

Socio-cultural Factors and the Transmission of HIV/AIDS in Malakand Division: A Qualitative Analysis

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Abstract:

The epidemic of HIV/AIDS has devastating impacts on many societal features of both urban and rural communities. Cultural factors have been played a significant role in human decision making and behavior around health. In simple terms, culture basically refers to the traditions and customs upheld by societies and communities because of their belief systems and values, which guide their decisions and shape their thinking, actions, attitudes and behaviors. The role of culture has been of particular significance both in the transmission of HIV/AIDS. Certain cultural practices such as: gender inequalities; unequal access to health care services; injectable drug users; unequal access to economic resources and opportunities; and male dominance contribute to the spread of HIV/AIDS. The current

study aims to investigate how various cultural factors contribute in the transmission of HIV/AIDS. The study was conducted in Malakand Division of Khyber Pakhtunkhwa province, while using a qualitative approach. Further, primary data was collected from 15 respondents through in-depth interview (using interview guide) while the selection of the sample was made through non-probability sampling using purposive sampling techniques. The collected information was qualitatively analyzed and a thematic discussion has been made for better understanding of the issue. The researchers also suggests some remedies.

Introduction

Historically, HIV/AIDS has been one of the worst diseases and the leading cause of death around the world. It is the most *fear* word in many societies of the world, and associated with many cultural myths and perceptions, and not discussed openly. The rapid increase in HIV has been the result of many different social webs and cultural practices of people. The stories of HIV patients are not their individual production, rather the socio-cultural context other than individual is at its back. In a broader sense, culture means 'to cultivate' and is generally used when referring to patterns of human activity and the structures that give these activities meaning and importance (Linton, 2016). Culture is the source of formation of our attitudes and behaviors; influences our actions; and we cannot act outside of the culture in which we had been born and grown (Loosli, 2004). Culture also means the way of life for an entire society, which includes: codes of conduct; norms of behavior; dress; language; law; morality; religion; and systems of belief and practices (Jary & Jary, 2008). Cultural norms and values influence a person's decision making including his/her decision regarding health (Guss, 2002). Moreover, culture is the learned, shared and transmitted values, beliefs, norms and life ways carried by groups of people that bind the individuals in society, guides their decisions, thinking and actions (Leninger, 1991). The role of culture has been of particular significance both in spread and fight against HIV/AIDS.

Certain cultural practices such as: gender inequalities; unequal access to health care services; injectable drug users; lack of HIV/AIDS related knowledge and information; unequal access to economic resources and opportunities; unequal power relations; male dominance; and polygamy contribute to the spread of HIV/AIDS. The socio-

cultural system influences one's knowledge and information about HIV as well as provides them opportunities of preventing themselves from the infection. Also socio-cultural factors determine and direct power relations between individuals in most societies around the world, which in turn form day to day life, influence one's social standing and access to resources including healthcare (Campbell, 2004).

Relevant literature shows that culturally driven gender inequalities have also contributed in the transmission of many diseases including deadly HIV/AIDS. Culturally produced unequal gender relations exist in matters related to sexual intercourse, and in many traditional cultures sex has been mainly practiced for the pleasure of men and in order to express masculinity (Reid & Cornell, 2004). In such hierarchically structured unequal power and gender relations individuals have different levels of access to wealth, political influence, respect and social recognition, where resources are not collectively held, rather used by few in order to increase their influence, wealth and control others. In patriarchal societies, the husband exercises power within the household and gender is an important concept in discussing HIV/AIDS. Women subordination and the apparent sexual and economic superiority of men over women has been regarded the central factor in women's poverty and make them vulnerable to HIV infection (Schoepf, 1988 & WHO, 1995). The disease (HIV/AIDS) has its roots in the socio-cultural fabric and this aspect needs be accessed properly in order to control further spread of the disease.

Statement of the Problem

HIV/AIDS have been regarded as the world's serious public health challenges and takes the lives of many individuals each day. In Pakistan,

HIV/AIDS is spreading at an alarming speed both in rural and urban communities. HIV/AIDS is a much feared word in Pakistan, the infected people are looked on with suspicion, and the disease is viewed as deadly and not discussed openly. Pakistan has been regarded as a high risk country for HIV/AIDS (Baqi, Shah, Baig & Mujeeb, 1997), while the government of Pakistan has been fighting against HIV/AIDS since the first case was reported in Pakistan in 1987. Most intervention for controlling HIV/AIDS is targeted on high risk populations and a wide range of other important factors are ignored. The present study was based on the premise that socio-cultural factors are pivotal in the transmission of HIV/AIDS, and ignoring these factors is myopic vision in controlling the disease. It is further argued that the transmission of many infections including HIV/AIDS is interwoven in the social fabric and many strands work together in this regards. This study particularly accounts for factors like: culture and HIV related information; culture; power relations and HIV; gender inequality and HIV, culture; social stigma and HIV and culture; poverty and the transmission of HIV/AIDS. The study was conducted in District Dir Lower and Upper of Malakand Division, Khyber Pakhtunkhwa, province of Pakistan in order to investigate that the broader socio-cultural factors have an impact on people's lives, and perpetuate the spread of HIV/AIDS.

