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CONCLUSION

South Africa has one of the highest incidence and prevalence of HIV/AIDS. Driven by the distinctive and dramatic interaction of sex, gender and power; the epidemic requires more than just a biomedical response. The report has shown that combined effects of male behaviour, such as multiple sex partners, control over women and coercive sex all create a sexual culture that makes both men and women vulnerable to being infected.

As such the response to the epidemic requires more engagement with greater understanding of sexuality and gender relationships. Regretfully, AIDS policies in South Africa fail to address these issues. A review of these policies, however, shows that the government is aware of the multifaceted nature of the epidemic but somehow fails to engage in depth with the real issues surrounding HIV/AIDS. A wide range of factors (social, economic, cultural and political) influence sexual behaviour, and the way people perceive the epidemic has received little attention in government policies. Even when it does, implementation is always a problem. As a result most policies end up insisting on ‘quick-fix’ solutions, which have little impact on the course of the epidemic.

Attempting to understand the epidemic requires a closer look at South Africa’s complex history, a history characterised by economic disparities and social transitions which shape the nature and pattern of the disease. A key lesson to be learnt in South Africa is that HIV/AIDS cannot be separated from the socio-cultural environment in which it occurs. Instead, a shift in the biomedical approach through which the epidemic is currently being viewed, is required. Individuals should instead be situated in relation to their cultural and historical environments.

It follows then that the response to the epidemic should be based on multicultural and multisectoral strategies. The biomedical explanation and its associated response have had negative repercussions on efforts to combat the epidemic. The emphasis in such programmes is on protecting individuals through the use of condoms and promoting abstinence. In many cases such programmes have been dubbed as ‘uncultural’. But

besides this challenge, these programmes suffer from two other flaws. Firstly, they are planned and implemented by clinic staff and other western medical practitioners. The consequence of such an approach is that other potential players are ignored. Secondly, such programmes fail to target men, the core perpetrators of the epidemic. Not targeting men in HIV/AIDS awareness campaigns adds to their denial and risk behaviour.

Stopping the spread of HIV/AIDS and treating those who are already infected, therefore, requires the development of new strategies of inclusion i.e. inclusion of other key role players in HIV/AIDS campaigns such as traditional healers and the inclusion of programmes that challenge male sexual behaviour. Evidence presented in this report has shown that traditional healers are one of the key players in the fight against HIV/AIDS. By addressing pressing issues such as condoms usage by men, gender stereotypes, myths surrounding HIV/AIDS as well as treating STI's, these healers could indeed be a useful resource in PHC. Their accounts of HIV/AIDS give insights into how people perceive HIV/AIDS and could be used to develop culturally sensitive interventions. The relationship of trust and mutual respect that healers have with their patients, who are mostly men, put healers in a better position to induce behaviour change as is evident in the way they discourage the contemporary practice of loverboy tradition and recommend the use of safety measures, such as condoms. Such a relationship is also important in breaking down myths surrounding HIV/AIDS and how it spreads.

Besides these roles, traditional healers are also actively reinventing earlier cultures such as respect for ancestors, virginity testing and male circumcision. Such traditional knowledge provides an alternative way of making sense of life-threatening conditions such as HIV/AIDS and as such it is a powerful resource to HIV/AIDS prevention. It informs and encodes people's behaviour and sexuality. While many may dismiss such knowledge and practices as a conservative backlash, rejecting the ways in which ordinary people make sense of HIV/AIDS reinforces old colonial ideological outlook which associates traditional healing with evil spirits and backwardness. The danger of such an outlook is that it results in hearing only one story (one told by nurses and doctors). In so doing other stories are being silenced and HIV/AIDS continue to kill millions of people.