



AFRICA REGIONAL SEXUALITY RESOURCE CENTRE

in Collaboration with

HEALTH SYSTEMS TRUST and WOMEN'S HEALTH RESOURCE  
UNIT OF THE UNIVERSITY OF CAPE TOWN (UCT), SOUTH  
AFRICA

**Understanding Human Sexuality Seminar Series  
(South Africa)**

## Sexuality and HIV

Dr. Judith Head

*Department of Sociology  
University of Cape Town  
South Africa*

*Cape Town, South Africa  
September 16, 2005*

© ARSRC 2005

***The views expressed in this presentation are solely those of the author and do not necessarily reflect the views of the ARSRC or any organisation providing support***

## **Introduction**

I convene an interdisciplinary programme in HIV/AIDS and Society. The core introductory course is called “Critical Issues in the Study of HIV/AIDS and Society.” In this course we explicitly take key social issues around the infection and epidemic and hold them up for scrutiny. In our view good and effective interventions to reduce the rate of infection and prevent transmission, must be the product of an open debate that sometimes challenges the conventional wisdom.

Our course is consciously interdisciplinary. We draw on theoretical approaches and insights from other disciplines to help us arrive at new understandings of key, and sometimes apparently intractable, challenges.

This is not a comfortable process, because we are looking at the familiar in new ways. It is rather like being in a hall of mirrors. The perspectives we are adopting may appear distorted. Sometimes, nevertheless, viewing things from a different perspective, or drawing on the theoretical insights from other disciplines, leads to radically new ways of seeing the issues. The hope is that this process generates new solutions to old problems.

What does this mean in practice in relation to HIV/AIDS?

## **Key Questions**

- 1) Why is the epidemic spreading so widely here in southern Africa, and not in the rich countries of the world?
- 2) Why after many years of work around prevention, is sexual behaviour not changing dramatically? Why is the infection still spreading?

The dominant explanation used to focus on sexual behaviour or rampant “promiscuity,” but this has been repudiated by the UN. There is no evidence to support the view that people in (South) Africa have more sexual partners than people elsewhere.

The explanation has shifted somewhat to one which focuses on concurrent relationships, particularly those involving “transactional” sex, as typified by the work of Rachel Jewkes, Suzanne Leclerc-Madlala and discussed in texts such as Walker, Reid and Cornell (2004) and Quarraisha Abdool Karim’s (2005) essay “Heterosexual Transmission of HIV – the Importance of a Gendered Perspective in HIV Prevention.” In the popular, but “highbrow” sphere, the work of Helen Epstein, who writes for the New York Times, shares this approach.

I want to raise some questions about some of the assumptions embedded in this literature. In order to do so, I shall first set out my premises.

(1) Drawing on theoretical underpinnings of epidemiology, we know that for most communicable diseases the existence of a disease agent and a host body is a necessary condition for disease but not usually (ever?) a sufficient one. Not everybody who is infected becomes ill. There are clear social patterns to disease.

Most strikingly, both morbidity and mortality are linked to social conditions. Mckeown's work, famously showed that mortality from TB, diphtheria, measles and whooping cough declined in 19th Century England and Wales as social conditions improved. Critically, these declines in mortality took place before the introduction of effective treatment in 1940s-50s.

But it was not just social conditions in general. Even as death rates were declining, some groups of people were more affected than others. There was, and remains, a clear socio-economic gradient to mortality and morbidity. This is true even in countries today with very good welfare systems and low levels of social inequality, such as Norway:

"In the mid-1990s, as in the mid-1980s, lower socio-economic positions, such as unemployment and early retirement, only basic education, and workers' occupations, are generally connected to poorer health. No substantial change is detected in this period." (Dahl E and Elstad JI, 2001).

(2) We know, from extensive research, that health is more fragile in poor countries than rich; that both morbidity and mortality are higher.

(3) We also know that under-nutrition is a key factor and co-factor in infant morbidity and mortality.

(4) Levels of poverty in South Africa and southern Africa are extremely high. Depending on the way it is measured as many as 40 % of the economically active population is unemployed in SA. There is a high dependency ratio and heavy reliance on remittances and welfare grants. A small but significant number of people have no source of income at all. For people like us it is almost impossible to imagine what this means for the quality of people's lives. What we know from numerous surveys is that many people regularly go hungry.

(5) Immunologists and virologists who investigate different clades of the HI virus think that the dominant sub-type in sub-Saharan Africa is particularly virulent.

Summary: In South (and southern) Africa we live with a particularly destructive form of the virus, which is working through a highly vulnerable population in an exceptionally poor part of the world. If we were talking about a "normal" disease, we'd stop here and acknowledge that ameliorating poverty is probably as important as medical intervention to prevent the further spread of the infection.

However, we are not talking about a "normal" disease but a sexually transmitted one; and we are not talking about a "normal" population, but one – mainly African - that has been the subject of intense fascination for four centuries; around whom pervasive myths about sexuality and behaviour have been woven. The explosive mix of sex and "race" lays the groundwork for the dominant explanation for the spread of HIV in South Africa. This argues that black/African South and southern Africans behave sexually in ways that are different from us (usually meaning either white middle class South Africans or northern Europeans and north Americans).

If you are interested in tracing the history of these ideas see Eileen Stillwaggon's (2003) paper: *Racial Metaphors: Interpreting Sex and AIDS in Africa*. More recently the thesis submitted by Liza Kendall (2005) developed these themes.

