Culture and the spread of HIV

Marié Joubert-Wallis
Department of Psychology
University of South Africa
joubert.m@gmail.com

Eduard Fourie
Department of Psychology
University of South Africa

Abstract
Cultural factors have been shown to play a role in human decision making and behaviour. The main objective of this study was to identify and evaluate the possible influence of Shangaan cultural beliefs, myths, and practices on the spread of HIV within the Mnisi tribe. A qualitative method of investigation was followed and interviews were conducted with three participants. Observations as well as a questionnaire were used. Two cultures, or patterns, influencing the spread of HIV in the Mnisi tribe were identified, namely: (1) the culture of power, and (2) the culture of poverty. The implementation of community and culture specific strategies to combat the spread of HIV is recommended.

Key words: culture; cultural beliefs; HIV and AIDS; myths; power; poverty; Shangaan culture

HIV and AIDS are complex issues affecting many individuals around the world. It has been the main subject of many international talks and seminars and has been incredibly costly to the international community, both directly and indirectly. It is unlikely that a cure for HIV and AIDS will be found in the near future and therefore the main aim of current investigations and interventions should be to stop the spread of HIV.

According to Muir (1991), individuals make limited choices when functioning in their environment. Their functioning is affected by political, economic, and legal structures, which form the norms and institutions of their society. Efforts that attempt to alter the sexual behaviour of individuals must acknowledge that behaviour is rooted and sustained through ongoing relationships and exchanges within individuals’ social network. Individuals usually behave in a manner that makes sense to them within their current situation or life space and their attitudes and choices are influenced by the social and cultural norms that they observe. People therefore need not (and in many societies or situations do not) act autonomously (Moncrieffe, 2004).
The course of the HIV epidemic is influenced by, amongst others, people’s expression of their sexuality, drug and alcohol use, the role of the media, the response of governmental institutions, and the public’s perception of the seriousness of the disease. The magnitude of the HIV and AIDS problem should force people to re-examine their social systems, beliefs, behaviours, and institutions (Muir, 1991). As the construction or understanding of any construct (including the constructs HIV and AIDS) can be linked to a person’s culture (Güss, 2002), the first author decided to investigate the spread of HIV from a cultural (specifically Shangaan cultural) perspective in more depth.

CULTURE AND HIV

South Africans have a wide range of beliefs, habits, and religious and healing practices, including aspects of both western and African worldviews. As in other cultures, Shangaan cultural identity and continuity are maintained through traditional practices. In the past it has been assumed that some traditional practices promote the transmission of HIV, but not many studies have been conducted to establish the linkage (Loosli, 2004).

A tradition (from the Latin word ‘traditio’, which means ‘to hand down’) can be seen as whatever is brought to the present from the past in a specific societal context. Tradition thus seems to be a fixed link between people and their ancestors. It can also be seen as an economically efficient way of transferring knowledge (Hayek & Sowell cited in Wikipedia, 2008b); decision-making, for example, consumes time, while cultural traditions offer a low-cost, consensually reliable manner to use less of the resources required to make decisions independently. According to Loosli (2004), traditions should be preserved to save the origin of mankind – to do good and not bad. People’s behaviour is largely influenced by the culture in which they have grown up (Loosli, 2004). As culture influences the day-to-day activities and decisions of individuals it also affects issues surrounding health.

The terms ‘culture’ and ‘race’ are at times used interchangeably. This is, however, problematic as the term ‘race’ refers to the concept of dividing people into different groups on the basis of various traits. Most commonly visible traits, such as skin colour, facial features, and hair texture, are used to place individuals into racial categories (Reber & Reber, 2001). The term ‘culture’, on the other hand, is a much broader term. The word ‘culture’ comes from the Latin ‘cultura’, which means ‘to cultivate’ and is generally used when referring to patterns of human activity and the structures that give these activities meaning and importance (Wikipedia, 2008a). According to Jary and Jary (cited in Wikipedia, 2008a), culture can be called the ‘way of life for an entire society’ (electronic version). Culture thus includes codes of conduct, norms of behaviour (e.g., law and morality), dress, language, religion, systems of belief, and rituals (Jary & Jary cited in Wikipedia, 2008a), and is visible
in a society’s music, literature, painting, sculptures, theatre, and so on (Williams, 1983). The term ‘culture’ has many usages and meanings, but here Mkhize’s (2004) definition is referred to. He argued that culture:

refers to knowledge that is passed on from one generation to another within a given society, through which people make sense of themselves and the world. It incorporates language, values, assumptions, norms of behaviour, ideas about illness and health, etc.’ (p. 34)

Through various empirical studies, Strohschneider (2002) found that cultural factors play a role in human decision making and stated that: ‘The process (of complex decision-making) is open to a number of cultural influences, among them educational practices, environmental predictability, and power distance’ (electronic version). Individual factors, such as knowledge and confidence, without doubt play a key role in sexual behaviour (Hook, 2004) and thus also in the spread of HIV. However, these (and other) individual factors are shaped by a person’s social context.

