

**PERCEPTIONS OF HIV/AIDS PREVENTION WORKERS IN
SOSHANGUVE OF THE ROLE OF TRADITIONAL AFRICAN BELIEFS IN
HIV/AIDS PREVENTION**

by

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DECLARATION

I declare that

PERCEPTIONS OF HIV/AIDS PREVENTION WORKERS IN

SOSHANGUVE OF THE ROLE OF TRADITIONAL AFRICAN BELIEFS IN

HIV/AIDS PREVENTION at VISTA UNIVERSITY is my own work and that all

sources that I have used or quoted have been indicated and acknowledged by means of

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SUMMARY

The aim of this study is to explore whether and how traditional African values manifest in a present-day, urban South African setting and whether these values could have an impact on HIV/AIDS prevention programmes. Five interviewees who work and live in Soshanguve confirmed that some traditional African beliefs still play a role in the lives of people in Soshanguve. Several authors stress the fact that certain traditional beliefs and values place people at risk with regard to HIV/AIDS infection. Some of the traditional African beliefs that continue to shape and inform the behaviour of people who live in Soshanguve could therefore place them at risk with regard to HIV/AIDS infection. These risks should be underlined in HIV/AIDS prevention programmes presented in Soshanguve.

In the problem statement for this study the question is asked: how can traditional African beliefs and values be utilised in HIV/AIDS prevention programmes in Soshanguve? According to the P-E-N model or strategy, traditional cultural beliefs and behaviours may be categorised as positive (P), exotic (E) or negative (N), and treated accordingly. In terms of the P-E-N model, positive cultural beliefs and behaviours are those which are known to be beneficial in HIV/AIDS prevention.

The emphasis in a community like Soshanguve should be on *positive* (P) beliefs and values that can be utilised in HIV/AIDS programmes. Traditional healers, community leaders and church leaders should all be involved in these programmes. Success stories in Africa point to the need for cultural sensitivity as well as the importance of involving the whole community in the fight against HIV/AIDS.

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CHAPTER 1

INTRODUCTION

Background to This Research

According to Whiteside and Sunter (2000) at the start of the twenty first century South Africa probably had the largest number of HIV/AIDS infected people of any country in the world. The only nation that comes close to South Africa in this statistic is India with a population of a billion people, compared to the South African population of less than fifty million.

Peter Doyle of Metropolitan Life developed a model for predicting AIDS prevalence in 1991. This model has been widely recognised as providing sober future scenarios concerning the AIDS epidemic (Crewe, 1992). Doyle developed two scenarios: his high projection (“Scenario 60”) calibrated HIV infection to data from other African countries and assumed no change in behavioural patterns. His low projection (“Scenario 61”) calibrated HIV infection as above but assumed significant changes in sexual behaviour taking place 12 years into the epidemic. The results of the Doyle scenarios are presented in the following table:

Table 1.1
Summary of Doyle Model Projection for South Africa

	1991	1995	2000	2005
HIV infected				
High	97 000	970 000	4 112 000	6 410 000
Low	97 000	970 000	3 700 000	4 762 000
AIDS deaths				
High	1 350	23 000	203 000	525 000
Low	1 350	23 000	197 000	429 000
AIDS sick				
High	1 190	25 000	259 000	743 000
Low	1 190	25 000	255 000	618 000
Cumulative deaths				
High	2 200	47 000	602 000	2 588 000
Low	2 200	47 000	594 000	2 321 000

Source: Crewe (1992). Centre for Health Policy, AIDS in South Africa

Current Situation

Whiteside and Sunter (2000, p. 69) used these statistics to underline the fact that “we are already running ahead of schedule because the latest estimate for 2000 is about 4,2 million HIV-positive adults and children”. This exceeds even the “high scenario” in Doyle’s Model.

In 1989 Agadzi described AIDS as an American and homosexual problem. The picture has changed and researchers must now face the reality of the AIDS pandemic in Africa. According to Van Dyk (2001a), unprotected sex between men and women accounts for most of the new HIV infections among adults in Africa. According to Green (1994) it also seems as if condom promotion had limited success in Africa. From these scenarios Crewe (1992) concluded that only a major change in sexual behaviour would prevent South Africa from suffering a massive human tragedy. According to current statistics (Van der Walt, 2003) a change in sexual behaviour has not taken place. It is especially the high incidence of HIV/AIDS in sub-Saharan Africa (Van der Walt, 2003) that poses many questions.

According to Leclerc-Madlala (2000), the general lack of behavioural change was at first attributed to scant information. She stresses that over time ongoing studies demonstrate a combination of adequate knowledge and continued high-risk behaviour: “Today there is hardly any doubt that more and better constructed information campaigns will do little to change behaviour” (Leclerc-Madlala, 2000, p. 29). This poses many questions concerning preventive programmes. Leclerc-Madlala, (2000, p. 29) is also of the opinion that we need to reflect with seriousness on what makes the African AIDS problem “so stubborn, so unrelenting, and so smug in silence.”

Formulation of the Problem

The problem that I deal with in this study is described by the following question:

How can traditional African beliefs and values be utilised in HIV/AIDS prevention programmes in Soshanguve?

Aim of the Study

The term “traditional African” is used by different authors to draw a distinction between African belief systems and western belief systems (Van Dyk, 2001b). It may also be used to compare the “traditional African” belief system with other belief systems such as the “eastern” belief system. According to Meyer, Moore and Viljoen (1997), the term “African” is used to describe diverse groups of indigenous people in the sub-Saharan region of Africa. There is a diversity amongst these people that includes religion, linguistic and cultural aspects as well as a life style somewhere between traditional and modern (Meyer et al, 1997). Notwithstanding these differences, Sow (1980) and Gyekye (1987) are of the opinion that it is possible to talk of an African perspective that can be distinguished from a western or eastern perspective. According to Sow (1980, p.125) there is a unity within the African culture that he describes as:

a unity that is evident in the realm of spirituality as well as in that of representation and expression, from works of art to behaviors manifested in everyday lifeThere is no doubt that, with a few variations, African thought has a distinctive character, deriving its principles from symbols and myths (merging into one universe and society in which the African person/personality is formed) as well as from a collective ritual (permitting precise location of the individual in relation to his environment and course of his development).

Meyer et al. (1997) warn psychologists not to evaluate data about the behaviour of Africans from a western perspective, without taking note of the worldview of Africans. Taking the differences between western and African beliefs and assumptions into account, the aim of the study is to explore if and how some traditional African values manifest in an urban South African present-day setting and if these values could have an impact on HIV/AIDS prevention programmes.

CHAPTER 2

TRADITIONAL AFRICAN BELIEFS AND VALUES

Belief Systems

In the beginning it was called “Juliana’s disease.” It was first noticed in the village of Lukunya, on the Ugandan border sometime in early 1983. A handsome Ugandan trader had come through selling cloth for women’s kangas patterned with the name Juliana. A village girl with no money traded the stranger sex for a kanga, as did several other women who coveted the beautiful Juliana cloth. Some months later the first girl became sick: she had no appetite, could hold down no food, and had constant diarrhoea, which filled her with shame. In a few weeks she wasted away, grew weak, and had to be carried everywhere. Before she died, two other women, also adorned in Juliana’s cloth, came down with the strange disease. The people of Lukunya decided that the Ugandan was a witch, and that Juliana’s cloth had evil powers. To conquer Juliana’s disease, traditional healers toiled to lift the stranger’s curse. They were, however, unable to lift the stranger’s curse and the death toll continued to rise. Within a year the curse had spread to the neighbouring villages. Rumours of widespread witchcraft were spreading throughout the Kagera region, and traditional healers felt compelled to solve the Juliana mystery (Garret, 1995, pp. 334-335).

Amid the millions of dead and dying AIDS victims, the debate about the origin, spread and ultimate expected outcome of the AIDS disease is alive. It is a debate that echoes different viewpoints and underlines the diversity of human belief systems. The Juliana story underlines a certain belief system. This belief system differs from other belief systems, such as the western belief system.

The Traditional African Worldview

According to Van der Hoeven (1992) many Africans live in two worlds: a traditional African world in which traditional beliefs and values play a huge role, but also in a world where western norms and values determine their lives. Van Dyk (2001a) works within the mainstream medical and psychological stream in South Africa and she also underlines differences between traditional African and western beliefs and assumptions. According to her the most important difference between traditional African thought approach and western thinking is the degree to which traditional African thought is characterised by a holistic outlook: “The traditional African approach is truly holistic in its integration of the biological, psychological and transpersonal aspects of illness” (Van Dyk, 2001a, p.227). According to Meyer

et al. (1997) the traditional African worldview is based on a holistic and anthropocentric ontology. Humankind forms an inseparable whole with the cosmos, and everything, including nature, spirits, and God, is seen in its relationship to man, who is the centre of the universe. Sow (1980) is an anthropologist and he distinguishes three cosmic orders within this cosmic whole. The macrocosm, the meso-cosmos and the microcosm (Sow, 1980). These three cosmic orders will now be discussed in order to arrive at a better understanding of the traditional African worldview.

The Macrocosm

According to Mbiti (1989), the daily functioning of traditional Africans is fundamentally a religious functioning. Religion influences all levels of their lives:

Wherever the African is, there is religion: he carries it to the fields where he is sowing seeds or harvesting a new crop; he takes it with him to the beer party or to attend a funeral ceremony; and if he is educated, he takes religion with him to the examination room at school or in the university; if he is a politician he takes it to the house of parliament (Mbiti 1989, p. 2).

According to Viljoen (1997) in traditional religious systems God is seen as a supreme being or creator who has withdrawn from human beings, and is distant and remote from the people. The living spirits of the deceased ancestors therefore play a more important role in the everyday existence of African people than God, who is believed to have left people to fend for themselves (Sow, 1980; Viljoen, 1997).

According to Mbiti (1989) traditional religion is not linked primarily to the individual. The whole community is influenced by religion, which also emphasises the collective functioning of the traditional African. Mbiti (1989, p. 2) goes so far as claiming that in traditional society there are no irreligious people. "To be human is to belong to the whole community, and to do so involves participating in the beliefs, ceremonies, rituals and festivals of the community".

The Meso-cosm

The meso-cosmos is according to Meyer et al. (1997) an intermediate universe which functions as a no-man's-land. Genies, evil spirits, witches and sorcerers dwell in this no-man's-land. Sow (1980, p. 6) calls the meso-cosm the

“structured collective imaginary” because it gives rise to all good and bad fortune. It also gives form to people’s desires, fears, anxieties and hopes for success. The psychological fate that the individual experiences on a day-to-day basis can, according to Sow (1980, p. 6), be described as follows:

... the day to day psychological fate of the individual human being is modulated by a subtle dialectic complex (often ambiguous) relation between humans and the creatures of the meso-cosmos (African genies and spirits): invisible but powerful, good or bad, gratifying or persecutory.

Behaviour according to the African-perspective is a result of external agents (Meyer et al., 1997). This also has according to Van Niekerk (1992) the implication that behaviour and events in the traditional context cannot always be linked to empirical and rational explanation, since it is often linked to unseen people and forces behind the empirical and rational reality.

The Microcosm

The microcosm represents everyday practical and social life. According to Meyer et al. (1997), it is on this level that the difference in ethos and values between western and African people has a direct impact on behaviour. According to Nobles (1991), the modern western ethos centres on individual survival; the “survival of the fittest”. The rationalism of Descartes (1596-1650) focuses on the subjective experience of the individual. His well-known proposition, *Cogito, ergo sum* (I think, therefore I am,) forms the basis for his philosophy. According to Viljoen (1997), the work of Descartes laid the foundation for introspective and subjective studies of the individual. In contrast with the western ethos, which places the primary emphasis on the individual, the African ethos emphasises the survival of the group and unity with nature. Mbiti (1989, p.106) maintains that the traditional African’s identity is fully linked to collective existence:

Only in terms of other people does the individual become conscious of his being, his duties, his privileges and responsibilities towards himself and towards other people. When he suffers, he does not suffer alone but with the corporate group; when he rejoices, he rejoices not alone but with his kinsmen, his neighbors and his relatives whether dead or living. ... Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can also say: “I am because we are; and since

we are therefore I am”. This is the cardinal point in the understanding of the African view of man.

The Traditional African Worldview and Illness

Without a thorough knowledge of these three cosmic orders, the psychological and social dimensions of AIDS in Africa cannot be fully understood and appreciated (Van Dyk, 2001b, p. 60).

