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The Curse of a Generation

Evaluating the Effects of Gender Roles and Marriage on HIV/AIDS in Sub-Saharan  
Africa and Developing an Efficient Prevention Plan

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Abstract

HIV/AIDS research in sub-Saharan Africa shows an important relationship between gender roles, marriage, and HIV prevalence. Research is collected and analyzed, and cultural issues are addressed in order to develop a prevention plan. The African church seems to be an efficient venue through which to reach sub-Saharan Africa, and the most efficient prevention plan to curb HIV/AIDS is abstinence.

### The Curse of a Generation

Throughout the history of the world, viruses and plagues have wreaked havoc on thousands, even millions of citizens. Epidemics of global proportion have torn down cities and civilizations. At times, nothing is left behind but the remnants of death and the orphans of lost families. Every century has seen its share of plagues. The Black Plague was a global epidemic that lasted from the 1300s into the 1900s in some countries. With a fatality rate close to 60%, many areas were completely wiped out by bubonic plague. From the 1600s to the 1800s, tuberculosis led to major problems. In England and Wales, over 10% of all deaths from 1651 to 1851 were from tuberculosis, peaking at 25% in 1802. Diseases like diphtheria devastated the world into the early 1900s. Diphtheria normally presented as a cough but reported a fatality rate up to 37% in some areas (Lancaster, 1990). These diseases and many others such as measles, polio, and smallpox were conquered with the creation of vaccines. Nowadays, it is almost unimaginable to think of any disease running rampant throughout the country, much less the world. However, a look across the Atlantic Ocean provides a gaze into a world afflicted, living in fear and daily feeling the effects of such a plague.

The HIV virus was abuzz in the late 1980s, causing questions throughout the world of origin and virulence. There was some fear that HIV/AIDS could develop into such a superbug. Yet, once it was realized that HIV/AIDS was preventable, it was somewhat forgotten, and for the majority of the last 15 years, HIV/AIDS in the United States has mainly affected certain social groups of people, specifically homosexual males and drug users (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2008).

However, in sub-Saharan Africa, HIV/AIDS is a plague. Comparing the statistics, it is the most deadly virus that Africa has ever seen, possibly even the world. Recently, there has been a surge by popular media figures like Bono and others to find a cure for AIDS and to help the people of sub-Saharan Africa. Although great progress has been made in creating effective antiretroviral therapies, as well as in developing microbicides and vaccines, very little has been learned in understanding the epidemiology of HIV (Bongaarts, 2007). Statistics must be compiled and analyzed, and the people of sub-Saharan Africa must be educated on how to protect themselves and their families from HIV/AIDS. Gender roles and marriage clearly play a large part in understanding the people of sub-Saharan Africa. Using this information, a plan can be developed to help the people of sub-Saharan Africa overcome the curse of their generation.

In the United States, HIV/AIDS is less commonly thought of as a problem for heterosexual couples, especially in marriage. However, in sub-Saharan Africa, the main mode of transmission for HIV/AIDS is through heterosexual intercourse, and marriage is the central social institution in sub-Saharan Africa for regulating and allowing sexual activity (Bongaarts). Traditional Western thinking proposes that married couples should not be concerned about acquiring HIV/AIDS, but fidelity is not reality, especially in sub-Saharan Africa. Polygamy is accepted and recognized as a rich cultural tradition in some areas (Buseh, Park, Stevens, McElmurry, & Kelber, 2006). This promotes the spread of HIV/AIDS and must be dealt with as a risk factor for HIV/AIDS. But, as these cultural standards have come into question, deeper issues have risen to the surface. Gender roles are significantly grounded in traditional male-female roles, and women are often treated

poorly. Masculinity for sub-Saharan African males has always been about showing power, and acquiring wives is a very typical way for a man to feel validation about his status in the community (Hunter, 2005). Recently, studies have shown that marriage is a greater risk factor for HIV/AIDS than being single (Clark, 2004). Both the statistics and the cultural issues must be considered to develop an efficient prevention plan.

Marriage at any age has correlation with HIV prevalence, but there is specific correlation dealing with marriage at a young age or at an older age. Typically, the factors that determine large epidemics of HIV/AIDS are high frequency of sexual partners, absence of condom use, absence of circumcision of males, and infection with other sexually transmitted diseases. Although females are generally much younger than their husbands are at marriage, female age at marriage has been overlooked. Female age is important in analyzing risk of infection. First, there is a link between a high average age at marriage and a long period of premarital intercourse. During this period of intercourse, partner changes are common, which facilitates the spread of HIV. Second, previous research had neglected the role of marriage in HIV transmission. Results had been inconclusive at best, but a closer look specifically at female ages reveals statistical correlations (Bongaarts).

The female age at first sexual intercourse has changed little over time. The median age at sexual intercourse throughout sub-Saharan Africa is between 16.3 and 20.8. However, median age at first marriage ranges from 16.3 in Niger to 28.9 in Namibia. The definition of marriage for Bongaarts's study was both formal marriage and consensual union. The four countries with the highest median ages at first marriage were

Botswana (25.7), Swaziland (25.8), South Africa (26.7), and Namibia (28.9). These four countries have among the highest HIV epidemics in the world. When age at first sexual intercourse is graphed along with HIV prevalence, it is seen that there is no statistical correlation between the two (Figure 1). However, in graphs of median age at first marriage and HIV prevalence, strong statistical correlation is found (Figure 2) (Bongaarts).

Other regions in Africa do not suffer from HIV/AIDS as severely as sub-Saharan Africa. Along with age at first marriage, another risk factor tied into HIV/AIDS prevalence is male circumcision. Table 1 compares the statistics for each region in Africa, and it is clear that sub-Saharan Africa has a much higher HIV prevalence, a higher median age at first marriage, and a much lower percentage of males circumcised. These factors have proven to be extremely statistically significant, as “an additional year of premarital sexual intercourse raises prevalence by 1.52 percent,” and, “a 10% increase in circumcision reduces prevalence by 1.28 percent” (Bongaarts, p. 5). Male circumcision percentage and median age at first marriage explain 64% of between-country variation in HIV prevalence. The only exception out of the sub-Saharan Africa countries is Lesotho, which has a high HIV prevalence but not a high median age at first marriage. However, ecological evidence cannot be relied upon solely because it does not prove a causal relationship (Bongaarts).