A factor that plays a prominent role in social constructions (or social knowledge), of which social norms and values are examples, is culture. Culture, according to Dalton, Elias, and Wandersman (2001), ‘is often expressed in what the society or group seeks to transmit (e.g., by education or example) to younger generations or to immigrants’ (p. 155). Behaviour that sprouts from cultural beliefs and traditions is thus important to individuals within a community as well as to the community as a whole and can therefore not simply be changed by education or knowledge about HIV or other health issues.

Strohschneider (2002) stated that individuals have limited freedom in making decisions as in many cultures decisions are more strongly influenced by the social and cultural context than by individual decisions. As culture influences marital systems, household structures, circumcision practices, sexual mores, and the social use of space, it is difficult to put culture into the concept of ‘high risk behaviour’ (Webb, 1997). Individual behaviour will vary according to context but it is not determined by it. There is no simple cause-effect link, only a relationship based on probability; an individual is more likely to contract HIV from participating in high-risk sexual activities than when he or she does not participate in such activities. Culture cannot be blamed for spreading HIV, but it can be seen as one of the factors contributing to the complexity of the spread thereof.

Considering how a person’s ‘life situation’ influences his or her behaviour, the question might be asked whether a person’s culture and its traditions complicate the basic modus operandi of the spread of HIV. The recognition of the importance of cultural, ethnical, and gender differences is important when seeking to understand the factors that influence social behaviour and social thought (Baron & Byrne, 2003). The aim of this investigation was to obtain a better understanding of the complexity of the spread of HIV from a cultural perspective. The main objective of this research...
was to identify and evaluate the possible influence of Shangaan cultural beliefs, myths, and behaviours on the spread of HIV within the Mnisi tribe.

The Shangaan culture

The Shangaan are a large group of people living mainly in southern Mozambique, but there is also a large Shangaan grouping in South Africa, where they are often referred to as the Tsonga. They speak Xitsonga as well as European languages, such as Portuguese, Afrikaans, and English. According to Niehaus (2002), the Shangaan identity in the South African Lowveld has developed from the assimilation of different identities from diverse origins, such as Mozambique and Swaziland.

Niehaus and Jonsson (2005) found that within the Lowveld area of South Africa, where the Shangaan people reside, the scale of the HIV and AIDS epidemic is ‘frightening’ (p. 179). Secrecy and denial heighten suspicion (Sanders & West, 2003) and the attribution of blame for HIV and AIDS is expressed differently between genders (Niehaus & Jonsson, 2005). Women tend to blame men and envious nurses for spreading HIV, while men raise ‘conspiracy theories, blaming translocal agents – such as Dr Wouter Basson, Americans, soldiers, and governments – for the pandemic’ (Niehaus & Jonsson, 2005, p. 179).

Traditional African thinking as embodied in the life of the Shangaan people epitomises communal life. Personhood is defined in relation to the community and possession of the qualities of personhood is reflected in a person’s association with others. In Shangaan culture (as in some other African groupings), this is referred to as ubuntu, the ‘concrete or practical realisation of the knowledge that the possession of the qualities of personhood is reflected in people’s relationship with others. Ubuntu is characterised by caring, just and respectful relationships’ (Mkhize, 2004, p. 50).

The ‘life world’ of the Mnisi people

The majority of the Mnisi tribe’s people fall within the low socio-economic class and live under the so-called bread line (Lehohla, 2002). They live in small houses made of bricks that they build themselves with mud and cement, roofed by corrugated iron. As many as four generations of a family live in a single house, on average a household contains 6.3 people (Orkin, 1998). Pit latrines are used and sanitation and waste removal services are non-existent (Orkin, 1998). Water is obtained from sometimes as far as five kilometres from homes and food is not always readily available. Mr D, one of the participants, said that ‘first thing to the people what’s important is water, the people they suffering with water’. Roads in and around the villages are gravel and taking a taxi is extremely expensive, but has to be done when someone needs to go to a town or a city as this is the only means of transport for the majority of people. Every village has its own school or a school situated near by. Many of the educators in these schools do not, however, have proper qualifications,
but due to the incredible shortage of educators in South Africa (Hazelhurst, 2007; Panchaud, Clarke, & Pillai, 2003), many schools use whoever is willing to help. Many of the tribe’s young people only finish school up to Grade 10 as by that time, many of them have their own children to care for and therefore have to find a paying job to do so.