According to Van Dyk (2001b), despite the differences between Africans from different cultures in terms of linguistics, religiosity, geography and ways of life, there is a dominant socio-religious philosophy that is shared by all Africans. Van Dyk links the way African people perceive illness to the three cosmic orders that I have already discussed. AIDS as an illness can also be linked to the traditional African's worldview.

Illness on the Macrocosmic Level

As indicated, ancestors form an important and inherent part of the functioning of traditional Africans. Ancestors usually play a role to preserve the honour and tradition of the tribe and to protect their people against evil and destructive forces (Bodibe, 1992; Hammond-Tooke, 1989; Van Dyk, 2001b). Van Dyk (2001b) also underlines that ancestors can punish their people by sending misfortune and illness if certain social norms are violated, culturally prescribed rites and practices are neglected or incorrectly performed, or when people do not listen to wise counsel.

Ancestor-caused illness is perceived to be much less frequent than illnesses from other causes. When they occur, the ontological balance is usually restored through sacrifices and offerings to the ancestors (Beuster, 1997; Mbiti, 1989).

As far as AIDS is concerned, Van Dyk (2001a) reports that she has not found any indication in the literature that AIDS is ever ascribed by traditional Africans to the wrath of ancestors, or to God's punishment. On the other hand Van Dyk (2001a) claims that the influence of Christianity can clearly be seen in the beliefs of some black Christians who believe that AIDS is God's punishment for immorality and sins. This belief is found amongst some Christians of all races (Van der Walt, 2003). Agadzi (1989, p. 148) asks the following question concerning God's punishment: "Could it be that the 'wrath of God' has at long last reached its maximum tolerant level ...?"

Illness on the Meso-cosmic Level

Knowledge about the meso-cosmos is according to Van Dyk (2001b) especially important for understanding the behaviour of Africans because nearly all forms of illness, disease, conflict, suffering, accident and death are ascribed to this level (Sow, 1980; Viljoen, 1997). Van Dyk (2001b) also underlines the fact that traditional Africans do not believe in chance, bad luck or fate:

They believe that every illness has an intention and special cause, and in order to combat the illness, the cause must be found and counteracted, uprooted or punished. In their quest to understand illness, the questions “why” and “who?” are uppermost in the minds of traditional Africans. (Van Dyk, 2001b, p.61)

In his research conducted in a traditional Ciskeian rural area in South Africa, Hammond-Tooke (1989, p.123) found that traditional healers classified illness and misfortune in terms of their causes, as follows: 72% were perceived to be caused by witches and sorcerers; 8% by the ancestors and about 17% by “non mystical” factors such as drunkenness and accidents. In an urban area the figures were different; 45% was being attributed to witchcraft or sorcery, 7% to ancestors and 48% to “non mystical” factors.

On a meso-cosmic level most Africans recognise an immediate cause as well as an ultimate cause for disease or misfortune (Van Dyk, 2001b). A patient with malaria may according to van Dyk (2001b) fully understand that she has been stung by a mosquito that carried malaria parasites and that this is the immediate cause of the illness. This person will still ask “why me and not another person?” According to Van Dyk (2001b, p. 61) the only answer that will really satisfy this person is: “that someone, by means of magical manipulation, has ‘caused’ or ‘sent’ the mosquito to sting her and not her neighbour.”

This is the reason why many traditional African people simultaneously consult traditional healers and medical doctors regarding the same problem. The traditional healer is consulted to diagnose the personal cause of the condition (e.g. bewitchment) or to prevent a recurrence of the condition by performing a ritual. The western doctor is consulted for medication to treat the condition symptomatically (Mbiti, 1989; Herselman, 1997; Van Dyk 2001b). Van Dyk (2001a) is of the opinion that if health care professionals do not understand this belief in the immediate and

ultimate causes of illness, they may feel threatened by the idea that black people do not trust white medicine.

On a meso-cosmic level witches or sorcerers also seem to play a significant role in the understanding of illness and misfortune in traditional African society (Felhaber, 1997). According to Van Dyk (2001a), African people often use the services of witches and sorcerers to send illness, misfortune, bad luck and suffering to their enemies. On the other hand, they also perceive their bad luck or illness as something that has been brought upon them by witches and sorcerers.

Witchcraft is believed to be the causal agent in HIV transmission and AIDS infection in many African countries (Van der Hoeven, 1992; Stanley, Leclerc-Madlala: 2000; Van Dyk, 2001b). This is found to be more so among the rural poor or least-educated people (Boahene, 1996). In his study, Yamba (1997) found that 18% of Zambian subjects named witchcraft as the cause of all recent deaths in their village. These included deaths from AIDS. More than 25% ascribed sexually transmitted diseases (STDs) to witchcraft.

According to Beuster (1997), accusations of witchcraft and sorcery mostly occur when the harmony of the group is threatened or disturbed by conflict, jealousy, unhealthy competition and tensions that arise in closed community life. It is understandable that AIDS has disturbed this harmony, especially in Africa.

Death is often only understood on a meso-cosmic level (Viljoen, 1997). Yamba (1997) points out that death is only accepted as natural when old people die. When younger people die it is seen as a punishment from evil spirits and witches. From the African perspective there is a strong link between witchcraft and the breakdown of society. To blame external factors has according to Van Dyk (2001b), a protective function because it prevents feelings of guilt and alleviates anxiety:

Belief in witches also helps people to impose meaning on the things that happen to them and provides answers that science cannot give, such as an explanation of the personal or the ultimate cause of illness (Van Dyk, 2001, p. 61).

Boahene (1996) found that people who believe that AIDS is caused by witches are more likely to be supportive of HIV/AIDS patients. This has contributed to the belief that these patients became infected with the virus through sources “beyond their control”.

Despite the psychological advantages of blaming HIV/AIDS on external forces, witchcraft beliefs also have some very negative implications. Rotter (1966) makes a distinction between internal and external locus of control. Persons who make use of internal locus of control believe that they can to a great extent determine what happens to them. On the other hand people could believe that they have little control over their own lives and what happens to them (external locus of control). If external forces (external locus of control) such as witches determine one's life, feelings of helplessness and hopelessness can arise.

According to Viljoen (1997), the belief that everything that happens to a person can be attributed to external, supernatural beings or powers implies that individuals cannot be held accountable for their own behaviour. Personal initiative in searching for solutions is then also repressed.

Witch-blaming also has a very high cost for the accused. There are still many examples of witches being hunted down and killed in Africa. According to Yamba (1997), in 1994 a person with the name of Charka started a witch-hunt in Chiawa, a village in Zambia. The witch-hunt started after a number of disasters had struck Chiawa. Nine people drowned after their boat ran into a hippo; a tractor overturned and nine people were crushed to death; and a number of people died from AIDS-related illnesses. A wealthy, beautiful woman called Bridget was one of the AIDS victims. Six months before her death Bridget invited most of the villagers to a party and announced that she had AIDS. A year after her death stories began to circulate that Bridget had died, not from AIDS, but from witchcraft. The proof for this reasoning was that none of the men who “moved” with Bridget had developed any AIDS symptoms. By February 1995, Charka's witch-finding had resulted in the death of sixteen local people.

Illness on the Microcosmic Level

On the microcosmic level, Van Dyk (2001b) identifies “pollution” and “germs” that could cause illnesses in the traditional African village. Pollution is linked to ritual impurities which are usually also associated with death, the reproductive system and the violation of sexual prohibitions. According to Van der Hoeven (1992), traditional healers link AIDS to pollution that is caused by sexual

intercourse with a woman who is menstruating or breast feeding, or who has recently had an abortion. On a micro-cosmic level traditional Africans do believe in some diseases such as colds, influenza, diarrhoea in children, STDs and malaria (Felhaber, 1997).

In a study conducted by Green, Jung and Dgedge (1993) in Mozambique they recognised two broad categories of illness believed to be sexually transmitted, namely *siki*- and *nyoka*-related illnesses. *Nyoka*-related illnesses are less serious genito-urinary problems that are believed to be caused by pollution as was discussed previously. *Siki* (derived from the word “sick”) refers to more serious STDs. Biomedical STDs like syphilis, gonorrhoea, chlamydia and chancroid are examples of *siki*-diseases and are believed to be caused by a common invisible *khoma* (a microscopic agent, small animal or insect). It is thought to be contracted sexually or through contact with genital discharges.

Van Dyk (2001b) admits that AIDS is generally not seen in Africa as either a *siki*- or *nyoka*- related illness, but as a deadly modern and foreign disease. Green et al. (1993) proposes that the AIDS message should be accommodated under the *siki* - diseases. The reason for this argument is that STDs are co-factors in the spread of HIV. Green (1994) proposes that the help of traditional healers should be sought in the control and prevention of AIDS in Africa, since they have had success in dealing with STDs.

The Traditional African Worldview and Sexuality

The influence of the African worldview can, according to Van Dyk (2001b, p. 62), also be seen in the traditional African’s perspective of sexuality: “For the traditional African, sex also conquers death and symbolises immortality”.

The Macrocosm: Personal Immortality Through Children

According to Mbiti (1989), history does not move forward into the future in traditional African thought. History moves backwards in time towards the “*Zamani*” (Swahili word for the past). As a person grows older he or she moves gradually from the “*Sasa*” (now-period that represents a person’s present experiences) to the *Zamani*. After physical death a person continues to exist. This period is called the “*Sasa*” where the “living-dead” exist as long as they are personally (by name)

remembered by surviving relatives and friends who knew them during their lives. Mbiti (1989, pp. 26-27) explains this as follows:

Unless a person has close relatives to remember him when he has physically died, then he is nobody and simply vanishes out of human existence like a flame when it is extinguished. Therefore it is a duty, religious and ontological, for everyone to get married; and if a man has no children or only daughters, he finds another wife so that through her, children (or sons) may be born who would survive him and keep him (with the other living-dead of the family) in personal immortality.

From this it may be concluded that it is fatal if a person is forgotten after death. In fact, it may be seen as the worst possible punishment for a traditional African. Procreation is a way of ensuring that a person's personal immortality is not destroyed. The failure to have children is according to Mbiti (1989) worse than committing genocide. She has not only become a dead end for her genealogical line, but also for herself because she will be "forgotten".

Marriage also forms part of the quest for immortality. According to Mbiti (1989), in Baroto custom an unmarried person deserves no respect in the eyes of society. When an unmarried person dies the body is beaten with a thorny bush as a sign of disrespect.

The Microcosm: The Importance of Having Children

Mbiti (1989) maintains that in Africa a man's wealth depends upon the growth of his tribe. African men believe that they can only thrive on the land of their ancestors if they have many wives and children to help them work their land. This makes children very important in the day-to-day microcosmic existence (Van Dyk, 2001b).

According to Van der Hoeven (1992) one must keep in mind that in a system that places so much emphasis on having children, less emphasis will be placed on official marriages. A woman's value is determined by her fertility. Leclerc-Madlala (2000, p.30) found that a husband will often insist that his wife should not worry about falling pregnant and passing the virus on to the child because "she has a marital duty to produce children". This could also be the reason why many women might try to prove their fertility before marriage even through casual sexual contact.

The danger that Van der Hoeven (1992) points out is that women who are part of this belief system run a high risk of being contaminated by the HI-Virus.

Unprotected sex between men and women accounts for most of the new HIV infections among adults in Africa (Van Dyk, 2001b; Whiteside & Sunter, 2000). I now discuss some of the sexual beliefs and customs that are part of the traditional African belief system. These beliefs and customs have an influence on sexual behaviour but may also represent a risk as far as HIV/AIDS infection is concerned.

Inheriting the Wife of the Deceased Brother

According to Mbiti (1989) it is a fairly common custom in Africa for the brother of the deceased husband to “inherit” his widow. Because of the extensive kinship system found in most African societies a person could have literally hundreds of brothers. The brother who inherits the wife and the children of the deceased relative then also performs all the duties of a husband and father. The children who are born after this inheritance generally also “belong” to the deceased man.

In some societies there is also the custom to get married “in absentia”. This happens when a man dies before he has children. His family may then arrange for him to get married in absentia. This ensures that the dead man is not cut off from the chain of life (Mbiti, 1989).

Where younger men die from AIDS, these customs could threaten to spread of the HI- Virus among the deceased person’s family members.

Resistance to the Use of Condoms

The importance of personal immortality, as well as the value of children in the lives of traditional Africans, helps us understand why it is difficult to persuade them to use condoms. This is also why African women continue to have children even when they know that they are HIV positive (Van Dyk, 2001b). On the whole, condoms are not popular in Africa. The feedback from women is that their partners do not want to use condoms (Setel, Lewis & Lyons, 1999; Stanley, 2000). Issues such as female fecundity, lack of pleasure, male potency and issues surrounding mutual trust are also given as reasons for not using condoms (Setel et al. 1999).

