The Social Implications of HIV/AIDS

The wide spreading of the AIDS/HIV epidemic is perpetuated by social constructions that are being spread by the uneducated masses. Stigmas have been attached to the deadly viruses such as, “It is a gay disease;” to the children in Africa thinking that the AIDS is only around the corner for them. According to a study preformed by Sheryl Thorburn of Oregon State University and Laura Bograt of Rand Corporation one of seven African Americans believe that the government introduced AIDS into the black population as a form of population control. There is no positive literature to offer these children and therefore their mind frame of AIDS is morphed into something negative. In this paper I am going to concentrate on adolescent sexuality behaviors, how funding for sex education of HIV greatly affects the spread of HIV, and how a major change in social institutions, norms, values, and practices surround the control and development of sexuality in youths (Mensch et al., 1999).

The decreasing hold of the community on sexuality and sexual behaviors may cultivate the population to HIV/AIDS related risks. After looking closely to Northern Namibia, there were only 4 cases of HIV recorded. In 1991 the number jumped to 1,261 and again in 1996 to 21,737, and more than 53,000 in 1998. According to UNAIDS 1998, Namibia is among the four worst affected countries by HIV. Although Malaria is a significant problem, AIDS has been the leading cause of mortality of Malaria and TB put
together. In a population of 2 million, 90% of those people were estimated HIV positive. 86.3% of the infected were between 15-44 years old. I choose to use a society that was comprised of an African American origin. In the U.S. alone, more than half of the new HIV/AIDS cases reported, were African Americans. The women diagnosed with HIV/AIDS were 70% African American women. Of the children born to HIV-infected mothers, 62% were African American.

A single member of the community can not explain social sexual constructs, so in Northern Namibia there were extensive interviews. They included health care workers, traditional healers, AIDS counselors, community and religious leaders, teachers, military personnel and people with HIV/AIDS. In the Owambo community, pre-initiation sexual relations consisted of customary arrangements that allowed young boys and girls to legitimate relationships that involve “playing” holding hands or touching (Loeb 1962). They are not allowed to perform sexual intercourse, but are encouraged to explore. Even at an early age sexuality is a positive aspect of life, and there are no negative results. And efundula is a ceremony that is symbolizes the woman’s journey from adolescent to adulthood (Becker 1993). This ceremony symbolized the fertility of the woman and her community, and that she would have a full sexual life. This ceremony had no correlation with the menstruation of the woman. Many parents held the ceremony when the women were 25 or 30 so their command for power would be longer (McKittrick 1995: 207). If the girl was pregnant and was non-initiated then they were killed or shunned from the community. “Owambo society did not see the girl as a victim of the boys overtures. She, even more than the boy, was someone who had jeopardized the community’s well being
by being reckless…the girl always bore the brunt of punishment which was unequal’ (McKittirck 1995: 208)

The sexual roles within the household favored males having more than one partner, while women can only have a sexual relationship with their husband. While married, the men had many sexual partners outside the marriage. If a woman participated in sex outside the marriage then she was burned and killed. The men’s only restriction is that they could not have sex with a married woman, and if they did, they would only be fined in cattle or property. An interview with a woman in the community resulted in her saying “now it is risky with STDZ and AIDS. Men don’t take account of this.” These ritualistic practices have been around before the introduction of the AIDS virus. The lack of sexual education in this area could greatly affect the sexual behaviors of Northern Namibia. With the emergence of HIV/AIDS the behaviors have only changed slightly. Condoms are used on small occasions. ‘Clean girls’ are also a solution to extra sexual partners. But looking for ‘clean girls’ only works if they are free of HIV/AIDS.

Commercialization of sex is a growing problem. 60% of the population live on $2 dollars a day. The government understands that lack of jobs and poverty contribute to the commercialization of sex. It is also taboo to discuss sex in public or with people of different ages. Discussion of sexual matters or sex health promotion work can not be achieved due to the taboo restraint. There is a challenge that deals with creating a model of sexual education that works with the ongoing traditions of Namibia.

The idea of education can be backed by the literacy problem of African youth. With the high incidence of HIV and AIDS among the young people, reading is significant. In Claudia Mitchell’s article she asks, “Where does literature/literacy figure
into the AIDS crisis, does anybody read, who has access to print, and who can afford to produce tests that are not read? There needs to be a “new literacy” to aid the prevention the spread of HIV/AIDS and survival of the citizens of Africa. The messages of HIV/AIDS prevention are abstinence, being faithful, and using condoms. The message gets lost in the idea the epidemic only affects the rural Black youth and gay community.

A HIV positive diagnosis is a death sentence. This adds an important angle that can help explain why there is a large rape total, “Last week one guy was telling his friends that he was going to rape all the girls who denied him before when he was clean. Now he was going to give them this AIDS and show them something” (Deane and Maphumalo 2000:11). One tenth grader in a essay competition wrote on AIDS and said:

“All around me there is despair. Instead of looking forward to the future in my country I now dread the obvious possibility that there might not even be one. Wherever I turn there are pessimists who feel the only solution is emigration. AIDS has robbed me of my hope. AIDS has affected me to such an extent that I am no longer afraid of murderers, tyrants or even harsh criminals. I am only afraid of AIDS.”