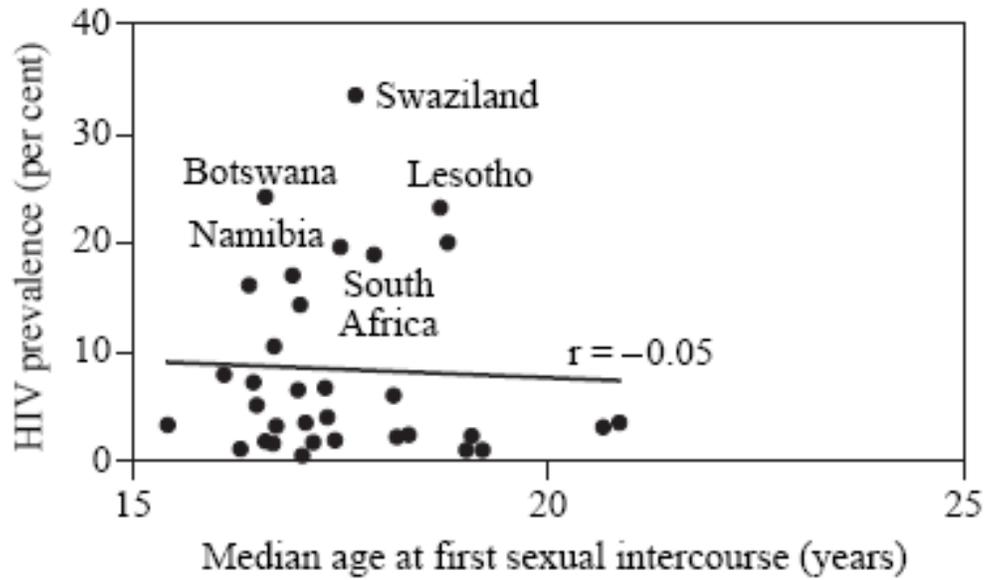


Figure 1. HIV prevalence by median age at first sexual intercourse for women in 33 countries in sub-Saharan Africa (Bongaarts)

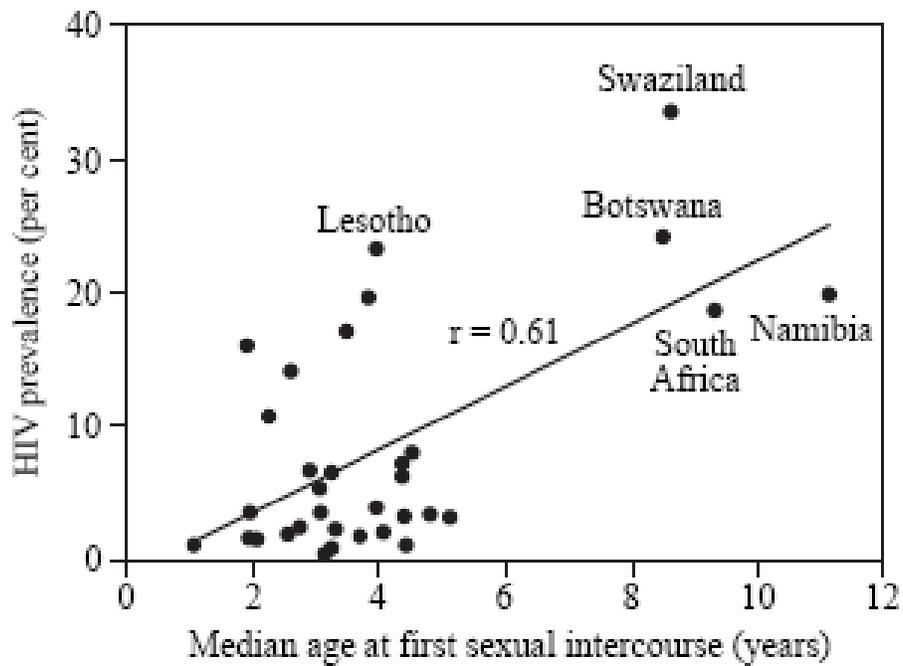


Figure 2. HIV prevalence by difference between the median age at marriage and median age at first sexual intercourse, 33 countries in sub-Saharan Africa (Bongaarts)

Table 1

*Unweighted averages of HIV prevalence among women aged 15-49, median ages at first sexual intercourse and first marriage, and proportion of males circumcised, given by region, from 2005 (Bongaarts)*