There is also a myth that condoms do not work because the virus can pass through the latex (Whiteside & Sunter, 2000, p. 19).

According to Green (1994), although AIDS awareness was reasonably high in Uganda in 1993, and millions of condoms had been distributed, only about 3 percent of Ugandan men were regularly using condoms at that time. Some of the reasons why traditional African people do not use condoms are now discussed.

Condoms Block the “Gift of Self”

In Rwanda it was found that the lack of condom use had nothing to do with ignorance (Taylor, 1990). Rwandans believe that the flow of fluids in sexual intercourse and reproduction represents the exchange of the “gifts of self”. They believe that the use of condoms will block this important flow between two partners, and that it may also block the flow of fertility. Van der Hoeven (1992) underlines the fact that traditional Africans regard the blockage of the natural flow of body fluids as an inevitable cause of illness and hardship. Rwandan women also fear that the condom might remain in the vagina after intercourse, which exposes them to the risk that they will become “blocked beings” (Taylor, 1990).

Condoms Prevent the “Ripening of the Foetus”

Some traditional Africans believe that repeated contributions of semen are needed to “ripen” the growing foetus in the womb (Schoepf, 1992).

Condoms therefore interfere with the process of natural foetal development. There is also a belief that semen contains important vitamins which are necessary for women’s continued physical and mental health, as well as their beauty and future fertility.

Sexual Rights of Family Members

Mbiti (1989) states that in some traditional African societies, brothers have sexual rights to the wives of their brothers. In some groups, members of the same “initiation batch” are entitled to have sexual relations with the wives of their fellow members. In cases where the husband is forced by circumstances to live away from his wife, it may be arranged that a friend will visit the wife and have sexual intercourse with her. The logic behind this arrangement is partly to satisfy her sexual

urges and thus prevent her from “going out with” anyone else. On the other hand it is seen as an arrangement that could ensure that the wife is fertilised and will raise children for the absent father. The same arrangement is according to Mbiti (1989) also made where the husband is too young, impotent or sterile.

Once again the huge emphasis on having children is underlined by these practices. In a continent where many men are migrant workers, these customs are often practical arrangements. The dangers as far as HIV/AIDS infection is concerned are also obvious.

Traditional Sexual Beliefs and Practices

The above-mentioned sexual beliefs and practices can be linked to perceptions concerning personal immortality. The importance of having children can be understood if the traditional African worldview on sexuality is taken into account. However, not all traditional African beliefs and practices can be linked to perceptions concerning immortality or the importance of having children. The following traditional beliefs and practices that form part of the traditional African belief system also have an influence on sexual behaviour.

Male Semen

According to Van der Hoeven (1992) in traditional African cultures there are beliefs concerning the potential of male semen. Regular sexual intercourse with a pregnant woman is considered good for the unborn baby in the sense that it strengthens the foetus.

On the other hand it is sometimes held that the gathering of semen in the human body could be fatal. Seeing or touching one's own semen could call up evil spirits and even cause impotency (Van der Hoeven, 1992).

“Dry” Sex

Some men believe that a dry vagina is a sign of faithfulness, while some insist on “dry sex” to heighten their sexual pleasure (Van Dyk, 2001a). To obtain this dry condition, women use herbs, antiseptic solutions, chemicals, cotton wool or newspapers to dry out the vagina (Runganga & Kasule, 1995). Van Dyk (2001a) points out that this practice is very dangerous because it may cause lacerations in the

vaginal walls, a condition that is conducive to the spread of the HI-Virus (Whiteside & Sunter, 2000).

“Unnatural” Sex

According to Crewe (1992), for many traditional Africans anything that causes the sexual act to be “unnatural” is unacceptable. The interference that condoms cause during the sexual act is perceived as “unnatural” and therefore unacceptable. According to Crewe, certain orthodox religious practices strengthen the belief that using condoms is “unnatural”. The Roman Catholic Church for example still condemns the use of condoms (Van der Walt, 2003).

“Real” Sex

Crewe (1992) suggests that one reason why men are reluctant to alter their sexual behaviour in the light of HIV/AIDS is that they do not regard safe sex as “real sex”. They also assume that safe sex cannot be enjoyable:

Indeed the very concept of alternative sexual pleasures is often denied by men. For them safe sex equals dull or uninteresting sex – an awkward reminder of the “heavy petting” of their youth. Safe sex also represents a challenge to male identity and self-esteem (Crewe, 1992, p. 33).

Condom Use as a Sign of Mistrust

According to Leclerc-Madlala (2000, p.30) “sex is regarded by the young as necessary, natural, an expression of love, and an activity that their peers expect of them if they are to be considered normal”. The use of condoms is seen as a sign of mistrust. It is also seen as the hallmark of one who indulges in casual sex.

Condom Use as Women’s Responsibility

When the question if condoms should be used is raised Crewe (1992) points out that women are often expected to be prepared to carry condoms, whereas men tend to be asked whether they are prepared to use them.

By implication it is the responsibility of women to be prepared for sexual contingencies, yet society has previously judged such women harshly. This has important implications: if women are supposed to be more responsible than men for contraception, for sexually transmitted diseases, for pregnancy and so on, who takes the blame when infection

occurs? It follows that when women and gay or bisexual men get infected it is their own fault, but that if heterosexual men (especially white men) get HIV, then someone gave it to them. It is clearly the woman's fault – she must have been careless enough to have had sex with an infected person (Crewe, 1992, p. 31).

It is according to Crewe (1992) a common attitude to blame the sexually active woman and not a virus for the disease. It is also this attitude that often causes a man to scorn the idea of using a condom because he cannot be infected, and if his partner is infectious she should not be having sex.

Polygamy

According to Mbiti (1989) getting married to two or more wives is a universal African custom. Yamba (1997) explains that polygamy does not contradict the message: "Do not have sex outside marriage". The problem is that polygamous marriages and the "socially accepted custom of married men taking girlfriends also facilitate the transmission of HIV" (Campbell & Kelly, 1995, p. 368). In a study of 2682 men and women at a Durban STD clinic, on average men reported that they had had more than 6 sexual partners during the previous year (O'Farrell & Windsor, 1991).

Property Grabbing

The practice of property grabbing in which the husband's family grab a married couple's property after his death serves to make women economically vulnerable and sometimes destitute. Women may then be forced to exchange sex for goods or money to provide for themselves and their children (Campbell & Kelly, 1995, p. 368).

This practice occurs in societies where male dominance is accepted and influences many aspects of females lives (Green, 1994). But "property grabbing" does not just leave the widow financially exploited: this practice could force the widow to become sexually active in order to obtain an income. In a society with a high HIV/AIDS infection rate this could expose herself to a deadly disease.

Cleansing Ritual for Widows

Van der Hoeven (1992) points out that a woman whose husband has died may be seen as impure and polluted. It is then regarded as the family's duty to perform a cleansing ritual to rid the widow of the impurity (Yamba, 1997). In most instances

the deceased husband's brother is appointed by the family to have sexual intercourse with the widow. This may take place over a period of time. After this ritual has been performed the widow is believed to be cleansed of the impurities, and is then permitted to engage in a new relationship. Van der Hoeven (1992) points out that nowadays more young men than before are dying of AIDS, and there is thus a strong possibility that their widows will also have the disease. The cleansing ritual may very well spread the HIV/AIDS virus amongst other family members (Yamba, 1997).

Men Have the "Right" to Force Themselves on Women

According to Leclerc-Madlala (2000) there is a common belief among traditional Africans, both men and women, that a man has a right, or even a duty, to force himself on a woman who displays reluctance or shyness. According to her, gender-based violence itself is often seen as a sign of affection and even a way of showing how deeply the man cares. Marital sex is expected of men as part of the marriage "deal". Even in cases where the woman discloses her HIV-positive status to the husband, Leclerc-Madlala says there are studies that show the husband is likely to continue to have intercourse with her and to refuse to be tested himself.

Sexual Intercourse With a Virgin

Setel et al. (1999) report that sexual intercourse with a virgin is believed to cure sexual diseases such as "chronic blennorrhagia". Govender (1999) of the Sunday Times quotes Leclerc-Madlala as saying that according to a 19th century belief, sex with a child provides a cure for syphilis. It is claimed that, as early as 1827, quack doctors kept special brothels in Liverpool to provide this cure.

Some traditional Africans evidently also believe that sex with a virgin brings good luck (Green 1994). In South Africa an "urban legend" even claims that AIDS can be cured if the infected person has sex with a virgin (Whiteside & Sunter, 2000, p. 58). Stanley (2000) links the "horrifying upsurge in South Africa in the rape of the very young" to the "virgin cure" tale. This may even have led to the rape of babies.

Sexual Intercourse With Teenagers and Schoolgirls

Van der Hoeven (1992) says there is a perception that schoolgirls cannot be HIV positive and that they therefore pose no threat in terms of AIDS infection. This

belief encourages prostitutes to wear school uniforms in their pursuit of clients. Green (1994) maintains that in societies where male dominance is accepted, it is possible for men to coerce women, including teenage girls, into sexual intercourse without much fear of having to account for their sexual behaviour, as long as the girl is currently unmarried. According to Green, unmarried and younger women have little power to resist sexual advances from older men. Cases of rape are traditionally settled by requiring the offender to pay a fine to the woman's family. As Green points out, this could be seen as a “payment for services”. In many cases the women did not want to render the “service”. Payment to her family therefore renders little comfort to the victim if the matter is settled in the traditional manner.

As long as male dominance is not disputed in traditional societies, these practices and beliefs will also remain undisputed. In order to understand the transmission of HIV/AIDS, the researcher has to understand sexual practices in the traditional society in their cultural context (Green, 1994).

AIDS as a Heterosexual Disease

AIDS is associated with homosexual behaviour in certain parts of the world (Whiteside & Sunter, 2000), whereas in Africa it is largely seen as a heterosexual disease (Stanley, 2000). Some African prostitutes have, however, according to Stanley (2000), started to offer anal sex in the belief that AIDS is only transmitted in conventional sexual intercourse.

Healthy-Looking People

Stanley (2000) reports that a study carried out in Mozambique found that many young women believe that HIV cannot be picked up from a “healthy-looking” man. There is even a myth that HIV-infected individuals who show no signs of the illness cannot infect their partners (Whiteside & Sunter, 2000). Yamba (1997) points out that fat people are also perceived to be healthy and beautiful.

Beliefs and Practices Linked to HIV/AIDS

The following beliefs and practices are not linked to sexual behaviour, but may be linked to people’s perceptions and day-to-day behaviour.

Physical Contact

Because of certain beliefs about HIV/AIDS in traditional Africa most people wish to have no physical contact with AIDS patients (Green, 1994). The impact of the fear of the disease is described as follows by a community worker who experiences the interaction between family members and children infected with HIV/AIDS: “Even more heartbreaking is to see the fear of the family to hug their children when the child is brought or picked up at the crèche” (Kitching, 2003, p. 22). Beliefs like these stigmatises the disease even more and increases the emotional burden that comes with the disease.

Traditional Healers

In a study conducted among traditional healers (Chipfakacha, 1997) it was reported that traditional healers do not see AIDS as a new or incurable disease. Old methods and medicines are used to “cure” AIDS. Many traditional healers still use their bare hands as a diagnostic tool and to apply topical medicine (Chipfakacha, 1997). Many also use their mouths to suck blood from a patient’s body as part of disease management.

Beliefs in Invisible Powers

According to Van Dyk (2001b) in traditional Africa disease is either attributed to natural agents, witchcraft or the displeasure of the ancestors. Even when traditional Africans attribute a disease to an external agent such as a germ or a virus, they will also search for the ultimate cause of the disease as I have already explained. According to Sow (1980) the day-to-day fate of traditional Africans is regulated and controlled by the complex relationship between humans and the invisible, but powerful, beings such as evil spirits, witches and sorcerers. Suffering, misfortunes, conflicts, accidents and deaths as well as nearly all forms of illness are, says Sow, ascribed to beings who operate from this zone.

Religious Beliefs

Crewe (1992) points out that in the Catholic Church the use of condoms as a prophylactic (preventative) against AIDS is forbidden. This has a serious, negative impact on AIDS campaigns that try to persuade people to use condoms to prevent

HIV/AIDS infection. Boahene (1996) stresses that some religious leaders have persuaded women to return to marriages where it was clear that the husbands had been unfaithful. Unfortunately, the phrase “till death do us part” may in some instances prove fatal.