Medical facilities are in the form of clinics where there are only nurses to assist patients (doctors are located at the hospital which is situated approximately 40 kilometres away). The medical equipment is rarely in a working condition and the medicine available for distribution consists mostly of Panado (paracetamol) which is given for any kind of ailment. According to one of the participants, Mr D, ‘when you go to the clinic you find that there’s no tablets, they give you maybe only Panado’. Antiretroviral (ARV) treatment is available on occasion, but cannot be taken on a daily basis as prescribed, as the clinics do not receive enough medication for all their patients. According to a local nurse, the major health problems in the area are: malnutrition, diarrhoeal diseases, tuberculosis (TB), hypertension, alcoholism, sexually transmitted infections (STIs), and HIV and AIDS (personal conversation with local nurse, October 9, 2007).

The belief in ancestors and religion influences most people’s attitudes and behaviours in times of illness, drought, infertility, or other misfortune. Most of the tribe’s people refer to themselves as Christians, but many also make use of sangomas (traditional healers) when they feel the need to do so. As one of the participants stated, ‘they [referring to the ancestors] are helping me and also them they’re helping by God you see, they are not alone and you will have to follow the instruction of your forefather’.

The cultural customs of dancing and singing form an important part of the Mnisi tribe’s daily lives (Niehaus, 2002). Boys and girls go to their separate initiation schools and are seen as men and women when they return after three months. It is preferred that women look after the children, clean the house, and prepare the food. Men, on the other hand, are seen as the breadwinners and are expected to work and bring money home to care for their families.

**METHOD**

**Research design**

According to Henning, Van Rensburg, and Smit (2004), it is the *purpose* of the research that influences the paradigm the researcher chooses to work within most. As the purpose of this study had to do with cultural interaction and people’s subjective interpretation thereof, a qualitative study, embedded in a social constructionist paradigm, was best suited to fit the purpose of this study. Qualitative research, according to Denzin and Lincoln (2005), makes the world visible through a set of
interpretive, material practices which transform the world, where the researcher can be seen as the maker of a quilt, piecing together a set of representations that is specific to a complex situation.

Postmodernism has the best fit for establishing the ways in which the people of the Mnisi tribe participate in the creation of their perceived realities. In this study, the first author did not rely on any ‘expert’ voice, but on the voice of science involved with the Mnisi people, their knowledge and their culture. The findings of this study are not generalisable (Babbie & Mouton, 2005), but may provide an enhanced understanding of the local knowledge (Creswell, 1998) of the Mnisi tribe and its people.

Social constructionism focuses on unveiling the ways in which perceived realities are created by individuals and groups. Socially constructed realities are seen as a dynamic process where reality is re-produced by individuals and groups in terms of their interpretations and their knowledge thereof (Wikipedia, 2006a).

Data gathering

Purposive sampling (Patton, 2002) was used to select the participants from the Mnisi tribe. Data were collected by interviewing three individuals, one man (Mr D) and two women (Ms J and Ms P). Each participant participated in from two to seven interviews, which were conducted in English. The participants were relatively fluent in English and all were between the ages of 37 and 40 years. The first author kept a diary of observations which assisted her in understanding the ‘ways of the Mnisi tribe’. The interviews and observations continued until a point of saturation was reached, that is, when new thoughts no longer added new ideas to what had already been said and observed (Terre Blanche, Durrheim, & Painter, 2006).

The purpose of the observational data was to give the first author a better understanding of the ‘ways of the Mnisi people’ which assured more credible and trustworthy interpretations of the data collected during the interviews. During the interview sessions, she asked the participants to explain and clarify the observations and questions that she had recorded in the journal – for example, why people within the tribe responded in certain ways to certain situations. The observations were of the interactions amongst the people, including the body language of and between individuals. The participants thus functioned as intermediates between the Mnisi tribe and the first author. As she was permanently employed within the vicinity of the Mnisi tribe villages, observation took place on a daily basis and ensured that she could gain a better cultural insight while doing the investigation. In order to make sure of the credibility and trustworthiness of the interpreted data, she went back to the participants to see whether her interpretation and that which she had written made sense to them, as well as whether it reflected their experiences.

A questionnaire was also completed by a number of individuals in the Mnisi tribe, aged between 12 and 52 years. The purpose of the questionnaire was to investigate
the knowledge the Mnisi tribe has of the spread of HIV and their understanding of the difference between HIV and AIDS. An interpreter was used for the completion of these questionnaires as most of the participants in this part of the study did not understand English. The information from the questionnaires was also discussed during the interviews with the three main participants.

**Ethical issues**

In accordance with the American Psychological Association’s (APA) (2003) ethical principles, participation in the research was neither deceitful, nor harmful to the participating individuals or their community. The participants were treated with respect with reference to their culture, to them as individuals, and within their different roles in the community.

Participants were made aware of the foreseeable uses of the information generated through the study, but were reassured of their privacy and of the confidential and anonymous nature of the study (Henning et al., 2004).

In order for participants to give their informed consent, they were informed about the purpose of the research, its expected duration, and the procedures that would be followed. They were informed about their right to decline to participate and to withdraw from the research once participation had begun. Participants were also asked to consent to the recording of their voices during the interviews, and were made aware of the function thereof, that is, for later transcription and analysis.