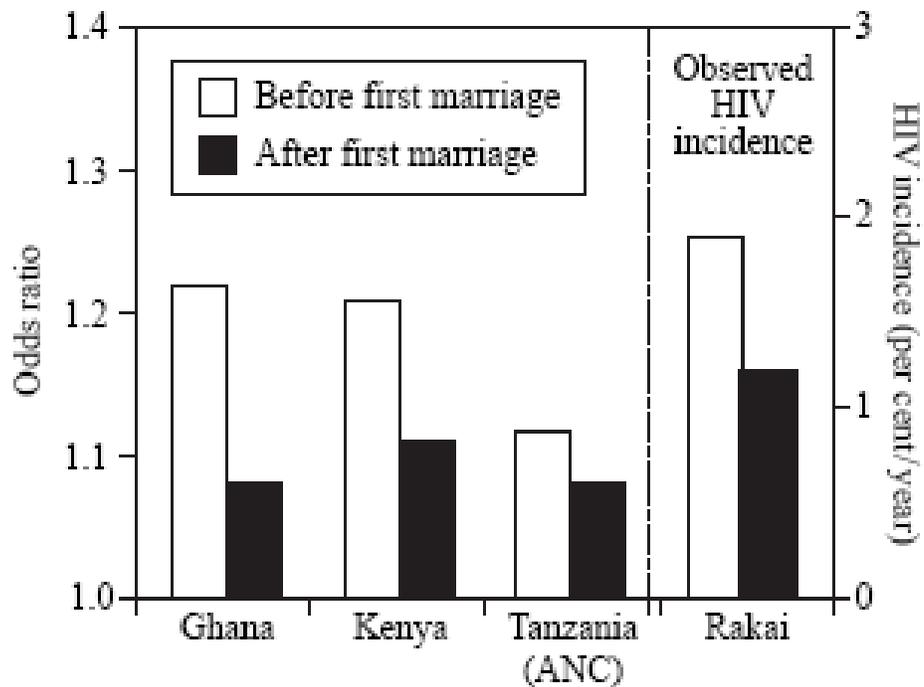
	Region			
	West	East/Middle	South	Total
HIV prevalence (per cent)	2.5	7.9 <sup>1</sup>	23.8 <sup>1</sup>	9.7
Median age at first sexual intercourse (years)	17.2	17.7	17.7	17.5
Median age at first marriage (years)	19.1	19.2	25.4 <sup>1</sup>	20.1
Difference, first sexual intercourse and first marriage (years)	1.9	1.4	7.7 <sup>1</sup>	2.6
Circumcised males (per cent)	77.8	46.9 <sup>1</sup>	21.2 <sup>1</sup>	54.3
<i>N</i>	12	16	5	33

<sup>1</sup>Significantly different from West Africa ( $p < 0.05$ ).

Some evidence appears contradictory to the idea that early marriage is a risk factor for HIV/AIDS. The odds ratio for HIV infection associated with a year of exposure is much higher before marriage than after marriage (figure 3, table 2). However, there are a few important factors to weigh when considering this. The duration of exposure increases HIV prevalence both before and after marriage, so there are effects on both sides of marriage. Also, the odds ratios are downwardly biased estimates of the actual odds ratio, since mortality is higher for infected individuals compared to uninfected individuals. This downward odds ratio bias is even greater when looking at odds ratios due to marital status. It is hard to establish the effects of marriage when looking at odds ratios, although it is entirely possible that the differences could be larger than shown in table 2 (Bongaarts).

Table 2.  
*Odds ratios for effects of duration of exposure to infection on HIV status among sexually active women aged 15-29 in 2003 in Kenya and Ghana (Bongaarts).*

	Odds ratio (95% CI)	
	Model 1	Model 2
<b>Kenya</b>		
Years since first sexual intercourse	1.16 (1.07–1.26)	
Exposure before first marriage (years)		1.21 (1.12–1.31)
Exposure after first marriage (years)		1.11 (1.02–1.21)
Urban residence	1.45 (0.92–2.29)	1.37 (0.86–2.18)
Years of education	1.05 (0.99–1.12)	1.02 (0.96–1.09)
Age	2.22 (0.98–4.99)	2.36 (1.08–5.19)
Age squared	0.98 (0.97–1.00)	0.98 (0.97–1.00)
Ever-married	1.44 (0.78–2.65)	
N	1,364	1,364
<b>Ghana</b>		
Years since first sexual intercourse	1.15 (1.00–1.32)	
Exposure before first marriage (years)		1.22 (1.07–1.40)
Exposure after first marriage (years)		1.08 (0.94–1.24)
Urban residence	1.14 (0.54–2.39)	1.02 (0.48–2.17)
Years of education	1.00 (0.92–1.08)	0.98 (0.91–1.05)
Age	0.63 (0.20–1.98)	0.54 (0.19–1.58)
Age squared	1.01 (0.99–1.03)	1.01 (0.99–1.04)
Ever-married	0.89 (0.32–2.50)	
N	2,009	2,009



*Figure 3.* Odds ratios for HIV infection associated with a year of exposure before and after first marriage in Ghana, Kenya, and Tanzania, and HIV incidence in Rakai 1994-2004 (Bongaarts).

In a survey of sexually active females between 15 and 19, Clark found that the HIV risk factors were frequency and duration of unprotected intercourse, number of partners, and HIV prevalence among partners. The first aspect of marriage that puts females at such a high risk is the greater frequency of sexual activity. Sexual activity among adolescent females occurs most frequently within marriage, as more than 80% of females who are sexually active between the ages of 15 and 19 are married (Clark). More infections occur within marriage than before it (Bongaarts). The key to analyzing marriage information is not to evaluate the risks for the population, but instead to

evaluate them for individual girls. When compared to unmarried adolescent females, married adolescent females were 8 to 12 times more likely to have had sex in the past week. The greater frequency in sexual activity is directly related to the cultural pressures married females face to get pregnant. In the study, between 20-33% of the married adolescent females were pregnant now, with another 20-25% hoping to get pregnant within the next year (Clark).