According to Van Der Walt (2003, p. 14), “Christian” Africa has much higher HIV/AIDS infection rates than “Islam” Africa. Despite the many geographic, economic and logistic reasons proffered for this, Van Der Walt is of the opinion that the strict sexual morals that are intrinsic to Islam, are by far the most important reason for the lower rate of HIV/AIDS infection in predominantly Muslim countries and communities in Africa.

The Role of Tourists in Bringing HIV/AIDS to Africa

There is a belief that HIV/AIDS was brought to Africa by European and American holidaymakers:

East and Central Africa are really the gateways to the spread of AIDS into Africa in view of their attractive tourist markets. The highly-developed tourist business is supported by the regular inflow of European and American holiday makers. It is also not difficult at this point to conclude that holidays and tourism in East and Central Africa have their side attractions such as promiscuity, prostitution, frequent homosexual indulgence, drug abuse and many vices which predispose to the spread of AIDS (Agadzi, 1989, p. 92).

Myths Concerning the Genesis of AIDS

Because of the ignorance and fear surrounding the disease, tales of its origins are irrational, and often reflect the need to blame some individual or group of people for the epidemic (Crewe, 1992, p. 8).

One of the most common beliefs regarding the origin of AIDS claims that the HI-Virus came from the green monkey in Central Africa (Whiteside & Sunter, 2000). In the extensive research carried out by Hooper (1999), he gives various explanations for his hypothesis that AIDS did, indeed, originate from the green monkey. The problem with this hypothesis, according to Crewe (1992), is that it introduces social tension into the AIDS debate. She is of the opinion that presenting HIV/AIDS as an infestation from the so-called Third World introduces racism into the discussion:

“central to such speculation are stereotypes about black animalism, sexual licence and the like” (Crewe, 1992, p. 9).

On the other side of the coin, a group of American scientists has been blamed for the origin of the virus. According to this narrative, a group of scientists was requested by the CIA or the FBI to develop a virus capable of destroying the body’s immune system for use in germ warfare. The virus “escaped” and spread rapidly, to develop into the AIDS pandemic (Crewe, 1992).

In South Africa, says Crewe (1992, p. 45) the distinction is not only racial: “Aids will largely affect the poor, whose lifestyle is quite alien to a secure white middle-class world-view. This reinforces the association of the illness with the foreign or primitive.”

Agadzi (1989) maintains, however, that many black prostitutes prefer white clients since they pay more and are not usually sexually aggressive. He sees this as the reason why AIDS, which “originated in America”, spread to Africa, carried by white tourists.

In the midst of the racial accusations and other, sometimes conflicting, hypotheses surrounding the origin of the AIDS virus, it may be wise to meditate on the following comments, made by Hooper (1999, p. 5):

Perhaps, as further years go by, the syndrome will work its way even further into our communal consciousness, and the tale of its arrival in our midst will be taught at mother’s knee. In the meantime, it will perhaps be useful to replay those first few, memorable bars - to help any who need help to lock on to the great, sad anthem which thrums away softly in the background.”

If the debate concerning the genesis of the AIDS virus causes divisions amongst those who are committed to fight the spread of the disease, there is little value in speculating further about the origin of the virus while people are dying on a daily basis.

Summary

The traditional African worldview influences all aspects of the day-to-day lives of many African people. Some of the traditional beliefs and values encourage behaviours that may place people who practise these beliefs and values at risk as far

as HIV/AIDS is concerned. The need for behavioural change is underlined by the negative picture painted by the statistics concerning HIV/AIDS infections in South Africa.

In the next chapter the concept of behavioural change is discussed.

CHAPTER 3

HIV/AIDS AND BEHAVIOURAL CHANGE

Introduction

According to Setel et al. (1999), a sentinel survey conducted in Zambia in 1996 indicated that girls who were attending school were four times less likely to be infected with AIDS than those who were not. One might assume that the girls who attended school were exposed to more information about HIV/AIDS than their non-school going counterparts, and that this information influenced their sexual behaviour. However, according to Van der Hoeven (1992), various studies, especially with young respondents, underline the fact that more knowledge (on its own) seldom leads to the expected behavioural change.

Van der Hoeven (1992) identifies five factors that collectively determine behavioural change, namely rational, practical, emotional, social and structural factors. These operate as follows:

- Facts that are incorporated in an educational programme contain a *rational* element. These facts include information about the AIDS virus, how it is transmitted, the risks involved in contracting the virus and how to protect oneself against these risks.
- Certain practical issues ensure safe behaviour, like procuring condoms and finding out how to use them.
- Without emotional involvement people are seldom motivated to change their behaviour. Van der Hoeven (1992) mentions smoking as an example. Everybody who smokes knows that smoking increases the risk of lung cancer and heart disease. Yet many smokers only stop smoking after suffering a heart attack or when a spot on the lung has been diagnosed.
- According to Van der Hoeven (1992), the social element is crucial in behavioural change. With younger people the role of the peer group is especially important. Only a few individuals will dare to go against the group. The peer group may therefore be used very effectively in AIDS prevention campaigns, particularly as

a “horizontal mechanism” (peer to peer), which is much more effective than a vertical (top-down) educational or awareness campaign.

- Lastly, Van der Hoeven (1992) discusses structural factors that have an influence on behavioural change. Thus attempts to change personal behaviour when the individual is in survival mode will fail. In some cultures women have such a subordinate position in relation to men that some forms of behavioural change are not tolerated. The possibility that behavioural change will take place in these circumstances is very small. In these cases structural changes should first take place, and then behavioural change might follow. The structural aspect of behaviour has many implications for the AIDS awareness campaigns that are undertaken in Africa (Van der Hoeven, 1992). Because of cultural, political as well as socio-economic reasons many people live in situations where they have lost the power to take care of their own lives. This makes the behavioural change very difficult.

These five factors that collectively determine behavioural change underline the complexity of such change. What complicates the message to “change” even further is that “contradictory” and “competing” information will usually confuse people. Yamba (1997, p. 200) describes this confusion as follows:

The Goba of Chiawa, who, like most groups in rural Africa, are now the target of HIV/AIDS prevention messages, find themselves drawn towards the orbit of three competing and contradictory forms of discourse, all of which claim to tell them how to lead safe lives, free from AIDS.

It is from the three “competing” and “contradictory” forms of discourse that people have to construct a “cosmology” for their own lives (Yamba, 1997).

- 1) The first discourse represents the biomedical paradigm. It purports to have a certain amount of knowledge about the cause and effect of AIDS. It is backed by social scientists, and its message is: “Treat your sexually transmitted diseases (STDs), use condoms and change your sexual behaviour in order to survive.”
- 2) The second discourse is the one that is advocated by missionaries and church elders, who are against the use of condoms and advise abstinence instead. This discourse even encourages a revival of past cultural beliefs as the only

responsible way to survive. One of these beliefs is that sexual intercourse with a menstruating woman or with a neighbour's wife leads to mystical diseases.

- 3) The third discourse deals with traditional ideas and perceived traditions. The proponents of these ideas are of the opinion that although the biomedical discourse claims certainty and usually has the backing of the authorities, it is not able to cure AIDS. It is also not able to explain why a particular person becomes infected. The biomedical discourse is perceived as reverting to concepts such as "chance" and "accident" to explain HIV/AIDS infection.

Yamba (1997) concludes that when modern epistemologies fail, rural Africans resort to traditional systems to make sense of their world. What is particularly confusing to rural Africans is the fact that some beliefs that were previously regarded as "primitive" by westerners, such as abstinence from sex during menstruation, are now seen as the most effective way of preventing AIDS through behavioural change by the same people. On the other hand, cultural practices that belong to the same complex of beliefs are being discouraged in terms of Western standards. These practices include the "cleansing" of a widow through ritual sexual intercourse with the deceased person's closest male relative and the traditional practice of polygamy.

Yamba's (1997) explanation of the three "competing" and "contradictory" discourses, as well as the aspects that determine behavioural change (Van der Hoeven, 1992) underline the complexities linked to the fight against AIDS. These complexities will have to be taken into account in the formulation of any theories regarding behavioural change directed at combating AIDS.

Psychological Theories of Behavioural Change

One of the theories of behavioural change focuses on the stages people pass through as they effect such change.

Behavior change is a process, and as such we need models that can describe the process and identify benchmarks along its way. Stages theories of behavioral change provide researchers with tools for identifying these benchmarks so that interventions can then be tailored to the place in the process that a group or community has attained with

the goal of advancing them from that place (Auerbach, Wypijewska, & Brodie, 1994, p. 84).

According to Auerbach et al. (1994), successful intervention might not result in the elimination of risky behaviour. Successful intervention is rather seen as any intervention that advances an individual or a group from one stage to another.

I now discuss two of the stage models of change that have been adapted for use with people who are placing themselves at risk of HIV infection.

The AIDS Risk Reduction Model (ARRM)

This model incorporates elements of the health belief and social cognitive learning models to describe the process through which individuals change their behaviour vis-à-vis HIV infection (Catania, Kegeles & Coates, 1990). Three stages are identified in the change process:

Stage 1. In this stage, the high-risk behaviour is labelled as problematic. This involves:

- knowing which sexual activities are associated with HIV transmission
- believing that one is personally susceptible to contracting HIV
- believing that having AIDS is undesirable

Stage 2. Here the individual makes a commitment to change high-risk behaviours.

This involves:

- weighing costs and benefits
- evaluating response efficacy
- incorporating the efficacy concept from social cognitive learning theory

Stage 3. The individual takes steps to actually perform the new behaviour.

These steps are influenced by social norms and problem-solving options.

The Stages of Change Model

This model was developed in the context of psychotherapy but is now also applied to HIV high-risk behaviour (Prochaska, DiClemente & Norcross, 1995). This model proposes four stages of change, which are discussed below.

Precontemplation. The individual does not intend to change the behaviour within the next six months.

Contemplation. The individual intends to change the behaviour within the next six months.

Preparation. The individual is seriously planning behavioural change within the next thirty days. The individual has made some attempt to modify his or her behaviour but has not yet met specific criteria.

Action. The individual has modified a behaviour and has met specific criteria for less than six months.

Maintenance. The individual continues the behavioural change beyond six months. It is accepted that movement through these stages does not occur in a linear manner. Individuals may make several attempts at behavioural change before they achieve their goal (Auerbach et al., 1994).

The model specifies ten cognitive, affective and behavioural strategies and techniques that people use as they progress through the stages of change over time. These include the following:

- consciousness raising: heightens the level of awareness
- self-re-evaluation: reappraises his or her problem
- social re-evaluation: focuses on the impact of a problem on others
- self-liberation: acknowledges the role of choice in behavioural change
- social liberation: involves changes in the environment that lead to more options for the individual
- counter-conditioning: changes the conditional stimuli that control responses
- stimulus control: restructures the environment to reduce the probability of a particular conditional stimulus
- contingency management: gives dramatic relief as through catharsis (Prochaska & DiClemente, 1984).

Critique of the Behavioural Change Model

Auerbach et al. (1994, p. 87) are of the opinion that, despite their conceptual contributions, “current theoretical models are limited in their ability to predict risk behavior for two main reasons”, which are discussed below.

With respect to sexual behaviour the models are based on the assumption that sexual encounters are regulated by self-formulated plans of action (Auerbach et al., 1994). They are also based on the assumption that individuals are acting in an intentional and volitional manner when engaging in sexual activity. Auerbach et al. (1994, p. 87) state that sexual behaviour is often impulsive and in part physically motivated:

A well-formulated plan of action that is the product of a careful weighing of potential harms and benefits can be dismissed in the context of a passionate sexual encounter when competing proximal goals (i.e. sexual gratification) offset well-informed intentions (i.e., to use a condom).

In the second place, Auerbach et al. (1994) emphasise that dominant theoretical models of behaviour do not easily accommodate contextual, personal and socio-cultural variables. These variables include gender and racial or ethnic culture. The behaviour of women and men and the relationship within which sexual activity occurs are influenced by gender roles and cultural values and norms. Unsafe sexual practices are often not the result of a lack of knowledge, motivation or skill. These practices have a specific meaning within a given personal and socio-cultural context. Barring the odd exception, current theoretical models of HIV risk behaviour do not easily accommodate contextual, personal and socio-cultural variables (Auerbach et al., 1994).

Attitudes

Petty (1995, p. 196) defines attitudes as referring to “general evaluations that people hold of themselves, other people, objects, and issues.

According to Judd, Drake, Downing, and Krosnic (1991), attitudes are lasting evaluations of various aspects of the social world. These evaluations are stored in the memory. Attitudes are important because they strongly influence social thought – the

way in which we think about and process social information. Attitudes often function as schemas, or cognitive frameworks that hold and organise information about specific concepts, situations or events (Wyer & Srull, 1994).