**Data analysis**

Viljoen (2004) held that it is profoundly impossible to follow any one epistemological approach in the analysis of qualitative data and argued that:

> The approach any researcher uses develops as a process in language and is a result of the voices that inform the creation of the socially constructed self. In this way one uses aspects of different approaches (some of which may be in conflict), at different times in the process. There is no metatheoretical perspective, metanarrative or single overarching epistemology. (p. 60)

The first author describes her method of analysis as thematic analysis, of which the main aim was to identify and analyse themes (or patterns) within the collected data. Different discourses that occurred within the data are discussed as such under a theme. Discourses are, according to Collins (2007), ‘systems of meaning that operate at individual, social, cultural and historical levels and inform how we interpret and understand our lived experiences’ (p. 29). Discourse analyses, that is, the attempt to work out what underlying systems of ideas are structuring the way the participants think and experience things (Collins, 2007), are therefore not excluded from the method of interpretation, but incorporated into the thematic analysis approach.
FINDINGS AND DISCUSSION

At the outset of this study, the first author aimed to investigate possible cultural influences in the spread of HIV within a Shangaan community where HIV and AIDS are devastating problems. During the interviews, Ms P noted that ‘nowadays we find that all the people is having HIV and AIDS. So you can’t ... can’t understand why AIDS is like this nowadays’. It, however, soon became clear that it is not the Shangaan culture per se that is contributing to the spread of HIV (either positively or negatively), but the cultures that have formed within the community due to their environment and living circumstances.

During the five interviews with both Ms J and Mr D, and the two interviews with Ms P, two ‘cultures’ emerged. What the first author means when she refers to ‘culture’ is how a certain construct contributes to the formation of certain attitudes and behaviours within the community. The two cultures that emerged were: (1) the culture of power, and (2) the culture of poverty.

Culture of power (‘... laws which are given to us ... ’)

According to Biko (1971, electronic version), ‘the most powerful weapon in the hands of the oppressor is the mind of the oppressed’. A characteristic of the community in which the participants live are the power relationships, which can be defined as the relationships between groups or individuals in a hierarchically structured society (Campbell, 2004). Traditional cultural practices, including gender-role expectations, hierarchical structures, power relationships, and so on, form a very important part of this community’s day-to-day life. In this hierarchically structured community, individuals have different levels of access to wealth, political influence, and symbolic respect and recognition. Many people feel that their needs and views are not respected or valued by those in charge and that there is no way in which they can contribute or participate in decision-making activities, be it in the context of the family, school, or neighbourhood.

HIV and AIDS tend to flourish in marginalised social groupings (Barnett & Whiteside, 2002), which include those with the least access to economic power (i.e., access to money and paid work), political power (i.e., access to formal political influence), and symbolic power (i.e., access to recognition and respect from other members of society). It is unlikely that individuals in these marginalised social groupings will have the power or influence to promote the development of a health-enabling environment (Campbell, 2004). Inequality resulting from social and economic health determinants has long been recognised as the cause of differences in health levels across gender and socio-economic standing (Craddock, 2000; Leon & Walt, 2000; Turshen, 1991). The spread and prevention of HIV are both enabled and constrained by the wider social context within which communities are located.
Here particular emphasis can be placed on the unequal power dynamics (Campbell, 2004) within the community – particularly the relationships between men and women, between rich and poor, and between accepted leaders and those who are not.

**Gender relationships**

A large body of work (e.g., McFadden, 1992; Schoepf, 1988; Shefer, 2003; World Health Organization [WHO], 1994) views gender inequality and men’s perceived sexual and economic superiority to women as central to HIV infection. Women’s power inequalities make them, according to the feminisation of poverty theory, especially vulnerable to HIV infection (Shefer, 2003). In a patriarchal culture men are seen as dominant in the family as well as society at large (Boonzaier, 2003). The community in which the participants live is established around such patrilineal lines. The men make important decisions on behalf of their families and the community. Men are seen as more intelligent and superior to women and women have to respect and accept men’s decisions. According to Ms P: ‘You must take your husband as he is your parent. Don’t say nothing to your husband, you must stay with him. And if he told you something don’t put another words which is going to make a problem’. A woman should always listen to either her husband or father. When asked whether a man may at times listen to the views of a woman, Ms P replied, laughing: ‘No, they can’t. Just because they say they are the head of the family always’.

This power dynamic between men and women also occurs in their sexual relationships. The discourse of power influences whether or not people practise safe sex (Collins, 2003). Men are seen as powerful and thus have the right to decide what happens in a relationship. They can, for example, put themselves and their partners at risk by having multiple sexual partners and by refusing to use condoms. According to Ms. J:

> In our culture we are allowed to have – if you are a man – you are allowed to have maybe two wives and wives did not allow to have two husband. So that ... you find that if the husband have got two wives sometimes he go outside and he want to find another girlfriend. So that’s why we find that they spread the HIV.