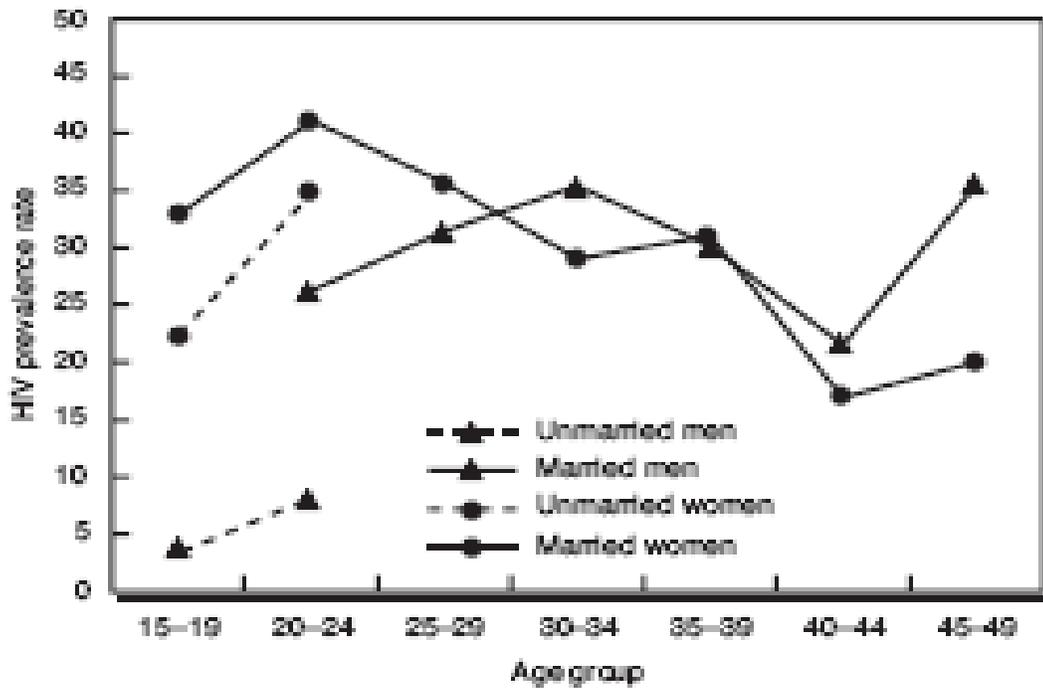
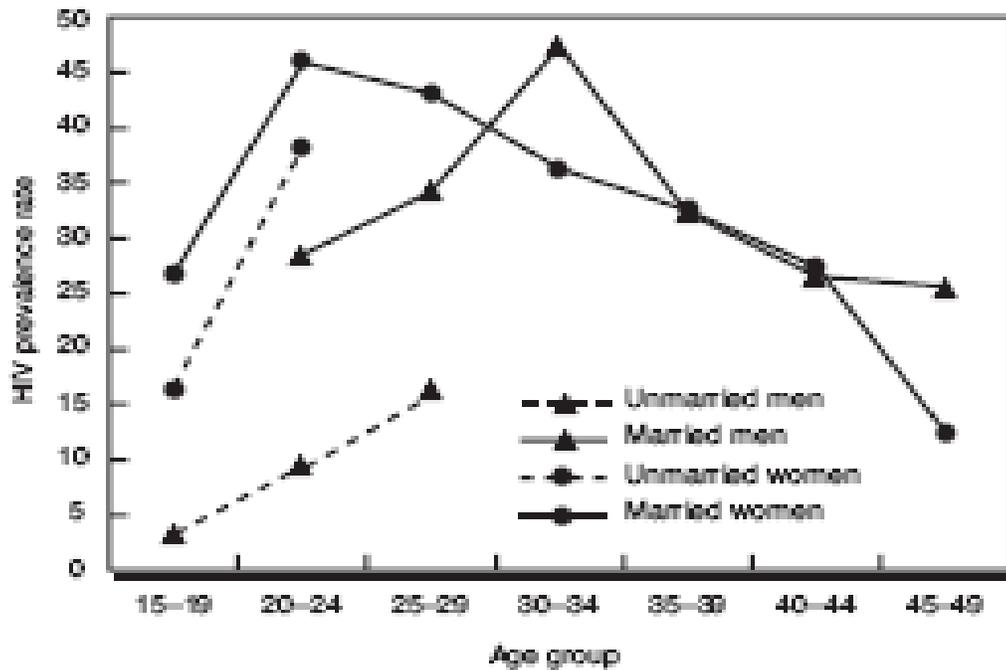


Figure 4. HIV prevalence among sexually active men and women, by marital status and age in Kismu, Kenya from 1997-98 (Clark)



*Figure 5.* HIV prevalence among sexually active men and women, by marital status and age in Ndola, Zambia from 1997-98 (Clark)

Married females did have lesser variation in the number of partners, but on average, married and single females have the same number of partners over the past year, since many married women averaged one partner with single females averaging somewhere between none and two (Clark). The proportion of married women with a non-spousal partner in the past year was about 2%, while the reported amount of never married women with such a partner was 57%, although the number of married women is most likely higher than reported (Bongaarts). Although this risk factor seems like less of a problem, polygamous marriage must be taken into account. Although the married women might only have one partner, their husbands might have two or three other wives,

along with any other women with whom they are sexually involved. Although such data is unaccounted for in the Clark survey, it must be remembered when thinking about risk factors for women who are married. Polygamous marriage will be discussed in greater detail later on, but it is important to note that females may be faithful to their husbands in marriage, but that does not ensure that they are at a lesser risk for HIV/AIDS (Clark).

The final risk factor in the Clark study was partner HIV prevalence rate. Partners for married women had HIV prevalence rates two to three times higher than the prevalence rates for single girls. Figures 4 and 5 both show high prevalence rates among those who are married, meaning that the married women are frequently engaging in sexual intercourse with their husbands, putting them at great risk for acquiring HIV (Clark). However, HIV infectiousness must be considered when discussing HIV prevalence. HIV infectiousness has been proven to be very high for a brief period after acquiring HIV. Then, the rate of transmission declines to a very low level for most HIV-positive individuals for some number of years. Infectiousness rises again years after infection as the onset of AIDS approaches, but this has a low epidemiological impact because of the reduced frequency of sexual intercourse owing to illness and changes in the virus within the host (Bongaarts). This is important because HIV infectivity is generally higher among younger men who have just acquired the virus. Married men in sub-Saharan Africa are typically older and have had the virus for a number of years. The differences in HIV infectivity could explain the higher odds ratios among never married women in table 2 and figure 3. Nevertheless, there is a great risk for married women and unmarried women based on the differences in infectivity and partner prevalence.

One risk factor that greatly affects married women is condom use. Condom use is affected by certain variables. In a study in South Africa, condom use was not associated with personally knowing someone with HIV/AIDS or who died of AIDS. Condom use was associated with younger age and urban residency where there is a stronger media influence and more information readily available on condom use, as well as condoms that can be easily acquired. There is also strong positive correlation between condom use and knowing that condoms protect against HIV/AIDS, higher education level, and sex with a non-marital partner (Camlin & Chimbwete, 2003).