Baron and Byrne (1997) state that attitudes have also been a focus of research because researchers assume that attitudes influence behaviour. According to Petty (1995), beliefs, emotions and behaviours can all contribute separately to people's attitudes. Millar and Tesser (1986) stress that attitudes can also be based on only one or two of these components. Some attitudes may be based mostly on feelings stimulated by the object, while others may be based mostly on thoughts stimulated by the object. Attitudes that appear identical when measured can be quite different in terms of their underlying basis or structure "and thus can be quite different in their temporal persistence, resistance or ability to predict behavior" (Petty, 1995, p. 237).

To change people's attitudes could be easier said than done. If all the factors that influence attitudes have to be taken into account in AIDS intervention programmes, this becomes a huge challenge. According to Van Dyk (2001a), the following attitudes and values are accepted by all cultures and religions as important for the survival of individuals and communities, and should be included in HIV/AIDS education and life-skills programmes:

- building of a realistic, positive self-concept
- respect for the self and others as unique and worthwhile beings
- self-control
- the right to privacy
- the right to protect oneself
- the right to say "no" to an older person or someone in authority
- the right to chastity
- loyalty and commitment in relationships
- honesty
- taking responsibility for one's actions
- respect for life

- non-discrimination towards and tolerance of anyone who is different from ourselves
- forgiveness
- loving and caring
- social justice
- friendliness, kindness and sensitivity

The Relationship Between Beliefs and Attitudes

According to Boyd (2003, p. 1), attitudes are generally the result of beliefs:

If your belief is that the world is out there to get you, then your attitude will be defensive. If your belief is that the world is a wonderful place to live, then your attitude will be cheerful. Whatever attitude a person is displaying is a reflection of something they are believing.

Boyd (2003) believes that the person adhering to these beliefs could even be unconscious of them. The attitude could then be blamed on other people, the weather, their job, et cetera.

Based on the theories concerning the role of beliefs and attitudes, I should like to propose the following assumptions concerning the relationship between attitudes and AIDS.

- AIDS is surrounded by an enormous body of beliefs linked to its causes and prevention and to possible cures for the disease.
- Because AIDS is a life-threatening disease it is also linked to intense human emotions.
- The threat that AIDS poses has a direct influence on the behaviour of individuals and society. It seems that in most cases people's attitudes are not formed by only one factor. Attitudes, beliefs, emotions and behaviours all play a role in most people's attitude towards AIDS.
- Sexual behaviour is often impulsive and physically motivated behaviour, a fact that complicates behavioural change.

Ways to Combat the Disease

Agadzi (1989, p. 170) enumerates some questions to be asked about the way in which AIDS information could be best communicated in Africa:

This definitely means that in addition to the use of the mass media, a more accessible approach should be adopted. Should it be the use of folklore to get messages to the people? A song in the local language could go a long way to excite people's appetite to know more about the disease. Could chiefs hold durbars to educate their people about the seriousness of the disease? ... Could AIDS be put in its proper perspective within the context of Christian and Muslim life? What are the various professional, occupational and voluntary groups doing for their members in terms of education on AIDS?

The following subsections examine some additional factors to be considered in the planning of any HIV/AIDS prevention programme.

Diffusion Theory

Diffusion Theory focuses on interventions that involve entire communities rather than individuals (Rogers, 1983). It takes into account socio-cultural influences that might inhibit or encourage particular behaviours. Opinion leaders are seen as a key channel for communicating new ideas.

Cultural Sensitivity

According to Auerbach et al. (1994, p. 94), it is a common belief that HIV information campaigns and prevention and treatment services will not be effective "unless they are carefully tailored to the beliefs and the practices of diverse cultural groups". The sensitive, private and potentially controversial nature of AIDS makes it even more crucial to take into account cultural beliefs and practices.

Gender Dynamics

The cultural pressures that women experience concerning sexual relationships and the bearing of children have already been discussed. Beliefs concerning personal immortality (Van Dyk, 2001b) increase the pressure that women experience concerning sexual relations. According to Campbell and Kelly (1995) many women believe that if they deny their male partners sex the latter will go elsewhere for sexual relief. This means that agreeing to sex could represent an attempt to ensure

fidelity. Another belief, which is shared by both sexes, is that “it is harmful to let a man not be sexually relieved when he feels the urge” (Campbell & Kelly, 1995, p. 368).

Leclerc-Madlala (2000, p. 3) who does her research in the traditional African context is of the opinion that the role of men, “particularly their attitudes and behaviours that reflect their sexual irresponsibility” needs to be addressed. She describes men’s sexual behaviour as a “certain death sentence, not only for themselves, but also for millions of women and children”.

Auerbach et al. (1994) maintain that a gender-specific approach to prevention would have to take into account the broader social context of women’s inequality in status and power relative to men. This inequality also has an influence on psychological development and gender role socialisation.

Studies on the progression in drug use and related criminal activities underline the gender differentiation (Auerbach et al., 1994). Men tend to be introduced to drugs by friends of the same sex. With women it occurs most often in the context of love or sexual relationships or friendships with someone of the opposite sex. This is valuable information that should be used in AIDS prevention campaigns. Auerbach et al. (1994) suggest that research is needed to document the extent to which fear or the actual experience of abuse deter women from discussing condom use with male partners. According to Green (1988), a good deal of female sexual behaviour in Africa can best be understood in terms of strategies for survival and adaptation to patterns of male dominance in low-income countries. African women gain access to economic resources through a range of sexual relationships with men (Barnett & Blakie, 1992, pp. 77-78):

The economic transaction may not be the main or express aspect of the relationship for the participants, but given women’s underlying unequal access to economic resources, sexual favours and reproductive potential are powerful resources – sometimes the only resources – on their side of the transaction.

Leclerc-Madlala (2000) is one of the African women who voice their strong concern about gender dynamics and AIDS:

What emerges most clearly from all these studies is the fact that there is an urgent need to recognise and accept the nature and shape of contemporary sexual practices by men that have dire consequences in

the wake of AIDS. By turning our collective attention to academic debates on the origins or existence of AIDS, we are conveniently avoiding facing up to sensitive issues around sexual culture. By pinning our hopes on vaccines and cures, we risk “overall-medicalising” our engagement with AIDS. We simply cannot afford to get lost among the trees and lose sight of the forest, the latter being the socio-cultural-sexual context that provides such a fertile breeding ground for HIV/AIDS (Leclerc-Madlala, 2000, p. 3).

HIV/AIDS Education

The “socio-cultural-sexual context” that Leclerc-Madlala (2000, p30) perceives as a “fertile breeding ground” for HIV/AIDS could on the other hand be a fertile breeding ground for HIV/AIDS education. The three cosmic orders, macro-meso-micro-cosmic orders, which I have already explained in chapter two, would have to be taken into account when AIDS education is planned within a “socio-cultural-sexual content”. I now discuss some educational ideas that could be of help in AIDS campaigns, taking the three cosmic orders into account.

Education on the Macrocosmic Level

I have already indicated that religion influences people on a macro cosmic level. Van Dyk (2001a) claims that traditional Africans do not believe that God is responsible for AIDS. Christianity has a big influence in South Africa and forms the largest religious group in South Africa. More than 70% of the population indicate that they are Christians (Van Der Walt 2003). Van Dyk (2001a) is of the opinion that the influence of Christianity can be seen in beliefs of some black Christians who believe that AIDS is Gods punishment for immorality and sins. According to Seely, Wagner, Mulemwa Kengeya-Kayonde, and Mulder (1991) Roman Catholics in Uganda specially believe that HIV/AIDS is Gods punishment for transgressions.

Among Christians there are many opinions concerning God’s role in the HIV/AIDS pandemic. By contrast with the viewpoint concerning God’s punishment, the example set by Jesus serves as a guideline for God’s position on AIDS in the minds of some Christians.

Leprosy is probably the disease most similar to AIDS with which Jesus was confronted. In the Old Testament lepers were treated as outcasts (2 Kings 7:3), and leprosy was seen as a punishment of God (Num. 12:19; 2 Chron. 26:19). Jesus took

an entirely different perspective on lepers. He touched them and was involved in their treatment (Matt. 8:2,3; Mark. 1:40-45).

Jesus also took a new perspective on the link between illness and sin. His disciples questioned him on sin and punishment when they met a man who had been blind since birth (John 9). Jesus taught them that there was no link between the sins of the blind man, or even the sins of his parents, and his blindness. The question that Jesus focused on instead was what God and humanity could do for the blind person.

Van Dyk's (2001b) claim that Christianity established the belief that AIDS is God's punishment is perhaps based on people's responses to AIDS. The teachings of Jesus, as recorded in the Bible, about involvement with the sick, the poor and outcasts reflect the opposite. On the macrocosmic level it would make a difference to the lives of millions of people if churches could set an example of understanding and compassion.

Education on the Meso-cosmic Level

On this level there are also ingrained beliefs to be taken in account when planning AIDS intervention programmes for Africa. According to Van Dyk (2001b, p. 62):

Aids education in Africa can only be successful if the deep-rooted beliefs of Africans are taken into account and integrated into AIDS prevention programs. The African belief is immediate and ultimate causes of illness should, for example, be used in AIDS education programs. Programs should recognize the belief that the personal or ultimate cause of an illness may be witchcraft, but the fact should be stressed that the immediate cause is a "germ" which is sexually transmitted.

Van Dyk (2001b) cites the counselling done by Zazayokwe (1989) among traditional Africans in South Africa to illustrate how the problem of causality can be dealt with. Zazayokwe tells people that they may know where the HIV infection originated, but that she knows what the disease does inside the body and how they can prevent contracting it.

Zazayokwe does not dispute the beliefs that witches cause AIDS, but works instead with information that patients can use to combat the "evil forces".

Seeley et al. (1991) are of the opinion that as AIDS became more widespread an explanation that combines scientific facts and witchcraft became more prevalent. According to them, people who are aware of the scientific facts about sexual transmission recognise the manner in which it is contracted. These same individuals would, however, often attribute the chance of being infected through a sexual act to the power of witchcraft.

Van Dyk (2001b) suggests that a link should be established between condoms and the use of “preventive charms”. She points out that through the ages traditional Africans have had their own forms of prophylaxis against witches and sorcerers. Charms and amulets are believed to have preventive and protective powers: “One may therefore ask why – in cases of casual sex – the condom cannot be introduced as preventive charm to block the sexual contact point against the evil spells of witches” (Van Dyk, 2001, p. 62). She also suggests that the help of traditional healers should be sought to “fortify” condoms with protective powers. They could then be distributed among the community as protective charms.

Sceptics may wonder whether it is possible to merge the traditional African belief system and medical knowledge with the western belief system and medical knowledge. As already indicated, research in Uganda shows that there has been a rapid decline in HIV/AIDS infections over the past ten years (Yahaya, 2003). Yahaya attributes this success to the integration of western and traditional African medicine. He is convinced that traditional healers could be “ambassadors” for western health practices and technology.

Education on the Microcosmic Level

As I have already explained, according to African tradition some illnesses have their source in the microcosm. The distinction between *siki*- and *nyoka*-illnesses has already been discussed. Van Dyk (2001b) points out that in Africa AIDS is generally not seen as either of these two illnesses, but is regarded as a deadly modern and foreign disease. Green et al. (1993) nevertheless propose that the AIDS message should be accommodated under *siki*-diseases. They argue that STDs are regarded as *siki*-illnesses. STDs are co-factors in the spread of HIV and the same treatment could be beneficial to both STD and HIV prevention and treatment.

According to Green (1994, p. 2), most STD cases in Africa are not presented at “biomedical health facilities” since patients with STDs usually consult traditional healers. Green maintains that STDs are regarded as an area in which traditional healers have a particular competence. He argues that the role of STDs in transmitting the AIDS virus has been given insufficient attention in AIDS prevention programmes:

For example, for some years a diagram purporting to show which sexual practices are most unsafe has been used for the purpose of AIDS education in many parts of Africa, courtesy of an influential U.S.-funded AIDS prevention project. Sexual practices are, in fact, ranked along a continuum ranging from unsafe to relatively safe. However, there is nothing at all about sexual intercourse with STD-infected partners anywhere on the chart. Intercourse with an STD-infected partner is probably the surest way of getting AIDS in Africa, yet there will be no preventive education on this if the risk chart is followed (Green, 1994, p. 4).