Several factors work together to produce the perceived male power, as well as women’s willingness to accept their decisions and behaviour. In this community (as in many others) women are more likely to be unemployed, to be less educated, and to have fewer and worse paid employment opportunities. They are often dependent on a man (or men) and thus forced to tolerate their behaviour. Particular ideas about masculinity also support the discourse of male power. The idea that men cannot help having multiple sexual partners due to their uncontrollable drive for sex, or that a man has to prove his ‘manhood’ by having many children and therefore has the right to object to the use of condoms, are but some of the ideas surrounding masculinity.
(Collins, 2003). However, as an increasing body of literature on men and masculinity (e.g., Cornell, 1995; Foreman, 1999; Morell, 2001) has shown, not all men practise the same ‘type’ of masculinity and many different constructions of male power exist.

In general women are seen as objects of men’s sexual urges, and women view sexual behaviour in terms of men’s sexual needs and urges. Ensuring a man’s pleasure is experienced as an expression of commitment and love from a woman. Ms P, for example, said that:

By the sex they say that if you are having a husband, maybe you are alone there from your husband, and then he say to you you must ... I have to find another woman just because you are one here, I’m not satisfied about you, for what you are doing for me here. So he want to take another one. You have to say, ‘Yes, you can take him’.

Condomless sex is seen as more pleasurable and it is thus expected of a woman, in order to satisfy her male partner. When asked why the community members do not want to use condoms, Ms J answered: ‘The other people they say they don’t eat the banana with the peel on’, and ‘they say it’s not nice to use something, without using their own flesh’. A request to use a condom can be interpreted as a sign of infidelity or that the person making the request is HIV positive. Ms J noted that:

The most for the women. If they told the men that if you want to sleep with me you can use the condom, so he would like to know why you said we can use the condoms. Maybe me you ... I’ve got another husband and you find that it’s not true. It’s because the men they go outside most.

Research (e.g., Miles-Doan, 1998; Schornstein, 1997) has shown that the lack of access to assistance from social institutions puts constraints on the options that poor women have. The problem of the spread of HIV may be aggravated by socio-cultural and religious inhibitions that prevent educated mothers from giving meaningful sex education to their pre-adolescent and adolescent daughters (Mbugua cited in Kalipeni, Oppong, & Zerai, 2007). The female participants indicated that they believe women have the right to make their own decisions and to refuse sex should a man object to using a condom. It is, however, clear that women’s social position within the community is not equal to that of men and that, even though women believe they have the right to say ‘no’ to a man, they would rarely act on this belief. Baylies and Bujra (2000) also found that women find it very difficult to challenge men’s power and negotiate about sex, as ‘[u]nequals cannot negotiate’ (p. xii).

Relationships between rich and poor

Poverty may well be the ‘principal cause of human misery today’ (Singer, 1993, p. 220). Socio-economic status brings forth a difference in power, especially economic resources and opportunities. According to Campbell (2004), many of the social
factors shaping individuals’ health-related behaviour are linked to the unequal distribution of political and economic power.

People who are poor often lack adequate food and shelter, as well as adequate opportunities for good education and health care. They are consequently extremely vulnerable to illness and economic displacement (Thelen, 2003). They are also, more often than not, treated negatively by institutions in society. Mr D said that they do not have access to quality health care and therefore, ‘she can stay ... take maybe two months or three months without seeing that she is HIV. So she is going to do the sex with the other boys where it’s the time where she’s spreading also’.

Within the Mnisi tribe – as in many other poor communities – violence and crime are prominent features of everyday life. Fanon (1963) argued that when people know only violence, this is what they will use to stop violence against themselves and their family. Rape and aggressive fighting, as well as murder, occur frequently in the participants’ community.

The power relationship between rich and poor often becomes a power relationship between men and women as men are more likely to be employed, to be more educated and to have better paid employment opportunities than women. Men show their ‘power’ by sleeping with many women. They also use their money to buy alcohol and drugs to show others how ‘powerful’ they are.

Relationships between accepted those who are leaders and those who are not

As previously mentioned, the Mnisi tribe believes in the principle of ubuntu, the respect people have toward each other. Within the Mnisi community, respect for older people and the ancestors is of utmost importance. According to Mr D:

Respect is a good thing to the people even if you are not here at home you will have to respect. So keeping respect is good, because they will ... everywhere you will walk in the community of at the other community you will hear the people speaking about your name, that there is a home of Mr D of there is this home of who he ... that children they are having respect to the people.