Methods and Procedures

The present study utilized qualitative research design. In this regard, the sample was taken from the total registered HIV-positive patients of District Dir Lower, District Dir Upper and District Swat (Pakistan National AIDS Control Program, 2019). Further, primary information was collected from 15 respondents through in-depth interview using an interview guide. The selection of samples was taken through non-probability sampling using purposive sampling technique (Neuman, 2002; Babbie, 1998). For maintaining the anonymity of the respondents codes were used instead of names. In order to develop insight into the issue under study, detailed primary information was collected from the selected respondents using secondary information as a base. Keeping in consideration the nature of the study, the collected information was elaborated, inter-

preted and thematically discussed under various themes and conclusions were drawn on its basis for clarification and understanding of the issue under study. For tackling ethical issues, prior consent (informed consent form) was signed from the respondent's explaining the study purpose, its nature, and objectives. The study and sampling technique were consistent with similar qualitative studies conducted by Delawala & Ahmed, 1995; Compton, 2006 & Mlobeli, 2007.

Results and Discussion

General and Demographic Characteristics of the Respondents

Demographic information shows that respondents who were interviewed belong to different age groups. In this regard, 05 (33.3%) respondents were in an age group from 25 to 35; 07 (46.6%) were in the age group of 36-45; while the remaining 03(20%) were in age group from 46 to 55. Further, information also shows that most of the respondents 07(46.6%) belong to a joint family system; 03(20%) were from an extended family; and the rest, 05 (33.3%) were from a nuclear family system. In addition, on the basis of education level, 06 (40%) of respondents were illiterate; 05 (33.3%) were educated up to primary level; while 2 (13.3%) each were educated up to middle school and above level. On the basis of marital status, respondents were distributed into married, unmarried categories i.e. married 12 (80%; unmarried 3 (20%). Demographic information is important and indicates the type of study participants, their social, economic and educational background along their social settings. It also shows the maturity level of research participants, their diversity and thus validity of data collected.

Table 1: General and Demographic Characteristics of the Respondents

Age Group	Frequency	Percentage	Total
25-35	05	33.3	05
36-45	07	46.6	07
46-55	03	20	03
Total	15	100	15
Family Type	Frequency	Percentage	Total
Joint Family	07	46.6	07
Extended Family	03	20	03
Nuclear Family	05	33.3	05
Total	15	100	15
Education	Frequency	Percentage	Total
Illiterate	06	40	06
Primary	05	33.3	05
Middle	02	13.3	02
Matric & Above	02	13.3	02
Total	15	100	15
Marital Status	Frequency	Percentage	Total
Married	12	80	12
Unmarried	03	20	03
Total	15	100	15

Culture, HIV/AIDS Related Knowledge and Transmission of the Disease

HIV/AIDS related knowledge and information influence the possibility of people engaging in unsafe sexual practices (Quine & Rutter, 2002). Hoosen & Collins (2004) & Perkel (1992) argued that HIV related knowledge is necessary for making people informed about the disease and provide them an opportunity of preventing the virus from spreading further. During this research the respondents were asked 15 specific questions in a face to face interview about their basic knowledge regarding HIV/AIDS; it was revealed that most of them have no in-depth understanding of these words. While most of these respondents used the terms HIV and AIDS synonymously. In this regard, respondent's HIV/AIDS related knowledge was not satisfactory and many believed that HIV/AIDS cannot be cured or prevented and they regarded HIV/AIDS is a syn-

onym for death. This was substantiated during field interview and a respondent shared similar views:

„...HIV/AIDS are synonymous to death and these are not curable. It transmits from one individual to another through eating together, sharing bed, and shaking hands. In my opinion HIV/AIDS simply means fatal disease...“

Similarly, majority of the respondents also believed that a person with HIV will show symptoms of illness soon after contracting the virus and that HIV is not a curable disease. Most of the respondents also did not know or understand the difficult names of other infections related to HIV/AIDS and therefore did not understand what healthcare providers tell them regarding the diagnoses of the illness.