Traditional healers often give sound biomedical advice to their STD patients. Some of this advice is also conducive to AIDS prevention (Van Dyk, 2001b). According to Green (1994) they advise patients:

- to abstain from sex while undergoing STD treatment
- to choose healthy partners who are unlikely to have *siki*- diseases
- not to have sex with soldiers and prostitutes
- to locate all recent sexual partners and persuade them to seek treatment

If the link between STDs and AIDS is understood (Whiteside & Sunter, 2000) it becomes obvious that the help of traditional healers should be used in the fight against AIDS. This again underlines Yahaya’s (2003) plea for team work that brings together western and traditional African inputs. Green et al. (1993) found that traditional healers understood the concept of latency very well. Their explanation to clients is that the *khoma* (germ) of *siki* hides in the body, ready to attack at a later stage. The latency of HIV can be explained to patients by using these local concepts. The knowledge about STDs that has been gathered through the ages could be valuable in the fight against AIDS at the microcosmic level.

Sexual Education

Green (1994) points out that AIDS is mainly a heterosexually transmitted disease in sub-Saharan Africa. Beliefs that influence sexual behaviour would have to be taken into account in AIDS education programmes. The importance of having children and the value of children in the lives of Africans have been discussed. It is important to understand these beliefs and practices so that the positive side of prevention can be integrated into AIDS education programmes.

Polygamy

Polygamy often helps to prevent or reduce unfaithfulness, prostitution, STDs and HIV. According to Van Dyk (2001b), polygamy often provides a healthy alternative or solution to problems that are inherent in certain cultural customs. In some African cultures sexual intercourse between a husband and his wife is prohibited while she is pregnant (Green, 1994). This abstinence is observed until childbirth. In some instances it is observed even after the child has been weaned. In such instances polygamy may prevent husbands from turning to other women for sexual intercourse.

In Africa many men are migrant workers. According to Whiteside and Sunter (2000), in 1985 there were 1 833 636 South Africans working as migrant workers. Among people who practise polygamy, one wife may accompany the husband while the others take care of the property and the children (Mbiti, 1989). This custom may also prevent men from turning to casual sex while they are away from home, working in the bigger towns or cities.

The Use of Condoms

According to Ngubane (1977) there is a widespread belief in many parts of Africa, including South Africa, that repeated contributions of semen are needed to form or ripen the growing foetus in the womb of the mother. Condoms are perceived to interfere in the natural process of foetal development. Schoepf (1992) points out that traditional healers realise that, while their ancestors were correct in stressing the health value of frequent sexual intercourse, they were not confronted by an AIDS epidemic. According to this writer, traditional healers in Kinshasa who were confronted with the reality of HIV/AIDS appealed to their clients that semen should

be seen as a metaphor for repeated intercourse. The value of repeated intercourse (using a condom) is underlined as a necessary act to nourish the mutual love and understanding between partners. The intimate relationship and not the semen becomes the important factor. Love and understanding are reported to be a crucial element in creating the right environment for foetal growth.

Boahene (1996) gives an example of church leaders in Tanzania who realised that their church members were caught between church policy and an aggressive campaign of condom distribution. They developed a “symbolic” AIDS prevention programme. This program views the individual in the content of an AIDS ‘flood’ –with specific reference to the flood of Noah. To survive this ‘flood’ the individual has to make a decision to get ‘on board’ one of the ‘boats’:

This “spiritual” context seems to allow people to evaluate their own risk and get “on board” the boat – reminiscent of Noah’s ark – that best meets their needs. There are three kinds of boats, namely abstinence, faithfulness and technology. The sides of the boat are high and slippery so people will have to help each other to get aboard. If someone does not like the first boat chosen, he/she should not go back to the river but should change boats (Boahene, 1996, p. 613).

According to Boahene (1996), this symbolic representation allows health educators to discuss issues relating to HIV/AIDS infection with religious people without offending their “sensibilities”. Euphemistic (symbolic) expressions also help to ease the stigmatisation and stress that are often associated with taboo-laden issues.

Van der Hoeven (1992) reports a change that has taken place in the cleansing ritual for widows in Uganda. As I have already observed, this ritual places young men at risk of HIV/AIDS infection, since the widow could have been infected by her late husband, and it may therefore have been implicated in the increase of young men dying as a result of AIDS.

Medical staff have warned traditional leaders and healers of the dangers of this practice. As a result, the ritual has been adapted by traditional leaders and healers. There is no sexual contact any more; instead symbolic acts are performed that would have the same cleansing value according to traditional healers and leaders.

These examples illustrate how traditional healers or community leaders can help to “reframe” beliefs and practices in such a way that condom use becomes more

acceptable. More “symbolic expressions” and “metaphors” based on traditional African or religious beliefs that are strong enough to support behavioural change are needed.

Green (1994) is of the opinion that traditional healers are eager to learn more about western health care and in so doing change the popular image of traditional healers as “primitive witchdoctors”. If traditional healers are respected for their knowledge and role in society, more traditional beliefs could be “reframed” in such a way that the resistance against the use of condoms could change.

The P-E-N Model

Airhihenbuwa (1989) proposed a strategy to which he refers as the P-E-N model, in terms of which traditional cultural beliefs and behaviours are categorised as positive (P), exotic (E) or negative (N) and treated accordingly.

Positive Cultural Beliefs and Behaviour

Classified under positive cultural beliefs and behaviours in the P-E-N model are behaviours and values that are known to be beneficial in HIV/AIDS prevention. These positive cultural beliefs and behaviours should be encouraged and reinforced in AIDS-prevention programmes. In attempting to appreciate the belief system and values of traditional African people the principal of collective existence could serve as a starting point. The concept of collective existence could, of course, be a valuable tool in the fight against the AIDS epidemic. The support of the group could be of great value to individuals as well as families who are AIDS victims. According to Chipfakacha (1997), healing in Africa takes place in a social setting where the members of the family understand, accept and support the patient.

The role traditional healers can play in the fight against AIDS is underlined by many researchers and could be used as a positive element in the fight against AIDS (Van der Hoeven, 1992; Green 1994; Van Dyk, 2001). Chipfakacha (1997) believes that traditional healing offers the following advantages compared to scientific medicine:

- The whole family is involved in the treatment, the focus of attention being not only the patient but also the reaction of the family and any close relatives.

- The traditional healer is surrounded by helpers who participate in the healing ceremony. Their duties are to explain matters to the patient, his or her relatives and the family and to answer their queries. This is an effective primary health care team, especially when dealing with psycho-social problems.
- Traditional healers use everyday language during consultation, they share the same worldview as their patients and there is a closeness and informality in their approach. .
- Traditional healing reinforces and articulates the cultural values of the community to which the helper belongs. Modern physicians, by contrast, are separated from their patients by social class, economic position, specialised education and cultural background.
- Traditional healers can easily define and treat illness in the community – the social, psychological, and moral dimensions associated with ill health and other misfortunes. They also provide culturally familiar explanations of the cause of ill health and its relationship to the social and supernatural worlds.

Dr Sekagaya Yahaya (2003) of Uganda recently discussed Uganda's success in its fight against AIDS at the University of South Africa. Research shows that the percentage of people who are infected with AIDS in Uganda has declined from 18,5% to 6,5% in the past ten years. Yahaya believes that the successful management of HIV/AIDS has been made possible by teamwork at all levels in the community. Traditional medicine is being used alongside western science and treatment. Auerbach et al. (1994) underline the fact that community leaders must be "carefully" identified and "intimately" involved and that the members of the community must be consulted in the formulation and organisation of any AIDS campaign since they can play a positive and constructive role.

Hickson and Mokhobo (1992) recommend that healing ceremonies, which include relatives and incorporate the guidance and cooperation of ancestors, should be used in the treatment of AIDS patients. Rituals like dancing, singing, storytelling, street theatre and drumming could be used in HIV/AIDS education. The dramatisation enables patients to express their emotions, to overcome anxiety and to accept and integrate the different parts of the self (Pasteur & Toldson, 1982; Hickson & Mokhobo, 1992; Van der Hoeven, 1992). Dancing, singing and drumming are

activities which draw communities together and give people a sense of belonging. This could be potentially healing because of the nurturing, comforting and reassuring impact it could have on individuals as well as the group.

As far as sexual intercourse is concerned there are positive traditional values and behaviours that could be utilised in AIDS -prevention programmes. These values underline the fact that sexual intercourse is discouraged or forbidden - immediately after a woman has given birth or during pregnancy

- with women who have aborted or miscarried
- with persons who have an STD
- when a woman is menstruating (Van der Hoeven, 1992; Green, 1994; Chipfakacha, 1997; Van Dyk, 2001a)

Chipfakacha (1997) quotes a slogan that is used in Botswana to motivate people to get involved in the fight against AIDS: “AIDS is your problem too. Share the challenge.”

All the “positive” cultural values and behaviours discussed here could form the basis for AIDS prevention campaigns.

Exotic Cultural Behaviour

The term “exotic” may have a negative or a positive connotation. Airhihenbuwa (1989) uses the term to describe unique traditional African behaviour. In this context, exotic cultural behaviour refers to traditional African customs and behaviour that may be unfamiliar to Westerners but are not perceived as health hazards.

It is difficult to draw a clear distinction between cultural behaviours that pose a health hazard and those that do not. Van Dyk (2001b) holds that polygamous marriages, cultural rituals, ceremonies and the use of herbal remedies are some of the behaviours that should not change because they do not pose health hazards. On the other hand, circumcision and tribal marking could be harmful to people’s health if they are not performed by trained persons using sterilised equipment.

According to Mbiti (1989), a child can only become fully integrated into society after undergoing specific rites of incorporation. Some of these rites involve

making tribal marks, for instance marks on the left shoulder, cutting holes in the ear lobes and plugging each hole with piece of wood to keep it open, as well as circumcision. The significance of these rituals to traditional African people, as described by Mbiti, underlines the importance of finding methods of making these rituals safer.

Taking into account that some behaviours are perceived as health threats and others not, Yamba (1997, p. 200) seems wise when he says: “What we have, therefore, is an *ad hoc* selection of what to recommend and what to discourage, based on no other logic than the desire to fight AIDS.”

Negative Cultural Behaviour

Adherence to some cultural beliefs and behaviours can be harmful to people's health. In the case of HIV/AIDS infection it has become clear that some practices are more than harmful: they are also deadly. I have discussed various beliefs and practices and in this section I mention only those that are negative and should be changed:

- having multiple sexual partners (Campbell & Kelly, 1995)
- cleansing rituals which could bring people into in direct contact with body fluids that are contaminated by the HI virus (Van der Hoeven, 1992; Green, 1994; Yamba, 1997)
- inheriting the wife of the deceased brother (Mbiti, 1969), because this practice increases the number of partners with whom a person has sex
- the practice of dry sex (Whiteside & Sunter 2000; Van Dyk, 2001a)
- cleansing of bodies for burial, which could bring people into direct contact with HIV-contaminated body fluids (Garrett, 1995)
- sucking of blood from patients' bodies (Chipfakacha, 1997)
- sexual intercourse with a virgin in the belief that it could cure HIV/AIDS (Green, 1994; Whiteside & Sunter, 2000)
- beliefs about “unnatural” and “real” sex because of resistance to condom use (Crewe, 1992)

- sexual intercourse with teenagers and schoolgirls in the belief that they will not be infected with the HI virus (Van der Hoeven, 1992)
- property grabbing of property that leaves a widow impoverished and vulnerable to sexual exploitation (Campbell & Kelly, 1995)
- beliefs that cause resistance towards condom use (Taylor, 1990; Van der Hoeven, 1992; Green, 1994; Setel et al. 1999; Stanley, 2000)

Summary

The socio-cultural sexual context influences behaviour as well as behavioural change. AIDS education for people who choose to adhere to African traditions that incorporate the three cosmic orders should be seen as a challenge and not a burden. Traditional beliefs and practices could be used in a positive way in AIDS programmes. In the case of “negative cultural behaviour” that poses a health threat, creative and non-threatening ways of changing such behaviour should be explored. Traditional healers and leaders should be involved in the whole education process.

CHAPTER 4

RESEARCH

Introduction

This chapter gives an account of the research that I have conducted. The problem I focused on was described in chapter 1, namely:

- How can traditional African beliefs and values be utilised in HIV/AIDS prevention programmes in Soshanguve?

The aim of the study was therefore to determine how traditional African values manifest in an present-day, urban South African setting and whether these values could have an impact on HIV/AIDS prevention programmes.