Condom use is specifically mentioned and taught by the Center for Disease Control (2005) to women as an effective way to prevent HIV transmission. Married adolescent females are much more likely to engage in unprotected intercourse than their single counterparts (Clark). In Camlin's study, only 12% of sexually active women had used a condom in their last sexual intercourse, while only 30% were aware that a healthy looking person could have HIV. Condom use was tragically low among married women, with only 7% of them using condoms in their last sexual intercourse with their spouse. Compared to women with regular marital partners, condom use was 3.7 times more likely among women with casual partners and 2.4 times more likely among non-marital regular partners (Camlin & Chimbwete). Since married women are having sex more frequently than unmarried women, and they are rarely using a condom for protection, they are at a much greater risk for acquiring HIV than would be estimated.

The great risk for married women to acquire HIV is directly related to the cultural gender roles assigned to women in sub-Saharan Africa. Women are largely subservient

to men, and the men have all the power in the relationship. As the bread winner for the family, the man must be able to find a job and provide financially. Because of this, many men travel away from rural areas into the cities. They may be gone for months at a time, possibly even years, before they return home. Often, alternate sexual relationships are formed at these sites, but there is not much the woman can do about it. In Swaziland, a woman said:

If the man is unfaithful, it's difficult for us to say anything. For example, if a man becomes unfaithful and gets an STD, he will accuse the woman of giving him the disease. He blames her for him having extramarital affairs with another woman. We as women can't really say anything. (Buseh, Glass, & McElmurry, 2002, p. 179)

In this culture, men are allowed to be unfaithful, because there is little punishment. If the wife even considers standing up to her husband, she risks all sorts of abuse. Around 2% of women reported being mistreated in some way in the past year, although it can be estimated that that figure is somewhat low (Camlin & Chimbwete).

Polygamy is one of the major cultural hurdles to overcoming the HIV/AIDS epidemic. Traditional African systems promote polygamy, especially in rural areas (Buseh et al. 2002). In Swaziland, polygamy is recognized as a barrier to overcoming the spread of HIV/AIDS, since it is considered a rich cultural tradition (Buseh et al. 2006). Going back through African history, the role of masculinity has much to do with polygamy in marriage. In KwaZulu-Natal, a province in South Africa where one in every three individuals is thought to be HIV positive, a man with multiple sexual partners is

historically known as the *isoka*. In the early 19<sup>th</sup> century, having multiple partners was not the most important thing to a man. He had to provide for his family and those around him. Providing was a great part of his masculinity. A man who was the head of household was known as the *umnumzana*, and this was the chief end of many men. The *isoka* was seen as strong and masculine, but being *umnumzana* was more important. Because of this, sexual practices outside of marriage typically consisted of *ukusoma*, or thigh sex, to prevent childbirth. Also, at this time men were not solely concerned with having multiple partners, and even women were able to have limited relations with multiple partners (Hunter).

By the 1940s, the law stated that only men could have multiple sexual partners. An *isoka* was much different than an *isifebe*, a woman engaging in plural relations. An *isifebe* was seen as a loose woman. In this time period, though, a man could have multiple partners if he were married to them. If a man were unmarried with multiple partners, he was criticized and labeled an *isoka lamanyala*, literally a dirty *isoka*. A genuine man was a married man. Another change for masculinity was the role of penetrative sex. Thigh sex, or *ukusoma*, was not seen as strongly as penetrative sex was as a mark of manliness. This led to a great increase in STIs for the *isoka*, but diseases such as syphilis were not enough to counter the change in perception (Hunter).

By the 1980s, a great shift in masculinity and the role of the *isoka* occurred. Employment became extremely difficult to find in the area. Because of this, it became harder for men to pay the *ilobolo*, or bridewealth. Poverty led to a change in the definition of masculinity. Wedlock is out of the financial reach for many men, so marital

rates have been on the decline since this time. Also, since many women now hold jobs, the man may not be the *umnumzana* for his family. For men, becoming *umnumzana* through working, being married and providing for a family is often unrealistic, so sexual conquests fill the void. Describing the male attitude towards relationships with women, a seventeen year-old male in KwaZulu-Natal said, “If he has six, I want seven, then he wants to have eight” (Hunter, p. 397). The concept of *isoka* has been altered and changed. Although previous generations may have had one or two girlfriends, the practice now is much greater than that. Yet men still claim the history and cultural role of *isoka* outside of marriage. A twenty-two year old woman noted, “They say that it is their culture to have more than one girl. They say my grandfather had six wives, I want to be like him” (Hunter, p.397). *Isoka lamanyala* no longer refers to an unmarried man with many girlfriends; rather, it refers to a man who cheats on a girl with her friend, or a man who spreads HIV. Also, the practice of *ukusoma* (thigh sex) is almost unheard of, and many males in urban areas are unaware the practice ever existed (Hunter). This is but one example of the cultural identity of masculinity. Once found in providing for a family, it is now identified with the amount of sexual partners one has. Clearly, the men in sub-Saharan Africa have lost touch with their identity and have attempted to find it through sexual relationships. This is only the tip of the gender-roles iceberg when discussing HIV/AIDS, but polygamy must be brought to an end.

Poverty has played a large part in shaping gender roles in current-day Africa. There are still many parts of Africa where women are still extremely economically dependent on men. Men are viewed as the dominant sex, and this places women in an

impossibly difficult place when trying to discuss their feelings on certain topics, especially sex. Women cannot challenge an extra-marital relationship or propose condom use, simply out of fear that they could be left to fend for themselves in a man-dominated economic landscape (Marshall & Taylor, 2006).

Poverty can also place women in sexually-compromising situations where sex is a crude form of payment. Because a man is so fiscally valuable, women are taught that they should satisfy the sexual needs of the husband, ignoring their own desires and not expecting mutual sexual satisfaction. Also, there are some cases of young women prostituting themselves in sexual relationships with older men. These “sugar daddies” give the young girls presents in exchange for sex. These young women more than likely still have a sexual partner their own age but cannot lose the material provisions given by the older man (Marshall & Taylor).