Most African leaders are in a position to influence political and social thinking surrounding issues of HIV and AIDS (Loosli, 2004). Unfortunately, these leaders do not always acknowledge the magnitude of the HIV and AIDS epidemic. This is evident, for example, in former president Thabo Mbeki’s, assertion that, ‘we could not blame everything on a single virus’ (cited in Horton, 2000). Malegapuru Makgoba, the president of the Medical Research Council of South Africa, argued that Mbeki’s comments were ‘absurd ... and a form of national denial’ (cited in Butler, 2000). Justice J. Cameron, a South African High Court judge living with AIDS, argued that ‘in my own country, a government that in its commitment to human rights and
democracy has been a shining example to Africa and the world, has at almost every conceivable turn mismanaged the epidemic’ (cited in Horton, 2000).

Baron and Byrne (2003) found that it is important for a person to form attitudes about issues, persons, objects, or groups, as this is the manner in which people organise and interpret social information. The behaviour and vocalisations of African leaders are observed and respected (and thus copied) by many of their supporters. Although this can be used to the advantage of many people, it has unfortunately been mismanaged and misused by many individuals in positions of leadership. Numerous examples of South African leaders mismanaging HIV and AIDS have been reported (e.g., Butler, 2000; Horton, 2000; Obisesan, 2007).

The chief, his indunas, and the older men in the community represent the state and the law in the Mnisi tribe. Ms P said: ‘Also when there is a meeting it’s that induna who is going to say “I have found something there at the chief”, so all the community must know all what he had find it there at the chief’, while Ms J, when asked whether it is important to listen to the older people, said: ‘If they say “this one it will not right” you can listen to them and if you don’t listen to them you will be in trouble’. Members of the community are taught from a young age that bad things will happen should they not abide by the laws of the culture and should they not comply with the requests of their ancestors (the highest level of leadership).

Sangomas (or traditional healers) play an enormous role in the everyday life of the Mnisi people. According to Ms J: If you have got a problem at the home you can go to the sangoma so they can tell you what’s happening to your house and the traditional healer, if you are sick you can go there so they will give you some medicines so you will use it’.

Many people affected by HIV and AIDS turn to traditional healers and traditional medicine for help as they are culturally more accepted, less expensive, and more available than ARVs (Bodeker, Carter, Burford, & Dvorak-Little, 2006). The participants commented as follows on whether sangomas are able to cure HIV and AIDS: Ms P noted that some of the sangomas have led the community members to believe that they are able to cure HIV and AIDS. Ms J said that some of the traditional healers will, although they cannot test for HIV, tell you that you do not have HIV and AIDS in order to sell their medicine to you. According to Mr D, some sangomas will tell you that they will try to help you while others say they know how to cure HIV and AIDS. He also said that when you are ‘lucky’ the ancestors will cure you from HIV and AIDS. Although there are growing concerns about unsafe practices and claims of traditional cures for AIDS, traditional health practitioners can play an important role in offering treatment for opportunistic infections and to deliver AIDS prevention messages to rural areas (Bodeker et al., 2006).

The people from the Mnisi tribe, as many African tribes, accept dreams as a way of communicating with the ancestors. Should the individual need more information, he or she will go to a sangoma who will assist him or her in understanding what the
ancestors wish to communicate. As soon as an individual knows what the ancestors want to communicate, action has to be taken in order to satisfy the ancestors’ needs and wants. Even the sangomas will obey the ancestors as the ancestors can take away their ‘powers’, rendering them unable to act as a sangoma. The individuals of the Mnisi community have a constant awareness of the presence of their ancestors. As mentioned above, the ancestors’ wishes should always be satisfied, and in addition the ancestors should also always be made to feel proud of their living relatives.

**Culture of poverty (‘…People are running after money …’)**

The Mnisi community comprises mainly poor individuals and households. Rising unemployment is worsening the poverty and inequality in the community. The participants all indicated the need to meet the most basic needs of the people in the community. According to Maslow’s hierarchy of needs (Moore, 2003), people will first work toward satisfying their most basic needs before they will satisfy their need for safety, and so on.

A causal relationship is not necessarily indicated by the association of poverty with increased HIV prevalence, but poverty may increase a person’s susceptibility to HIV and AIDS (Fenton, 2004). Halperin (2001) argued that although it cannot be denied that poverty has contributed to the spread of HIV, people should not come to the simplistic conclusion that poverty is what causes AIDS. Coovadia (cited in Horton, 2000) held that although poverty exacerbates HIV and AIDS, it is *not the basic cause*.

Poverty is, however, one of the key factors leading people to behave in a manner which exposes them to the risk of HIV infection (United Nations [UN], 2005). Poverty also exacerbates the impact of HIV and AIDS (African Studies Center, 2003). This interrelatedness has been substantiated by Butler (2000) who held that ‘the cause of the link between HIV and AIDS and poverty is probably bidirectional: the economic consequences of epidemic disease help to trap populations in further poverty and disease’ (p. 1445).