The research problem as well as the aim of the study provided the guidelines for the research. Theoretical concepts such as traditional African belief systems, the traditional African worldview, sexual behaviour and behavioural change, which have been discussed in chapters 1, 2 and 3, also provided a framework for the research. The focus of the study was on traditional African beliefs and their influence on sexual behaviour.

Demarcation of the Field of Study

This study focuses on the role of traditional African belief systems in the lives of some people in Soshanguve (North of Pretoria) and the implications they have for HIV/AIDS prevention programmes. Five persons who work and live in Soshanguve were interviewed. They are all involved with HIV/AIDS prevention programmes. The results of this study may help them in making some adjustments to the HIV/AIDS programmes in which they are currently involved.

Method

This research takes a qualitative approach. According to Tesch (1990) qualitative data refers to any information that the researcher gathers that is not expressed in numbers. Qualitative data include information such as words, pictures, drawings, paintings, photographs, films, videotapes, music and sound tracks (Struwig

& Stead, 2001). In this study tape recordings were made of semi-standardised interviews. By making use of content analysis (Struwig & Stead, 2001) I tried to “see through the eyes of the participant” (Struwig & Stead, 2001.p12) in order to get a better idea of the world of the participants. Emphasis is placed on the participant’s perspective and description of events, beliefs and behaviours (Struwig & Stead, 2001). Phenomenology is used as research method in this study. According to Struwig and Stead (2001) the goal of phenomenology is to find common themes to illustrate the range of meanings of a phenomenon. The common themes that emerged from the interviews are summarized and compared to the information that was gathered in the literature study.

Five participants are interviewed in this study. According to Struwig and Stead (2001.p17) qualitative research is “more idiographic in that case studies or relatively small samples are employed with few claims made regarding the wider representativeness of the sample or the generalisability of the findings”. The five participants work and live in Soshanguve. Three of the participants are social workers, one is a community leader and the other a clergyman in a local Christian church. The social workers are female and the community leader and clergymen are males. They belong to the Sotho ethnic group and their ages are in the thirty to forty-five year range. According to all five of them, they are confronted by the effects of HIV/AIDS in their work environments on a daily basis.

Semi-Standardised Interviews

The themes for the semi-standardised interviews were determined by the problems that are the focus of this study and by the aim of the study. The interviewees were asked to comment on the following questions:

- Is the AIDS pandemic under control or getting worse?
- Do traditional African beliefs still play a role in Soshanguve?
- If they were of the opinion that traditional African beliefs still play a role they were asked to explain how these beliefs impact on the sexual behaviour of the average person in Soshanguve.
- Do certain traditional beliefs influence people’s use of condoms?
- What can be done to make AIDS awareness programmes more effective?

The following was explained to individual interviewees:

- The interviewees were given the assurance that all their responses would stay anonymous.
- It was explained that there were no right or wrong answers and that their personal experiences and perceptions were of interest to me. Interviewees were encouraged to pose questions if anything was unclear to them.
- Interviewees were advised that notes would be taken during the interview for future reference.

Results of the Individual Interviews

In order to ensure anonymity fictitious names are used here to identify the interviewees.

Interview with Mary

Mary is a social worker who stays and works in Soshanguve. She has an office in Soshanguve and runs HIV/AIDS prevention programmes. She saw AIDS as a growing problem in Soshanguve. According to her many people were ill with AIDS-related diseases and many people were dying. The number of funerals that were taking place gave her the impression that there were more people who were dying now, especially younger people. She thought that the AIDS programmes made a difference but she was concerned about the many people who were moving to Soshanguve from rural areas. These people were not “educated” and they held to the “old traditions”. They believed that AIDS was a “white man's problem” since it was unknown in their culture. They also did not understand “things such as germs and viruses”. According to Mary, “uneducated” people see AIDS as bad luck, or as a curse: “may be you have been bewitched or some witchcraft or spell has been cast.” She added that these people often said that the person concerned had eaten something wrong. “They call it ‘*sejeso*’ if you ate something that makes you ill.” Then the food had been “bewitched by someone that wants to harm you.”

She identifies uneducated people as “young boys who just play dice in the streets, who do not go to school, and are unemployed. They think like the rural people and do not have all the information that the people who go to school or to

University have.” According to Mary the “uneducated” persons are people that move into Soshanguve from other places but could also be people that grew up in Soshanguve.

As far as condom use is concerned, Mary was of the opinion that fewer than 50% of people used condoms, and that there were still many negative beliefs concerning condoms. One of these is related to the fact that many people did not see AIDS as a sexually transmitted disease. They could therefore not see that there was any reason why they should use condoms. Others thought that condoms caused infections. There were also people who maintained that if the condom burst it could make the woman infertile.

In answer to the question whether traditional beliefs still played a role in sexual behaviour Mary indicated that “there is still a common myth that sex with a virgin can cure sexual illnesses. This is a big problem and it is not a new problem”. She stated that according to many African traditions one should get married first and then engage in sexual relationships. According to her, children were becoming sexually active at a very early age. Contrary to “traditional beliefs”, according to Mary, many men did not want to get married before “you have given him a child”. To the question why men wanted children before they married, Mary replied that “men want their surnames to continue after their death.”

She indicated that polygamy is common amongst “rural” people but that “educated people do not believe in polygamy.” According to her, “educated” women were not prepared to “share attention with other women.” Even in rural areas polygamy caused “problems between the wives.” Wives who were unemployed were dependent on men and were prepared to “share the man with other wives just because they have no other choice.”

As far as traditional customs were concerned, she mentioned a practice in rural areas whereby men expected their wives not to take a bath during the time of their absence from home. This implied that the wife could not take a bath for weeks or even months during the absence of the husband. The reason for this practice was that “the wife would not wash away evidence that she has been with another man.” Mary linked this practice to the practice of “dry sex”, saying that some of her

friend's husbands accused them of "unfaithfulness" if they were not "dry" during intercourse.

Mary observed that many people were still "afraid" to make physical contact with AIDS victims, and even refused to share "cups and plates" with them. They also refused to share a bathroom, which caused tension in families.

AIDS programmes were of no help "if they just give information concerning AIDS." Mary suggested that HIV/AIDS sufferers be used to "tell about their experience with AIDS because people should experience the real thing."

Interview with Reverend X

Reverend X stays and works in Soshanguve. He has a congregation in Soshanguve and is involved with various HIV/AIDS prevention programmes. According to him HIV/AIDS was a growing problem. His perception was based on the number of people who were dying from AIDS-related diseases: "pneumonia, TB and weight loss". He was of the opinion that the AIDS programmes were not effective: "People get the information and some act accordingly. People have a choice what to do with the information and many people do not change their behaviour."

Rev. X said that condoms were new to the community and people did not want to use them. He admitted that he himself did not want to use condoms. He believed that the main reason for people's negative attitude towards condom use was linked to their "understanding of sex". He maintained that in the traditional African belief system, sex was not in the first place focused on pleasure: "Not the pleasure but procreation is the drive behind sex. This is also the reason why the use of contraceptive pills is uncommon amongst black women". A pregnant woman was someone very special and "a pleasure to see".

"Polygamy is common in rural areas and uncommon in urban areas. It is too expensive to have more than one wife and many children. In rural areas, where people survive from what they produce on the land, people can have many wives and children. The biggest problem is not polygamy but extra-marital sexual relations". Polygamy did not imply that a man with more than one wife did not have sexual relations with other women: "African men are highly sexed."

Rev. X stated that many people denied the existence of AIDS. The necessary information concerning the dangers of AIDS were available, yet “despite this people are making up stories about witches, evil spirits and so forth. These are methods to wipe the problem under the carpet.”

This interviewee maintained that “traditional healers can play a big role in the fight against AIDS. They are already part of the professional team.” He was also of the opinion that the church could play a bigger role in supporting AIDS patients. As a result of many negative perceptions concerning people with AIDS, “many families abandon their relatives as soon as it becomes evident that they have AIDS.” He stressed that if the church followed the example of Jesus “we would take care of the sick”.

Rev. X believed that much could be learned from traditional practices that could stop the high level of AIDS infections. “Chastity is the thing that we should bring back into society. Parents should teach their children to abstain from sex until marriage. Parents do not talk to their children concerning sex. This was not so in the past. Children knew very well that they had to obey the traditions but now they are just doing as they want.” Parents no longer “extended” their knowledge to their children because they “are not proud of their traditions any more. There is not enough communication between parents and children. Children do not have respect for older people any more. That is the reason why bad things happen to them. If they are willing to learn from their parents they will not make all the mistakes they are making.”

Rev. X finally admitted that he was not a very traditional person himself but he respected the traditions. “It would have been much better if some of these traditions were still obeyed because many of the traditions are in line with the message of the Bible.”

Interview with Elize

Elize is a social worker who works and stays in Soshanguve. She is employed by a private organisation and works primarily with alcohol and drug dependant persons. Some of these persons have also been infected with HIV/AIDS. She is also a volunteer worker at a local Church that runs HIV/AIDS prevention programmes.

She was of the opinion that the “worst is still to come” concerning the AIDS pandemic because “many people are ill with AIDS-related illnesses”. What concerned her was that people did not want to talk about AIDS and some people said that “you cannot die from AIDS”. Many people, she said, thought that it was a “homosexual or white man’s” disease.

According to Elize, people from rural areas “do not believe in western medicine and they think that AIDS is a curse”. People who had become used to western medicine did not understand why some people died of AIDS and others not. “That is why they think maybe there is a curse, somebody that went to a traditional healer to do you harm because they hate you. People can cause you harm by the food that they give you, by things that they put in your food, by things that they put in or around your house or in your possessions. People who hide something in your car that will cause you to make an accident.”

Elize said she did not believe in all the “traditional beliefs” but acknowledged that she was not “sure about the powers of evil people.” One of her family members had become ill after he had had an argument with another man. “This man told him that he is going to put a curse on him. He became ill and he died after a year.”

Many of the people who live in Soshanguve, according to Elize, are “very westernised and do not use traditional medicine or visit traditional healers. Many other people do not want to use western medicine. They only use the medicine that the traditional healers would give them.” She encouraged people to use western as well as traditional medicine.

Concerning traditional African beliefs, Elize held the opinion that there were some beliefs that could be dangerous, like circumcision. “It is a very dangerous ritual since they use the same sharp tools for all the young boys and they don’t clean it all the time.” She was also concerned about the “cuts that traditional healers make and then put medicine in it.” She described this as “a problem of a sharp tool that they do not clean before they use it.”

Sex-related traditional beliefs that stipulate that “the brother of the man that died has to take his wife till she can take another man” also caused her concern. She

mentioned that “if the man that died had AIDS, his wife could also have AIDS and then his brother could also get AIDS.”

Elize felt that the campaigns “that want people to use condoms” were suspect: “Men are negative towards condoms. They say it is unnatural and causes infections.” She estimated that fewer than 30% of people in Soshanguve used condoms.

Many AIDS programmes were being presented in Soshanguve. “People know about AIDS and they see people dying from AIDS.” Yet, said Elize, “they still continue as if AIDS does not exist.” She believed that women were more concerned about AIDS infection than men: “Men especially do not want to use condoms or want to talk about safe sex. They say we want to throw away the black traditions. Women are having a very hard time. Especially if the women are becoming more westernised the men get angry with them. That is why you get many women that do not want to get married any more. They say men are treating them bad.” Tension was therefore growing between men who wanted to enforce “traditions such as polygamy and women who are very negative towards such traditions.”

Elize was of the opinion that the AIDS campaigns would not have any effect if “men do not change. Women die because men are reckless in their sexual behaviour.” According to her women were eager to get more information concerning AIDS but men “do not care”.

Interview with Ina

Ina is a social worker who is employed by a private welfare organisation. She does community work and she is involved with HIV/AIDS awareness programmes. Ina was of the opinion that the AIDS epidemic was under control in Soshanguve because there were fewer funerals than two years ago. “More people know about the disease and people are less careless,” she said. The stigma attached to AIDS was “not so severe any more because people know that they can get AIDS too. They know that if they are not infected they are already affected by AIDS.” Yet despite the fact that the stigma attached to AIDS was less severe, she admitted that “people are still very reluctant to touch people with AIDS or to use the same utensils.”

Not many people used condoms, according to Ina. “Especially with a new girlfriend the men get too excited to use a condom.” Expecting the other person to use a condom also “shows that you do not trust him.”

In Ina’s view, AIDS had changed the way that traditional rituals were being performed. According to her, the traditional healers were well informed. They expected people who visited them “to bring their own blades”. By doing so, the traditional healers “prevent AIDS to spread when they have to make cuts.” Ina was also of the opinion that the community was better informed. The community expected the traditional healers “to be informed about AIDS and not to take any chances.”