I am suggesting, following these two authors, that the conventional wisdom around sexuality and HIV/AIDS in South Africa, needs to be challenged. We need to look at some of the assumptions embedded in the work; the scope and extent of the studies cited and their generalisability.

I shall take Helen Epstein's (HE's) article "The Fidelity Fix" for the NYT (13 June 2004) which is typical of a serious journalistic attempt to grapple with the issue of the gender dimensions of the spread of HIV/AIDS. It reflects the dominant thinking around the gender dimensions of the epidemic.

In the article HE argues that

"Studies show that people in southern Africa don't have nearly as many sexual partners as, say, homosexual men in San Francisco did in the 1980s...but many people....do have a small number of longer-term, simultaneous or "concurrent" sexual relationships, that may overlap for a few months or even years....Long term concurrency is far more common in Africa than in Asia and the West, where heterosexual people tend to practice 'serial monogamy' .....marriage rates in southern Africa have plummeted since the 1970's, and men and women increasingly form temporary unions lasting months or years. High rates of female poverty mean some women rely on these liaisons for survival.'

The argument is that the infection is spreading so rapidly because these concurrent relationships involve the partners in a "giant network...a web of sexual relationships that can extend across huge regions." In addition, vulnerable young girls are seduced by men with material goods that they also want. "Unfortunately, these glamorous men are also most likely to be unfaithful and thus, H.I.V.-positive."

### **The Issues**

What are the issues that these characterisations raise? There are five in my view. (a.) How generalisable is the evidence? Epstein does not present any evidence. She refers to Rachel Jewkes' work but does not say how large her studies were or how representative. Leclerc-Madlala's qualitative studies of a small area outside Durban, are often generalised to SA as a whole.

(b.) The assumption that concurrency fans the spread of the infection more than serial monogamy is a statement that can only be tested empirically. The rate of partner change and numbers of partners and their status is clearly critical.

(c.) Sexual violence: stereotypes of gender roles are invoked to describe brutal (uncivilized) African and passive oppressed women. There is no attempt in the literature to disaggregate the categories "women" and "men" by social class, by cultural milieu, by age or by temperament.

(d.) Rapid partner change is very common in Europe and the United States among young people. The explosive rate of a range of STIs is a major public

health challenge in these areas, yet these behaviours are not challenged or held up to the critical scrutiny that the supposedly different behaviour of (African) people in South Africa is.

(e.) Transactional sex is itself a problematic concept. Friederich Engels wrote about what he called bourgeois marriage as a form of prostitution almost 150 years ago. He was referring to the exchange of sexual favours in return for material comfort. Its not just poor African girls who are attracted to men with means. Power and wealth are attractive. Moreover, we are all complex beings with complex, intertwined and sometimes unconscious motivations.

(f.) Condom use is not normal for anyone.

Part of problem with the dominant approach is that it is sexually reductionist. It discounts what most young people know only too well, and what most older people tend to forget. Youthful sexuality is about exploration and pleasure, but it is also about love, trust, and respect. These are complex feelings and emotions that lie at the heart of our humanity. As human beings we are impetuous, self-justifying and prone to make mistakes. Unless we acknowledge the complexities of our humanity when we talk about HIV/AIDS prevention I suspect we will always miss the mark.

So, where does this reasoning lead and what needs to be done?

### **Way Forward**

I am not denying that (sexual) violence is a problem, nor am I wanting to downplay the predominantly sexual spread of the epidemic. I am suggesting that we need a much more sophisticated and nuanced understanding of gender and sexual relations. We urgently need a national prevalence study based on a representative sample of the national population. This needs to be analysed using socio-economic status or social class categories. If the fragmentary evidence that infection rates are much higher among the lower social strata than the higher strata, is confirmed, then we may need to look to conventional public health approaches – and predominantly alleviating poverty and narrowing social inequality – as part of the solution.

Finally, in my view we need to combat the “othering” tendency of our investigations. This is obviously built into our methodologies; we study an “other.” It is time we started our researches by examining ourselves. Honest and critical self-reflection will teach us a great deal about human frailty. If we start to realise that “there but for the Grace of God go I” we may start to ask new, and more fruitful, questions about the gender dimensions and complexities of the epidemic in SA.

## Bibliography

- Dahl, E and J.I. Elstad (2001) "Recent Changes in Social Structure and Health Inequalities in Norway" *Scand J Public Health Suppl.*; 55:7-17"
- Karim, Q., (2005) "Heterosexual Transmission of HIV – the Importance of a Gendered Perspective in HIV Prevention." in S. Karim and Q. Karim eds., *HIV/AIDS in South Africa*, Cambridge University Press
- Kendall, L. (2005) "(Mis)understandings: Exploring the Meaning of HIV/AIDS in South Africa: An Analysis of Texts and the Cultural-Political Contexts that Produced them". A dissertation submitted to the Faculty of Humanities, University of Cape Town, South Africa.
- Walker, L, Reid G. and M. Cornell, (2004) *Waiting to Happen: HIV/AIDS in South Africa: the bigger picture*. Boulder CO: Lynne Rienner
- Stillwaggon, E. (December 2003 ) "Racial Metaphors: Interpreting Sex and AIDS in Africa" in eds., A. Saith and B. White, *Development and Change*, Volume 34: Issue 5, The Hague: Institute of Social Studies