Poverty drives women into these risky behaviors because sexual relationships are more than likely the only means of income they can attain. Commercial sexual transactions are all but inevitable among women heading their own household. Women with a husband who travels for work, as mentioned earlier, or any woman who has been separated or divorced are more likely to supplement their incomes through commercial sex work. Commercial sex workers are a cesspool of infection, passing HIV/AIDS and countless other sexually transmitted infections (STIs) throughout the general population. These women are desperate for income, yet they are at a great risk for receiving and spreading HIV/AIDS, especially since they are most likely engaging in unprotected sexual activity. Even with the recent rise in the amount of HIV/AIDS prevention

programs, there has been an increase in the commercial sex trade in sub-Saharan Africa (Mbirimtengerenji, 2007).

Women who are officially commercial sex workers are not the only ones using sex as a bargaining tool. There are millions of commercial sex workers in sub-Saharan Africa, but there are also millions of other women using sex as a form of payment in exchange for goods. These women engage in sexual activity, normally unprotected, having little regard for their lives. The questions they are asking are difficult ones. If their life is already so bad, what does it mean to get HIV/AIDS? If HIV/AIDS might not kill them for another ten years, they will probably die from something else during that time period anyway, so why bother using a condom? Men paying for the sex will usually pay a great deal more to not use a condom, and since these women are desperate to support themselves and their families, the risk is worth it. Girls of all age are at risk to be trafficked or prostituted, putting the younger girls at enormously great risks of acquiring HIV (Mbirimtengerenji). The poverty and economic roles forcing women to prostitute themselves are only aiding the spread of HIV/AIDS throughout sub-Saharan Africa.

Developing a prevention plan for HIV/AIDS in sub-Saharan Africa is a difficult task. There have been many attempts over the last decade to curb the existing epidemic and fight the spread of new infection. The statistics show some progress has been made, but the severity of the problem lies in sub-Saharan Africa. First, the percentage of people with HIV who are female is still significantly higher in sub-Saharan Africa than in the rest of the world (figure 6). Over the last seven years, the HIV prevalence percentage has leveled off in sub-Saharan Africa, but it has seen a steady decline throughout the rest

of Africa (figure 7). Sub-Saharan Africa does have the highest number of policies in place related to women’s vulnerability to HIV, but still nearly 90% of the world’s orphans live in sub-Saharan Africa (UNAIDS). This shows that the prevention programs in place now are working to curtail the problem, but not to defeat or eradicate it.

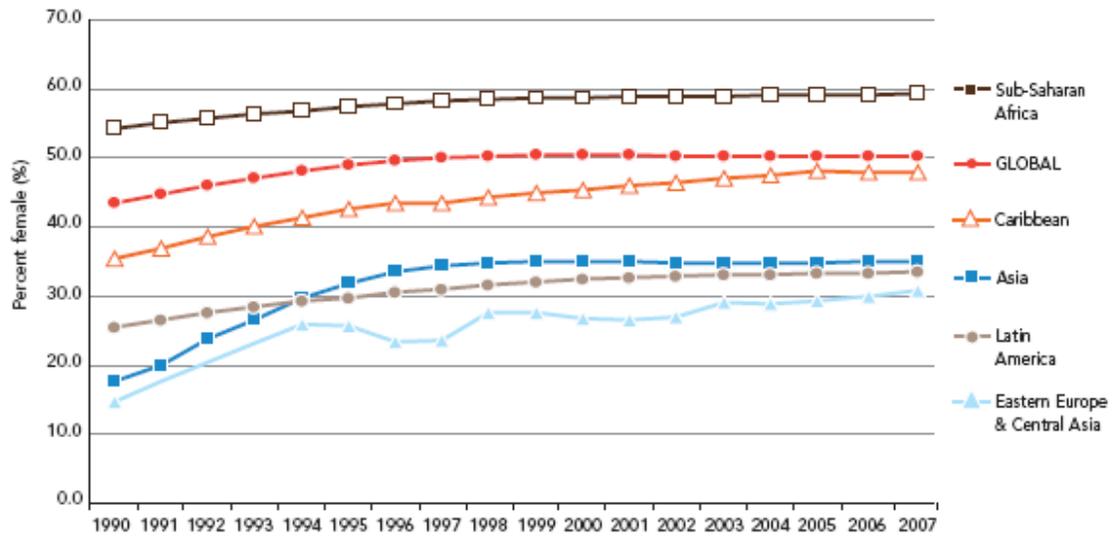
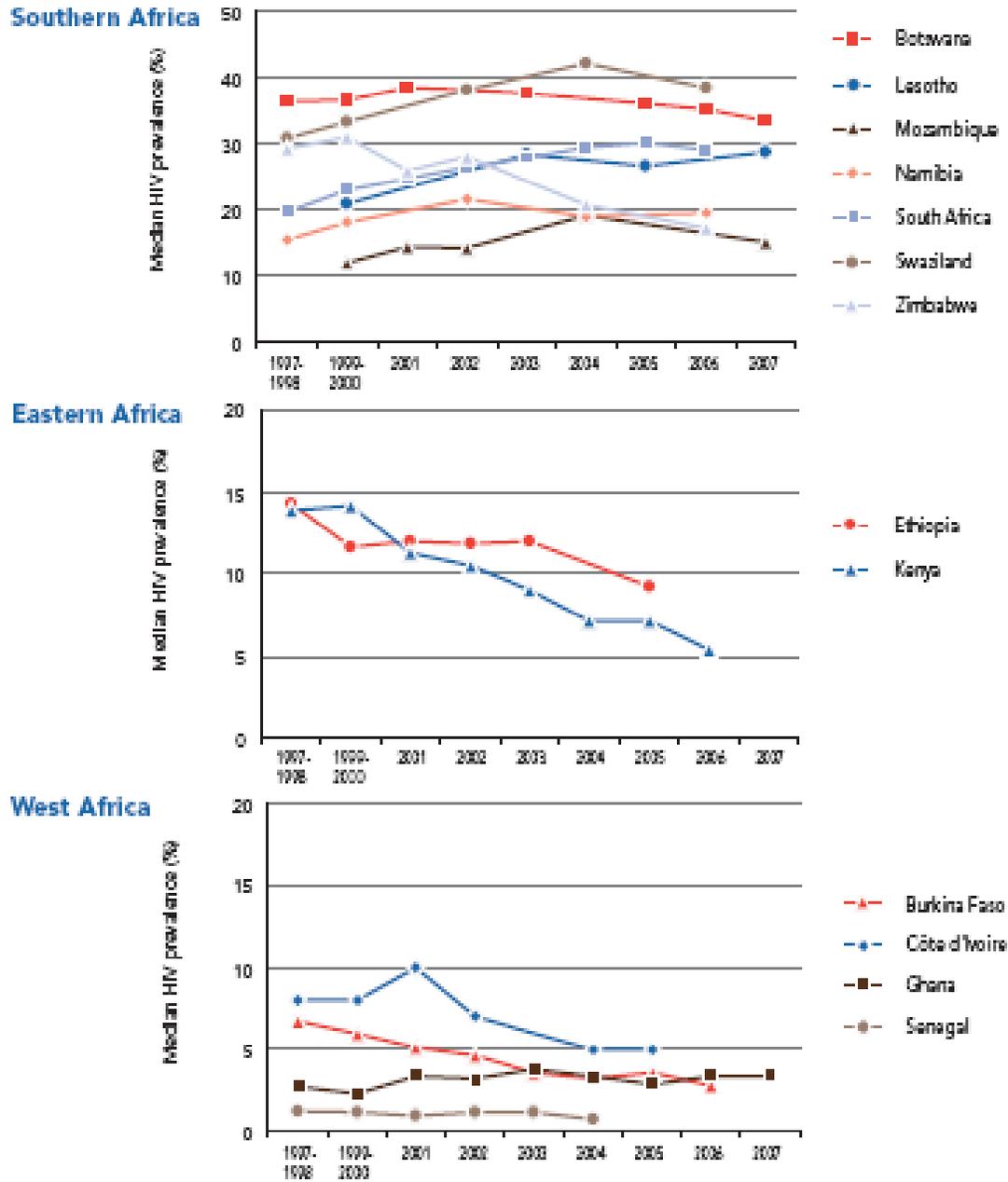