The role of poverty and economic deprivation in the transmission of HIV is complex and manifests through migration, gender, and cultural politics (Kalipeni et al., 2007). Poverty alleviation programmes are increasingly being implemented in sub-Saharan Africa by international development agencies and donors with the goal of reducing the prevalence of HIV (O’Farrell, 2001). Community-based economic ventures that promote economic security (and reduce circular migration and thus keep families intact) should complement the usual strategies, for example, the ABC approach (USAID, 2006).

The participants indicated a number of ways in which the need for money and resources can force people to behave in a manner they might not have, if they had basic resources at their disposal. Fulfilling immediate needs for food, water, and shelter seems to be a greater priority than worrying about the potential long-term
consequences of unsafe sex (Hlatshwayo & Stein, 1997). People have various degrees of freedom to change their identities and associated high-risk behaviours. A woman, for example, whose sexual partner assists her in supporting herself and her children, will have less freedom to refuse sex with a condom-resisting partner than a woman who can support her family on her own (Campbell, 2004). Women might also improve their economic situation by having concurrent partners (Shelton, Cassell, & Adetunji, 2005) and thus concurrent sources of income to support them and their children. Mr D argued that women sell their bodies for money and for lifts to and from the places they need to be; in his opinion, this is how HIV is spreading.

As the community in which the participants live is of low socio-economic standing, with very few work opportunities, men and women leave their homes in order to find employment elsewhere. Studies have shown that migrant workers often participate in high risk sexual behaviours during the times they spend away from home and that the infection rate among such workers is high (UN, 2005). The person who leaves home looking for employment undergoes individual changes and also changes the family characteristics. Couples are separated and individuals who spend a long time away from their regular partners are more likely to engage in casual sex (UN, 2005) and in turn the partner might engage in casual sex while his or her working partner is not home, and so the disease is spread in the community.

It also often happens that women cannot find employment even in big cities and are then forced to prostitute themselves in order to get money to provide food for their families. According to Mr D, even people with a tertiary education struggle to find work and then have to resort to desperate measures.

Giving birth to a child and registering him or her at the Department of Home Affairs gives poor South African women the right to receive a grant of R240 per child each month, as stated by a female participant, ‘we find the money from the government’. A child cannot be fed, clothed, and schooled on this amount of money, but to a person who has absolutely no income and no means of looking after herself and her family, having a baby simply to receive the grant money might look like a viable option. As soon as a child can walk, he or she also plays a role in the household, helping with the chores.

In a poor community children often have few or no extramural activities and often become sexually active at a very young age. Ms J said that she wishes there could be a centre where children could go after school, because ‘if they are playing they will no time to go at the road’. The children are often picked up on the side of the road and then paid for sex. In houses where there is no money this might seem like the only solution for a child to find money for food.

It has been found that in communities with a low socio-economic standing the use of alcohol and the prevalence of violence are extremely high (Dalton et al., 2001). Due to excessive use of alcohol people regularly fight with each other, and the fights often end up with one or more individuals bleeding. According to Mr D,
the excessive use of alcohol also leads to many women being raped. Unfortunately, a woman’s excessive use of alcohol also contributes to the probability of her being raped. It also happens that men buy drinks for a woman in order to get her intoxicated, with the intention of raping her.

Mr D indicated that ‘people are running after money’, but without money none of a person’s basic needs can be fulfilled. Should this then not be the first level of intervention? Poverty alleviation should be a priority, but together with this, people should be educated on the optimal use of their resources.

CONCLUSION

HIV crosses social, physical, cultural, cross cultural, ideological, economic, political, religious, moral, legislative, and international borders. The virus affects people all over the world, rich and poor as well as young and old. Most of all, it disproportionately affects those individuals and groups of people who already face social and economic disadvantages. The risk of being infected with HIV, as well as the impact of the epidemic on individuals infected with it or affected by it, differ significantly depending on a person’s personal, social, and environmental circumstances. Mkhize (2004) held that ‘People are stratified differentially by factors, such as access to power, economic wealth, and other opportunities. These divisions, often assumed to be ‘natural’, involve various forms of domination’ (Mkhize, 2004, p. 423). He was also convinced that domination is established and maintained through processes of violence, political exclusion, economic and sexual exploitation, and cultural alienation.

The HIV and AIDS epidemic has its roots in a series of complex processes including the micro-dynamics of human sexual desire, as well as the macro-dynamics of gender, economics, and politics. Addressing the challenge to stop the spread of HIV will thus require the co-operation of a wide range of sectors, as it is too complex a problem to be solved by a single constituency.

