transmissions. However, most prevention interventions in Zambia have targeted uninfected individuals, or infected individuals who do not yet know their HIV status. The goal of these interventions has been to prevent individuals from becoming infected and to encourage HIV testing. The content of primary prevention interventions has been generally informational or more about awareness without necessary aiming to tackle deep rooted cultural, or gender factors that promote the transmission of HIV.

There have been a number of studies done in other countries that aim at positive-prevention (working with positive people to encourage healthy lifestyle and

avoiding spreading infections) also negative-prevention (developing healthy behaviours among negative people to prevent HIV infections). The Center for Disease Control and Prevention has labelled some of the following as the best-evidence prevention intervention programs[15];

The ***Communal Effectance in HIV Prevention***

This is an intervention in a small group (3–6 - Low income, single, inner-city females attending urban clinics). This intervention emphasizes negotiation skills training and the idea that women's sexual behaviour not only affects themselves but also those around them. Women are taught to protect themselves from HIV infection through cognitive rehearsals, role plays, discussions, and interactive videos. The intervention sessions provide women with general HIV and AIDS prevention information, and inform them on how drugs and alcohol can lead to risky sex behaviours. The sessions also offer condom use skills and teach women how to take control of their sexual encounters. Women are also taught skills on how to refuse unwanted sexual propositions and how to negotiate sexual safety with their partners. The final 3 sessions emphasize the maintenance of behaviour change, review skills and techniques discussed in earlier sessions, and focus on relapse prevention. This intervention is based on Social Learning Theory, Conservation of Resources (COR) Theory and Theory of Gender and Power. The original evaluation study was conducted in a medium-sized mid-western city (in the USA) between 1995 and 1999. The study sample included 935 women. After the 6 to 7-month follow-up, women who received the HIV prevention intervention reported significantly fewer episodes of unprotected vaginal or anal sex than women in the standard care group.[16]

Sister-to-Sister

Sister -to- Sister Programme includes two skills-building interventions – ***Group*****or*****One-on-one***. These Skills-building interventions are culturally-sensitive, gender-appropriate, single-session interventions developed to increase self-efficacy and skills to use condoms correctly and to negotiate condom use with sex partners. The interventions encourage women to respect and protect themselves, not only for their own sake, but also for their family and community. The interventions are delivered by female African-American nurses and can be delivered to small groups of women (3-5 women) or individuals. Both group and one-on-one formats involve video viewing, condom demonstration, practice with an anatomical model, and role playing to increase self-efficacy and skills to negotiate condom use. The additional activities used in the group format include group discussions, brainstorming, and interactive exercises and games. The original evaluation study was conducted in Newark, New Jersey between 1993 and 1996 and uses Social Cognitive Theory as the theoretical basis. The following were the findings;

Combined *Group* and ***One-on-one Skills*** compared to ***Health Promotion: Skills*** Intervention women, compared to *Health Promotion* women, reported a significantly lower frequency of unprotected sexual intercourse at the 3-month follow-up (p = .02) and a significantly greater proportion of condom protected sexual intercourse at the 12-month follow-up (p = .03), and were significantly more likely to report using a condom at last sexual intercourse at the 3- and 12-month follow-ups (p = .05, p = .03, respectively). *Skills* Intervention women were significantly less likely to test positive for STD than comparison women at the 12-month follow-up (p = .03).

Group Skills compared to ***Health Promotion****:* At the 12-month follow-up, *Group Skills* women, compared to *Health Promotion* women, reported a significantly greater proportion condom-protected sexual intercourse (p = .003) and were significantly more likely to report using a condom at last sexual intercourse (p = .05).

One-on-one Skills compared to ***Health Promotion****: One-on-one Skills* women were significantly less likely to test positive for STD than comparison women at the 12-month follow-up (p = .03).

Combined Group**and*****One-on-one Skills*** compared to ***Combined Group*****and*****One-on-one Information****: Skills* intervention women, compared to *Information* women, reported a significantly greater proportion of condom protected sexual intercourse at the 3- and 12-month follow-ups (p = .02, p = .05, respectively), a significantly lower frequency of unprotected sexual intercourse at the 3- and 12-month follow-ups (p = .01, p = .02, respectively), and were significantly more likely to report using a condom at last sexual intercourse at the 12-month follow-up (p = .01).[17]

There has not been much done to equip women on the fight against Aids in countries like Zambia. Most interventions that have been done empower men with knowledge on how to use condoms and do not adequately educate women in the some capacity. Hence, the use of best evidenced interventions like sister to sister allow for the empowering of women and equipping them with the right knowledge and skills in the fight against HIV and AIDS. Such an intervention can easily be adapted to fit the local conditions by transcribing the materials into local languages. Further, this intervention does not aim to fight culture but to change attitudes and behaviour through knowledge and life skills. By equipping women with self-efficacy and assertiveness they will be able to make informed decision for themselves.

CONCLUSION

There is evidence that some negative cultural beliefs, traditions and practices, which are deep rooted in the social and sexual lives of most Zambian ethnic groups, have also contributed to the transmission of the disease. However, the advent of HIV and AIDS has added a new dimension to cultural practices, and to some extent, the practice of sexual cleansing was reported to have declined in prevalence in the sample communities[12]. This was mainly attributed to awareness activities by government institutions, Non-Governmental Organisations, as well as traditional leaders. In most cases, sexual cleansing had been discarded because of HIV and AIDS. Also some traditional leaders have taken steps to either discourage or completely abolish some of the cultural practices that have a negative impact. For example, Chief Mpezeni of Eastern Province has abolished sexual cleansing and Chief Liteta of Central Province has banned early marriages[12].

Although there has been a stride in decreasing the negative impact of cultural practices that lead to HIV transmission, increased information should constitute the thrust of any future attempts to eradicate the beliefs which support some of the highlighted cultural practices. In line with this strategy, co-opting families and influential local personalities such as headmen, politicians and church elders among the communities would be of benefit in addressing the challenge of tackling the cultural issues that may exacerbate the transmission and spread of HIV and AIDS. It is also important to empower women with skills that will promote assertiveness in their safe sex negotiations and also promote their economic assertiveness and independence.

It should also be appreciated that interventions that stand a better chance of success need to address both male and female behavioural practices because both sexes are involved in the practices that increase the transmission of HIV and AIDS.

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