Figure 7. Percent of adults (15+) living with HIV who are female, 1990-2007 (UNAIDS).



Note: Analysis restricted to consistent surveillance sites for all countries except South Africa (by province) and Swaziland (by region). Source: National surveillance reports and UNAIDS/WHO/UNICEF, Epidemiological Fact Sheets on HIV and AIDS, July 2008.

Figure 8. HIV prevalence (%) among pregnant women attending antenatal clinics in sub-Saharan Africa from 1997-2007 (UNAIDS).

The first step in preventing HIV transmission in sub-Saharan Africa is to try to deal with cultural issues and to educate the people about HIV prevention. Increased knowledge about HIV/AIDS is linked to a decrease in social stigma, and decreasing social stigma is the first step in changing how the society perceives HIV/AIDS. In urban areas, there is a strong mass media influence about preventing HIV, but the local culture drowns out the voice of the media. There is correlation between HIV prevention in the mass media and a student's level of HIV prevention knowledge, so it is still important to stress HIV prevention through the media (Buseh et al., 2006).

Even though the mass media is important, students actually preferred receiving information from their parents or adults rather than the mass media (Buseh et al., 2006). There is well-documented correlation between young people discussing sex with their parents and lower levels of sexual risk-taking compared to their peers. Most young people reacted positively and expressed desire to discuss such issues with their parents, but they also acknowledged a low likelihood of any type of discussion ever occurring (Phetla et al., 2008). The problem is that communication about sex in sub-Saharan Africa is very taboo. Although the people of sub-Saharan Africa know the dangers of HIV/AIDS, there are strong social and cultural barriers that hinder communication between husband and wife as well as parent-to-child (Helleringer & Kohler, 2005). Historically, it is not seen as proper for sex to be discussed across generations, so promoting dialogue interaction among families on sexual issues is extremely difficult (Hunter).

The lines of communication must be opened for there to be a change in the next generation. In a recent study, sessions were conducted that encouraged adult female participants to talk with young people and challenge the cultural barriers about sex and sexual health. Integrated with discussion on economic skills and gender-based inequities, a curriculum of concrete skills and role-playing exercises helped women to better discuss these issues with young people. After completing these sessions, the participants showed an overall increase in discussion about sexuality and sex between women and children, with 80.3% compared to 49.4% in the control group. 97.6% of participants had discussed condom use. No longer using vague ideas about the dangers of sexual activity, the women were able to use concrete facts and knowledge to impress upon children the reality of HIV/AIDS. Knowledge was power for these women, and all they needed was a little encouragement and education. Such a drastic change only required a few sessions to help these women know what to say and how to say it (Phetla et al.). This is a simple but extremely necessary step to take in all areas of sub-Saharan Africa.

In rural and tribal areas, access to mass media and other influences are limited, so different approaches must be adopted and executed. There is some discussion about the effectiveness of incorporating HIV/AIDS prevention into folk media. Folk media is the term for information exchange through cultural methods like storytelling, drama, puppetry, songs, dancing, proverbs, and visual art. Folk media is a vital part of tradition, and it is also a great way to change public perceptions on certain issues. If folk media can be integrated with FM radio, a cheap and effective way to reach many in Africa, HIV/AIDS prevention messages could become accessible, relevant, and informative for

many rural areas throughout sub-Saharan Africa (Panford, Nyaney, Amoah, & Aidoo, 2001).