While HIV/AIDS are a worldwide crisis, in South Africa the numbers are rising at alarming rates. The national rate is 22.8%, and the large number of growth is in youth and young women. Studies have shown young women are more than three to four times likely to be infected with the HIV virus. Here is an observation from Charles (1990) of UNESCO:

“HIV/AIDS presents the greatest learning challenge to education systems. In the past, the consequences of failure to learn involved simply a delay in progress from one academic level to another or confinement (sometimes temporary) to a lower socio-economic order. With HIV/AIDS the consequence of pedagogic failure is terminal.”

In the literature provided the youth do not find themselves to be a victim of the problem. The presentation views HIV/AIDS as a disease that affects adult males. If there
is no literature addressing the AIDS as a problem of the youth, then this problem is viewed as someone else’s problem. In Gross’ research there was a strong depiction of the transmission of HIV/AIDS through blood-to-blood contact. There is an elusion that injecting drug usage and unprotected heterosexual sex does not affect the AIDS problem. There are also no roles that show young adults in pressure situations where high-risk can be avoided (Gross 1990).

There is a high incident of gender-based violence, which can be connected to the high occurrence of HIV/AIDS among young girls (Mlamleli et al. 2001, Kumar et al. 2001). Writers have the opportunity to use literature to address issues like “aggressive masculinity, biological vulnerability, negotiating sex ( and the dangers of saying “No”), HIV testing, disclosure, and so on.” Education in the school is limited to abstinence, in a community where youth is already sexually active at the age of 14; this could be a problem. Literature would be a great way to explore the other issues that affect the youth.

According to a study done in Yaounde, Cameroon with 426 men and 510 women aged 15-24, HIV is 5-7% higher prevalent in young women than in men, even though they have fewer sexual partners. Before we discuss the sexual activity of women we first need to focus on the initiation of the female sexuality. In most traditional communities marriage is the end of virginity. As the age for first sexual experience lowers, sex is no longer limited to marriage. The change is related to the modification that appears to be the main factor in the new development of the norms and adaptation of new sexual behaviors. In 1998, 8% of women in the north were having premarital sex, compared to 69% in the central –south province. In sub-Saharan Africa women 55% are infected with HIV.
Yaounde, the administration capital of Cameroon, is situated in the central province and has a population of over 1 million. In 1988, the prevalence of HIV among pregnant women was 1-5% (Kaptue et al., 1991). Ten years later, it was 55% (Glynn, 200). Among commercial sex workers, a prevalence of 6-9% was recorded in 1987-88 (Kaptue et al., unpublished); in 1997, it was 34% (Tongo et al., 1999), (Morison et al., 2001). At the national level, in 2000, HIV prevalence among pregnant women was estimated at 11% (Macauley, 2001), with some regional differences: the prevalence for HIV ranged form 4% to 17.8% among pregnant women from urban areas and from 6.4% to 14% among women from semi-urban/rural areas.

In this research there were medical tests and questionnaires. The information collected consisted of the sexual partners in the individual’s lifetime and the last 12 months. For those that were sexually active they were asked specific information on the last sexual relationship. Age, education, ethnic group, relationship length, condom use and if there was an exchange of money. They also asked the age of first intercourse, the number of partners in the last 12 months and lifetime. They also asked who had sexual relations with an older or younger person. The second phase of the research was medical testing. Univarite and multivariate tests were performed among the youth of Yaounde. The following chart shows the findings.

Through the research, people noted that of those who had never had sexual intercourse, 3% of men and 9% of women had sexually transmitted diseases. “Most importantly, a recent study from Masaka, Uganda (Carpenter et al., 1999), showed that HIV incidence among discordant couples was significantly higher among women aged 13-24 who had HIV-positive spouses than among men in the same age group who had an infected partner.” According to the Demographic and Health Survey (DHS, 1998), states 90% of young Cameroonians between the age of 15-24 said they know about AIDS. A scary statistic says 35% of the young Cameroonians do not know how to avoid contracting the virus. The government also funds family planning services. However,
many adolescents in Cameroon do not have access to the service. The factors contributing to this problem are geographic or physical, financial, and cultural.

In the United States we are fortunate enough to have the lead federal agency in HIV prevention. The Center for Disease Control (CDC) is the primary distributor of federal funds to state and local health departments and nongovernmental agencies for HIV prevention programs (Foster et al. 1999; Institute of Medicine 1997). Billion of dollars have been raised to prevent the spread of HIV/AIDS. The CDC designates $560 million to state and local health departments and nongovernmental agencies for HIV prevention. The departments used funding to hold activities. The activities included: “(a) screening for HIV and other STDs; (b) counseling to help uninfected persons remain uninfected and to help infected person avoid infecting others; (c) educational and risk reduction interventions to increase awareness of the potential risks of sexual activity and to teach methods to reduce this risk, such as abstinence or the use of condoms; (d) medical treatment of persons with curable bacterial STDs such as chlamydia, gonorrhea, and syphilis; and (e) notification and treatment of the sex partners of persons with STDs (Valdiserri et al. 1997; Institute of Medicine 1997). These activities have been found to reduce the risky sexual behavior by 20-30% (Kamb et al. 1998).

The United States may not have the alarming numbers compared to the African communities discussed in this paper, but we need to education ourselves to overturn HIV/AIDS. We are fortunate to have a government that will provide funding and spread prevention information. Aside from needle usage with an infected person, sexual behavior is responsible for a large number of infected people. This problem crosses
cultures. By looking closely at these communities where it is an everyday problem we can change our behaviors to protect ourselves against the virus.

Work Cited