„...He is an illiterate person, and for him it is not easy to understand the complicated names of HIV related infections. It is also difficult to know about the proper diagnosis, treatment and prevention of the disease...“

Relevant research studies shows that HIV related knowledge and information is important in the fight against the disease and poor knowledge about the disease promote the spread of the infection. Individual factors such as knowledge and confidence without a doubt, plays a key role in sexual behavior and thus contributes in the spread of HIV (Hook, 2004), while these factors are shaped by a person's social context in which he is living.

Culture, Imbalance Power Relations and HIV/AIDS Transmission

The power relations can be defined as the relations between groups or individuals in a hierarchically structured society. Traditional cultural practices, such as gender-role expectations, power-relations and hierarchical structures, form a very important part of the community's day to day life (Campbell, 2004). Various research studies indicate that in any society socio-economic inequalities have been contributing in the transmission of sexually transmitted diseases including HIV/AIDS. In socially constructed power relations, individuals have different levels of access to wealth, influence, respect and social recognition, while few accumulated social and economic resources. Primary information also indicates

similar results and during an interview a respondents told that:

„...Poor people’s access is barred to social and economic resources and majority of the sick people are the poor people. As the poor have no power; are most vulnerable to disease; so HIV/AIDS mostly infect the poor...“

Analyzing the field information, it is evident that excessive numbers of the respondents were poor. They have lesser access to productive resources and health care services. The public issue like HIV/AIDS was interpreted with bias and disguise, while the poor were looking to the rich class for its solution.

„...In our culture the poor are looked upon with disgust and they are considered as the vectors of the infection. While the rich people blame the poor for HIV/AIDS transmission and they decide and define daily good and bad from their own point of view ignoring their wrong doing...“

Literary evidences indicate that HIV/AIDS mostly flourish in marginalized social groups having no access to economic power and resources (Barnett & Whiteside, 2001). And they could not promote healthy a society and a health-enabling environment because of the broader socio-cultural determinants of the society (Campbell, 2004 & Craddock, 1991). In this way it is important to look at the social, economic, cultural, political, gender and environmental factors along with the biological causes (Kalipeni *et al*, 2007). The spread of HIV is determined by the wider social context within which communities are located (Campbell, 2004), and the existing gulf between rich and poor significantly contributes to the spread of this deadly disease.

Culture, Gender Relations and Transmission of HIV/AIDS

In patriarchal societies men are seen as more intelligent, independent and superior to women. In these societies gender remains an important concept in HIV/AIDS related discussion. Further, men are seen as powerful in the family and in society and they make major decisions, while women are supposed to respect and accept men’s decisions (Shefer & Boonzaier, 2003). Such dependency keep women poor and make them vulnerable to various health issues (McFadden,

1992, Schoepf, 1988). Field information indicates imbalance in gender relation between men and women, where men enjoyed economic superiority and made major decisions, while women’s role was limited to indoor activities: An extract from the field interview:

„...Yes, in our culture men are dominant, and they are regarded as superior and decision makers. Men accumulate and spend money according to their own will, while women are deprived of economic opportunities and decision making process...“

Relevant studies also found that power relations between a man and woman also occur in their sexual relations, and it is men who decide what will happen in such relationships, and thus put themselves and their partners at risk by having multiple sexual partners and in majority of situations refuse to use condoms (Collins, 2003). In this regard a respondent during interview explained:

„...In our society women are always at the mercy of men (fathers and husbands). Men are sexually and economically stronger than women, and have several wives, while women choices are restrained. Women’s access to health services are also decided by the males in society...“

Generally, womens’ unemployment, lack of education, and worst paid jobs, make men more powerful, and subjugate women. In most parts of the world women are dependent on men and thus forced to tolerate their dictates without considering the consequences of these on their lives (Shefer, 2003), while men in order to show their masculinity are not willing to use condoms (Collins, 2003). Women are seen as objects for men’s sexual pleasure, and it is expected of them to accept sex without condoms in order to satisfy her male partner. It was explained by a respondent during a field interview that:

„...In our society women are dependent on men and accept their decisions in life. Decision about sex, and the use of condoms is also made by men not women...“

In this context, women accept unprotected sex because of the belief that 1) accepting unprotected sex is an evidence of trust, 2) desires for using a condom can be understood as a sign of disloyalty or 3) that the person making the request is HIV positive (Willig, 1999 & Guardian, 2006). Fur-

ther, sex by using contraceptives is also regarded as unreligious and it is regarded as controlling the population. Similar opinions were also expressed by a respondent during an interview:

„...Using a condom is un-Islamic and contrary to religious teaching of producing more children. Nothing happens without the will of Allah. The use of contraceptive could not control disease...“

In this sense, men's demonstration to maintain their status quo and their vested interests would bring harm to many in the world (Baaylies & Bujra, 2007). Thus, gender power relations aggravate the problem of HIV/AIDS, and many educated mothers thus avoid providing sex education to their adult daughters (Mbugua, 2007). In the present context too, men's dominance and economic superiority kept women deprived of their rights and most of the women are poor because of their lesser access to economic resources. It also leads men to exercise their power in sexual relations and thus expose both men and women to infections and diseases including HIV/AIDS.