People’s health-related behaviour is shaped by social factors, which are linked to the unequal distribution of economic and political power. This power is often held by a small group of educated and/or wealthy people. The challenges surrounding HIV in the Mnisi tribe are numerous. Social conditions, habits, and the rules of patriarchal communities are complicated issues to address. Certain aspects of cultural practices can facilitate the spread of HIV. Phaiya (cited in Loosli, 2004) argued that it is time to review some traditional practices. The efforts of public health interventions have been dented by beliefs that drive cultural practices. The risks linked to these practices should not be trivialised. Communities should be involved in addressing beliefs, concepts, and rituals that put individuals in danger of HIV infection. Centuries-old practices and beliefs will not be changed within a short period of time; it is a long-lasting endeavour, which should be undertaken at every
level, that is, household, community, provincial, and national. Community leaders should become more involved in the development of strategies that will enable peoples’ sexual attitudes to be modified. Particular attention should be paid to the gender relations in the community. The community members should be encouraged to gather and reflect on solutions and the implementation thereof. Culture should be seen, and used, as a resource that can strengthen the fight against HIV and AIDS. Acting on people’s attitudes and their motivation is not a mere formality, but will take time and continuous endeavours. Awareness is not enough; an attempt has to be made to transform not just rituals, but also people’s values and attitudes.

Prevention of HIV and AIDS must be the mainstay response to the epidemic within the Mnisi community. Intervention programmes that wish to decrease the rate of HIV infection are most effective when an appropriate combination of interventions is tailored to the specific risk factors of a community (UN, 2005). These programmes should also be accessible to everyone in need. Government needs to improve the effectiveness of its strategies; knowledge gaps between different segments of the population need to be closed, and antiretroviral treatment should be accessible to all individuals who need it. Responses to HIV and AIDS need to take contextual circumstances that may increase an individual’s vulnerability to contracting the virus, into account.

The future of HIV and AIDS is in no way predetermined. The response of individuals, families, communities, nations, and the world, today and tomorrow, will determine the eventual course of HIV and AIDS (UN, 2005). Although the impact of HIV and AIDS on the Mnisi tribe and its individuals has been devastating and has left many weary, ‘this weariness of the heart is the root of an unbelievable courage’ (Fanon, 1963, p. 20). By using and building on this courage and inner strength of the Mnisi tribe and individuals, the fight against the spread of HIV can be victorious.

Limitations of the study

As convenience sampling was used to select the participants for the investigation, the information obtained may not be representative of all the individuals in the Mnisi tribe. This may also be the case due to the small sample size and the relatively small number of interviews held with each participant. By using a sample of three participants, first author could not make valid assumptions or draw conclusions about an entire culture.

In cases where interpreters were used, the questions and answers might not have been translated to have the exact English meaning, while those translated into English might not have the exact meaning as in Tsonga. The answers obtained from the questionnaire might thus not be representative of the HIV and AIDS knowledge of the Mnisi tribe as a whole.

Observations provide rich and complex descriptions of what actually happens between individuals within different situations and can be carried out with little
community disturbance. It is, however, very subjective and the researcher consequently tends to focus on certain aspects and neglect others. There might therefore be information that the first author ‘missed’ during the investigation which might lead to further insight into the cultures that are present in the Mnisi tribe. The coding and analysis of the interviews were also done using subjective interpretations and existing literature which may lead to the same problem. The analysed data was, however, presented to and discussed with the participants (member checks) to improve the credibility of the findings.

A limitation to the communication of any study of any kind is that writing has a reductionistic function and it is therefore impossible to convey everything that happened during the interviews and observations that were made to the reader. The reader can also never be aware of all the texts that were used, or that played a part in the construction of this specific text.

Recommendations

The information provided by this study, in combination with previous research findings, could be used to implement community and culture specific strategies in the Mnisi community in order to combat the spread of HIV. Examples of what are meant by community and culture specific strategies are strategies that would increase the economic and political power of the Mnisi women relative to the Mnisi men, and of poor individuals and families relative to wealthier ones. Although knowledge alone cannot stop the spread of HIV, it is a starting point for individuals’ willing to protect themselves against contracting the virus. The contributions of individuals from all levels and sectors of the community should be used and incorporated into a strategy that can be implemented to stop the spread of HIV in the Mnisi community. Using sangomas (traditional healers), who are seen and respected as part of the community leadership, to educate individuals on issues surrounding HIV and AIDS may prove more productive than using individuals from other cultures who speak different languages and have different experiences and values. In order to implement successful interventions it is, however, advised that further research into the specific needs of community members in different age groups should be done.

Further research on the Mnisi tribe’s culture and the different cultures that have, over the years, formed within the community should be conducted in order to investigate specific cultural effects on the spread of HIV in the community. The findings of the research should then be used to implement an intervention programme that would be culturally appropriate and acceptable to community members.
BIOGRAPHICAL NOTES

Marié Joubert-Wallis completed her MSc in psychology at Unisa in 2008. She is currently working in the field of Human Resources.

Eduard Fourie is a senior lecturer in the Department of Psychology at Unisa. His research interests include institutional identity, well-being of employees and community psychology. He teaches community psychology and is the editor of New Voices in Psychology.

REFERENCES


CULTURE AND THE SPREAD OF HIV