She observed that a considerable number of problems surrounded the practice of circumcision: “The boys are not in a position to demand new or clean blades when they are being circumcised at the initiation schools. They dare not challenge the authority of the teachers at these schools.”

Ina asserted that polygamy did not occur amongst “middle-class people in Soshanguve but amongst women who are not in a position to object to another woman in her husband’s life.” Women who were financially dependent on their husbands had to accept polygamy: “They have no power to protest against their husband’s decisions.”

Witchcraft still played a role in Soshanguve, although Ina maintained that Christian people did not believe in “the power of witches”. They only believed that “God has power”. Those who believed in witchcraft also thought that “AIDS is caused by witches”. These people refused to use western medicine because they said it would not help. Ina felt that people should use western as well as traditional medicine if they had AIDS: “That will be the best for these people, then they can make sure that they are getting the best treatment.”

According to Ina, AIDS programmes had been successful in giving the information that people needed. She commented that people did not believe “healthy people who talk about AIDS. They just say you lie, you know nothing.” She suggested that people who were “already ill with AIDS” should give others the information. She suggested, too, that the whole community should be part of AIDS

programmes. According to her, churches could “get more people who can talk about AIDS when the people are at the church.”

Interview with Hosea

Hosea is a community leader who lives and works in Soshanguve. He is involved with a HIV/AIDS prevention programme which a local Church facilitates. He was not sure whether the HIV/ AIDS epidemic was under control or getting worse. “Sometimes I do not see so many young people who are ill and who are dying. Other times many young people are dying and we think it is because of AIDS. Maybe it is the same.”

The “face of Soshanguve” was changing, according to Hosea. “Many people are moving in from other places like Zimbabwe and Nigeria and from rural areas.” The newcomers brought “new values and beliefs. There are many people who cannot talk one of the South African black languages.” Hosea said that these people were making it difficult to live in Soshanguve. “They bring drugs and bad things with them.”

Hosea did not see himself as a traditional person but thought that many of the traditions, beliefs and values were good. Society was changing and people “do not know what they are doing or believing. Younger people do not respect the older people as it was with our traditions. They take girlfriends when they are still very young and they want to live like men with the girlfriends.” In his tradition he had not been allowed to be seen with a girlfriend before he was a man. His own children were still young and “they want to be with girlfriends and boyfriends.”

Hosea felt that drugs played an important role in the AIDS epidemic. “Nigerians bring drugs into Soshanguve. Young people start to use drugs and later on the only way that they can pay for their addiction is by selling sex. They cannot earn enough money to pay for the drugs so they become prostitutes.”

Many men did not want to use condoms: “Even if they are with prostitutes they do not want to use condoms. They say it is not part of their culture. Many men say that condoms make them ill, it gives infections and make them sterile.”

Hosea linked the use of drugs amongst young people to the breakdown of traditional value systems, especially the lack of respect for older people: “The young

people do not listen to their parents or to the older people. We did not use drugs. We were too scared of what our parents would do to us if they catch us.” Discipline in schools was also a problem. “Children don’t listen to the teachers any more. The teachers warn them about AIDS and drugs but they do not listen. That is the reason why so many young people die. They think they know everything and that older people cannot teach them anything.”

Hosea was convinced that parents should take responsibility for the behaviour of their children. “They should prevent them from using drugs and from engaging in sexual relationships when they are still in their parents' homes”. Traditional values should become part of society again: “Sex was meant for older people that are married, not for young children that still stay with their parents. Many young people are going to die because they moved away from these traditions.”

“Parents, community leaders and all the old people should get together to solve this problem. When younger people respected the older people there were not so many problems,” was Hosea's conclusion.

CHAPTER 5

COMPILED RESULTS OF THE SEMI-STANDARDISED INTERVIEWS

In this chapter I discuss the results of the semi-standardised interviews. I focus on the themes that emerged in the interviews. The five questions that were used as guidelines in the semi-standardised interviews form the basis for the discussion.

Is the AIDS Pandemic Under Control or Getting Worse?

Four of the interviewees were of the opinion that the situation in Soshanguve was getting worse as far as the spreading of AIDS is concerned. No official statistics were at their disposal but their perceptions were based on the perceived number of deaths, as well as the kind of illnesses that caused these deaths. Their roles in the community as social workers, their involvement with the local Church as well as the leadership roles that they play in the community puts them in contact with the day to day realities in Soshanguve. One of the interviewees was of the opinion that fewer people were dying from AIDS than two years ago. This underlines the fact that perceptions differ between people who come in contact with more or less the same reality.

According to Whiteside and Sunter (2000, p. 28), “people will only start dying in large numbers some years from now Because people will be dying of the many opportunistic infections brought on by AIDS, the true impact of the epidemic will remain camouflaged and largely invisible.”

It is understandable that without access to official statistics, the interviewees took the number of people who died, or were seriously ill with AIDS-related symptoms, as an indication of whether or not the AIDS epidemic was getting worse. The specific nature of AIDS (as explained by Whiteside & Sunter, 2000) underlines the fact that the current death rate does not necessarily reflect the current infection rate of the disease.

Do Traditional African Beliefs Still Play a Role in Soshanguve?

The interviewees were of the opinion that traditional African beliefs did still play a role in Soshanguve. They distinguished between those who identified strongly

with the traditional African belief system and those who were not as committed to it. The “rural people” who moved into Soshanguve were perceived to be “traditional” in their belief system, while the “urban people” were perceived to be “not so traditional”. A distinction was also made between “western and African”, “educated and uneducated” and “middle-class and poor”.

Concerning medicine, the interviewees indicated that some people in Soshanguve used western medicine, some used African medicine and some used both. The way medicine was used also seemed to point to a transition from an African belief system towards a western belief system.

One of the interviewees maintained that certain adaptations had been made to traditional customs. Traditional healers asked people to bring their own blades for the making of the “cuts” where medicine was to be applied. On the other hand, as far as circumcision was concerned, it seemed that “teachers” were managing the rituals during circumcision in ways that the boys were unable to object to. There were fears that these rituals were not only unhygienic but also conducive to the spreading of the AIDS virus. Witchcraft still played a role in the lives of many people in Soshanguve. Some people still linked AIDS to evil forces, curses and witchcraft.

How Does the African Belief System Influence Sexual Behaviour?

The interviewees indicated that the African belief system did have an influence on sexual behaviour. Polygamy, cleansing rituals, circumcision, as well as the importance of procreation were mentioned as beliefs and behaviours that could have an influence on sexual behaviour.

One of the interviewees made a connection between “power” and sexual behaviour. Women who were financially independent of their husbands were also in a position to object to polygamy. On the other hand, those who did not have “power” and were financially dependent on their husbands and were not in a position to object to the latter’s sexual behaviour.

One of the interviewees held the view that there was a breakdown in society because of the lack of respect for traditional beliefs and values. He linked younger people’s use of drugs and the fact that they engaged in sexual relationships at an

early age to their disrespect for older people and traditions. According to traditional African beliefs and values, he claimed, sex should be part of marriage.

Do Certain Traditional Beliefs Influence People's Use of Condoms?

The percentage of people who used condoms was perceived to be low. The interviewees put forward a number of reasons for people's reluctance to use condoms. Condoms were new, strange, unnatural, took away pleasure, could burst and cause infertility and infections. These beliefs and perceptions were not, however, linked to traditional beliefs.

The perception that AIDS as an illness did not exist could be linked to traditional beliefs concerning illness. The fact that sex was linked to "procreation" and that condoms prevented procreation ran counter to traditional thinking and this was another reason for people's negativity towards condom use. The reasons interviewees gave for the lack of condom use could not, however, all be linked to traditional African beliefs.

What can be Done to Make AIDS Awareness Programmes More Effective?

Denial rather than a lack of information concerning AIDS seemed to be the problem. It was suggested that people who were infected with AIDS should talk to people who were not infected. There seemed to be a perception that messages conveyed by AIDS patients would more readily persuade others to change their behaviour.

The submissive role of many women and children seemed to put them in a position where they had to accept behaviours of others that could be threatening as far as HIV/AIDS infection was concerned. Wives who were dependent on their husbands for basic needs were reported to be the victims of polygamy. They had to accept it if their husband wanted another wife. Boys who were part of the circumcision ritual also seemed to accept life-threatening treatment from their "teachers" without protest.

For behavioural change to take place, people had to be in a position to make the choice to change. In many instances poverty was linked to the lack of "power" to make choices because people could not afford alternatives. Even if people had all the

information they needed concerning AIDS but were not in a position to make the right choices, they were high AIDS risks.

Respect for older people and traditional values were seen as a possible means of curbing for drug abuse as well as indulging in sex from an early age. Community leaders, parents and older people in the community could do more to revive traditional norms and values.

Traditional healers still played a significant role in the lives of most of the people in Soshanguve. It would seem that many people used both western and traditional medicine. The feedback from some of the interviewees underlined the role of traditional healers in giving people advice concerning AIDS. The traditional healers' contribution to the fight against AIDS was important and could be strengthened. Interviewees also felt that community leaders should be involved in the planning and implementation of HIV/AIDS programmes. Churches already played a role in the fight against AIDS, and should increase their efforts in future.

Summary of the Results of the Interviews

The sample that was used for the research is not representative of the South African population. The results should therefore be evaluated as the perceptions of a group of professional people who live and work in a typical township that was founded during the apartheid years. The information gleaned from the interviews supports the theories as well as the results of other research projects that have been documented in this paper. The following points summarise the results of the interviews:

- The AIDS pandemic is not under control.
- Traditional African beliefs still play a significant role in the lives of some of the people who live in Soshanguve.
- Traditional belief systems influence sexual behaviour.
- The perception among interviewees was that the percentage of people who use condoms in Soshanguve is low. There is also a perception that traditional beliefs stigmatise the use of condoms.
- HIV/AIDS prevention programmes should take traditional African beliefs into account. These programmes should be inclusive with regard to worldviews and

traditional beliefs. All the role players in the community should be consulted and should, if possible, participate in the fight against AIDS.

Evaluation of the Problem That Guided This Study

The following problem guided this study:

How can traditional African beliefs and values be utilised in HIV/AIDS prevention programmes in Soshanguve?

In the literature study it was emphasised that AIDS is mainly a heterosexually transmitted disease in Southern Africa. Many traditional beliefs and values that influence behaviour, especially sexual behaviour, were discussed. The interviews that were conducted confirmed that some of the traditional beliefs discussed in the literature study still play a role in Soshanguve, a township north of Pretoria.

It was indicated in the literature study that some of the traditional beliefs, especially those that influence sexual behaviour, could have a direct impact on HIV/AIDS infections. The literature study stressed that the behavioural change that can curb the spread of HIV/AIDS is a complex issue. What complicates it further is the fact that sexual behaviour is often impulsive and irrational. This underlines the assertion that was found in both the literature study and the interviews, namely that having information concerning AIDS does not automatically lead to behavioural change.

As discussed, the P-E-N model categorises traditional African beliefs and values as (P) positive, (E) exotic, and (N) negative as far as HIV/AIDS infection is concerned. In the literature study and the interviews *positive* traditional African beliefs and values were discussed. During the interviews some of these *positive* beliefs and values were also mentioned. Some of the *positive* beliefs and values are collective existence, respect for traditional leaders and older people, the role of traditional healers and of traditional beliefs and values concerning sexual intercourse, and these should be utilised in the fight against AIDS. Churches, the community as well as traditional healers and leaders should join hands in AIDS prevention programmes.

Suggestions for Further Studies

In both the literature study and the account of the interviews, references were made to HIV/AIDS programmes. No specific programmes were mentioned or evaluated. It is possible that some of these programmes do, in fact, recognise the specific African worldview that was presented and do make provision for traditional African beliefs and values. It is also possible that some programmes include the community and recognise traditional healers and leaders as valuable partners in the fight against HIV/AIDS. Further studies could develop programmes that take the results of this study into account.

Conclusion

Traditional African beliefs and values play a role in the lives of millions of people in Southern Africa. Many of the traditional African beliefs and values have a direct influence on people's behaviour, especially their sexual behaviour. Several authors stress the fact that certain traditional beliefs and values place people at risk as far as HIV/AIDS infection is concerned. According to the P-E-N model these beliefs and values are categorised as *negative* because they pose a threat to people's health.

Success stories in Africa point to the involvement of the whole community in the fight against HIV/AIDS. The focus of communities should be on *positive* traditional beliefs and values that can be built into HIV/AIDS awareness programmes. Traditional healers, community leaders and church leaders should all be involved in developing these programmes.

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