Cultural norms can be integrated into HIV education and prevention. For example, in many areas of Uganda, the *senga* (father's sister) is responsible for socializing adolescent girls into sex and marriage. The *senga* is somewhat like a female father, but in recent years, socio-economic changes have weakened the role of the *senga* as a medium for communication on sexuality. To combat this, modernized *sengas* were chosen by the community. These women were chosen because they were trusted by other women and seemed approachable. The modern *sengas* were then educated using a sexual health information curriculum focusing on HIV/AIDS, condom use, talking about sex, and other important issues. Over the next year, over 400 visits were made to the *sengas*, many of them about STD information and sexual information. The *sengas* specifically were designed to help the poor and uneducated, and they succeeded in counseling and encouraging many young men and women on sexual issues. The *sengas* became community counselors, and they were socially acceptable because they were based on a cultural practice. They were able to mix traditional cultural information on becoming a good wife and being faithful with modern messages empowering women to discuss safe sex and to educate their partners (Muyinda, Nakuya, Whitworth, & Pool, 2004).

Another idea involving tribal traditions and HIV education is involving HIV prevention with the traditional coming of age ceremonies. In urban areas, coming of age ceremonies are declining and even disappearing, but there are still areas in Africa where such practices are valued. Although it is just one aspect of an effective prevention plan,

incorporating education into the traditions of hard-to-reach tribes throughout sub-Saharan Africa would be an extremely applicable way to educate each and every tribe. The traditional ceremony already incorporates instructional forums on puberty, sex, and marriage. This setting is perfect for incorporating messages on HIV/AIDS. AIDS outreach workers could help educate tribal leaders and inform them on how to convey vital information through the ceremony (Groce, Mawar, & Macnamara, 2006). This allows each tribe to establish their own way of communicating and to teach their young people about HIV/AIDS, all while transferring information that can save their villages.

In regard to age at marriage, there is some debate over how much change would occur if women were to be married earlier or later. Very early marriage is a negative, because it puts girls at risk who would otherwise not be sexually active (Bongaarts). Delaying marriage is also not the only answer, because a delay in marriage most likely postpones childbirth, which in turn could increase the probability that the mother is infected at the time of birth (Clark). Also, Bongaarts showed that late marriage can also be a risk factor for acquiring HIV/AIDS. The key issue in age at marriage is the timing of the first marriage in relation to the timing of first sexual intercourse. If a girl gets married before she would typically become sexually active, then she is at a greater risk than if she were not married. Similarly, if a girl gets married long after her first sexual intercourse, she increases the likelihood of having multiple partners and therefore increasing her risk for HIV/AIDS (Bongaarts).

There is one means by which treating and implementing HIV/AIDS prevention plans can be most effective – the African church. The church in Africa has been

acknowledged as a key factor against AIDS in Africa (Scheffler, 2008). Non-governmental organizations reach 30 percent of the poor in Africa, but the churches reach 90 percent of them (Sugden, 2005). It is recognized that the church is not perfect. Many churches struggle to separate cultural ideology and Biblical teaching. One example is the Biblical texts on wives submitting to husbands. Taken out of context, these texts can be interpreted to support an unbalanced view of gender roles. However, they forget to incorporate other passages dealing with equal submission to one another in love and men and women both being created in God's image. Many churches have the ability to reach more people than non-governmental organizations, but there is a need for proper teaching and education for those in the church (Marshall & Taylor). Combined with small groups encouraging discussion about sex and counselors to answer specific questions, the church is a great avenue to encourage HIV/AIDS prevention and help stop the epidemic before it continues to destroy this generation.

The message the church must preach is one of abstinence, because "in every African country where HIV infections have declined, this decline has been associated with a decrease in the proportion of men and women reporting more than one sex partner over the course of a year" (Green & Ruark, 2008, p. 22). Uganda is one successful example of abstinence education. In early 1990, Uganda had an HIV infection rate of 15 percent. The rate fell to 5 percent by 2001, and stood at an estimated 6.7 percent by 2005. The strategy used by the Ugandan government was the "ABC" approach – abstinence, being faithful, and condom use. This is a balanced approach to HIV prevention. Even though there is some skepticism surrounding the ABC system, there are

clear results that cannot be ignored (Murphy, Greene, Mihailovic & Olupot-Olupot, 2006).

Although Uganda is the most prominent example of the ABC approach being effective, there are many other countries that have implemented the ABC system for HIV prevention. Thailand, Kenya, Cambodia, Ethiopia, and Haiti are just a few of many countries that have experienced national or sub-national declines in HIV after adopting the ABC approach. The message of abstinence, faithfulness, and condom use must be adjusted and balanced based on social and cultural factors. The ABC approach has been most effective when integrated into the lives of the people it is being taught to, and it

Is good public health, based on respect for local culture. It is an African solution, developed in Africa, not in the United States, and has universally adaptable themes. Also, the ABC strategy's effectiveness has been affirmed by other leaders in the international community as the most effective way to prevent sexual transmission of HIV. (World Health Organization, 2008, p. 1)

Internationally, the recognition that the ABC system can work anywhere and has worked in sub-Saharan Africa before is evidence that it should continue to be taught to the people. The results in Uganda have proven to be unique in sub-Saharan Africa, as other sub-Saharan African countries have not experienced such drastic changes in HIV prevalence (WHO). However, abstinence education can work in sub-Saharan Africa because the nature of the message relates to the depth of the problem. The heart of sub-Saharan African gender roles is multifaceted, and the ABC approach promotes education,

community involvement, and personal responsibility. Abstinence is truly the only way to change sexual behavior and ensure the end of sexual HIV transmission (Green & Ruark).

HIV/AIDS has the potential to ruin the future of sub-Saharan Africa. Already, 90% of the world's orphans live in sub-Saharan Africa, and although transmission rates have slowed, they have not stopped. This generation has the chance to analyze the overwhelming amount of evidence before them and to recognize how the problem should be addressed. Gender roles and marriage are two crucial areas that need to be focused on through education. Prevention programs must be integrated into the culture, and the church needs to take the lead in counseling and small groups promoting abstinence. Outside of abstinence, no other method can truly preach a possible end to heterosexual HIV transmission, which is the main method of transmission in sub-Saharan Africa. When history looks back at this time period, a crucial balance will be have been swayed, and either HIV/AIDS continued its dominance and prevalence throughout sub-Saharan Africa, or the first steps were carried into leaps and bounds preventing HIV transmission throughout the area.

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