Culture, Poverty and the Transmission of HIV/AIDS

Culture determines the socio-economic status especially access to economic resources and opportunities (Singer, 1993), and multiple social factors which determine individuals' health-related behavior are linked to the unequal distribution of economic power (Campbell, 2004). Poor people often lack adequate food, nutrition, shelter, and have lesser access to productive resources; education and they are extremely vulnerable to illness like HIV (Thelen, 2003). Field information also shows similar results and it was revealed by a respondent during an interview:

„...Poverty compelled him to work at early age of 13 in an auto mechanic workshop. Behavior of the owner was intolerable and harsh, and thus, he fled to Lahore where he worked in a hotel. He was exposed to many risks and unhealthy practices there...“

In this regard, the poor will at first work towards fulfilling their most basic needs before they will satisfy their need for health, safety, etc. (More, 2003). Similar studies also show that there is a close interrelatedness between culture and poverty as well as between poverty and

HIV/AIDS. Halperin (2001) & Coovadia (2000) argue that it is a fact that poverty has contributed to the spread of the disease. The analysis further supports the literature that poverty also exacerbates the risks of HIV/AIDS in many direct and indirect ways. In the given context a respondent explained during an interview:

„...He is a poor man, and because of his poverty he migrated to many parts of the country as well as abroad for earning a livelihood. He added that he also went to Malaysia, and it was during his stay abroad that he acquired the infection...“

Because people of rural areas are of low socio-economic position, and having far fewer work opportunities these men leave their homes in order to find employment elsewhere. Different research has shown that migrant workers often participate in high risk sexual behaviors during the times they spent away from home and infection rates among such workers is thus higher than the general population (United Nations, 2005). An extract from an field interview:

„...Actually, people of rural areas are poor having no economic opportunities. We migrate to big cities for finding a job, where we also found different situations. Away from home sometimes compel you to engage in unsafe sexual practices...“

The need for money and economic survival many times force people to behave in manners that might increase the risk of HIV, and satisfying basic needs of food, water, and shelter look to be the greater priority of the poor than the potential long-term consequences of risky health behaviors including unsafe sex (Halatshwayo & Stein, 1997). People's level of economic freedom are associated with high-risk behaviors i.e. a woman whose sexual partner economically supporting her and her children, will have less freedom to refuse sex without a condom, but a woman who can support her family economically on her own can resist sex without a condom (Campbell, 2004). Women in order to improve their economic situation and to support her children might also have concurrent partners.

Conclusion

The study concluded that culture plays a significant role in shaping people's lives including their health. Culture is a source of knowledge and

information, and these in turn are vital in promotion and prevention of various diseases including HIV/AIDS. Further, culture determines the streams and dimensions of interactions between males and females and influences their power relations. Such relations are considered significant in decisions related to health and accessing health. Furthermore, cultural settings and many social strands also shape our behavior and attitudes, particularly our health related behavior. It also determines the male and female different access to economic resources and accumulation of property which in turn is regarded as a decisive factor in controlling various diseases including HIV/AIDS.

Recommendations

HIV/AIDS is not only a medical issue but it is interwoven in the socio-cultural fabric of society. The spread as well as control of the infection could be found in social context and cultural factors and the study suggests redefining of certain cultural myths and perceptions that prevent HIV/AIDS patients from seeking prevention and treatment. Further, as HIV/AIDS is a taboo word and not openly discussed in our society, this issue should be discussed in all its forms and manifestation, in order to prevent its transmission. Moreover, as HIV/AIDS related knowledge and its disseminations is culturally defined and determined, the study thus recommends promotion of HIV/AIDS related information and education for both men and women, and increases their access to information and HIV prevention methods in order to reduce HIV/AIDS. In order to effectively fight the menace of HIV/AIDS, there is a need for specifying the role and place of the various religious leaders and institution to help the country's HIV response program and provide spiritual counseling to individuals living with HIV/AIDS. Furthermore, the fight against the disease is impossible without behavioral change and thus it is a necessary to tackle those sociocultural behaviors and values that expose individuals to the risk of HIV.

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