

https://dspace.org/

The perceptions of Malawians living in Gauteng, South Africa, on the contributions of indigenous Malawian tribes' cultural practices in HIV infection in Malawi.

Munlo, Juliana

2011-11-08
http://hdl.handle.net/10539/10717

Downloaded from a DSpace repository. https://dspace.org/

CHAPTER 1: INTRODUCTION

1.1 OVERVIEW OF THE STUDY

It has been established that HIV infection continues to increase day by day, regardless of the knowledge that people have on HIV transmission and condom use. Although a number of interventions have been designed to promote safe sex, very few have been proven effective, as the extent of infection continues to increase worldwide. In Malawi, awareness of HIV transmission is generally high; however, the rate of infection still increases. One of the reasons for the mismatch between knowledge of HIV transmission and prevention has been identified as cultural practice (Mwale, 2008). Traditional practice has a significant role to play in the lives of many tribes in Malawi. However, some of these cultural practices have been identified as promoting HIV transmission. Loosli (2004) states that traditional practice is important in maintaining cultural identity and continuity; however, some aspects of it have been linked to the proliferation of HIV and AIDS. In Malawi, practices such as wife inheritance (known as *kuhara* among the Tumbuka tribe) polygamy (known as *mitala* among the Tumbuka tribe), initiation practices (known as *jando* and *msondo* among the Yao tribe or *chinamwali* among the Chewa tribe) and the practice of *fisi* (hyena) in the Chewa tribe, are cultural practices which imply risky behaviour which is likely to promote HIV infection (Mwale, 2008). Parker (2001,p.163) argues that “during the first decade of the epidemic, most social science research focused on the behavioural causes of HIV infection and failed to examine broader social and cultural factors until the early 1980s when the importance of cultural practice in shaping sexual practice relative to HIV transmission was identified”. Given the high prevalence of HIV in Malawi, it is therefore important to find out what role these practices play in promoting HIV infection. In turn, it may guide the design of culturally appropriate intervention programmes that may contribute to successfully curb the HIV infection that is caused by the cultural practice of the Yao, Tumbuka and Chewa tribes in Malawi.

1.2. STATEMENT OF THE PROBLEM AND RATIONALE FOR THE STUDY

Malawi struggles with one of the highest HIV and AIDS burdens in the world, with nearly one out of every seven adults infected with HIV. In Malawi, the HIV prevalence in rural areas is only about two thirds in comparison to urban areas. However, 85% of Malawians live in rural communities, so the overall burden of HIV and AIDS is higher in rural areas (McCreary, Kaponda, Norr, Jere, Chipeta, Davis & Batista, 2007). It can be argued that despite the gradual increase in the availability of HIV testing and antiretroviral therapies, new cases of HIV infection continue to outnumber those entering treatment. Therefore, HIV prevention through behavioural change remains the challenge in the fight against HIV and AIDS.

Over 90% of Malawi's population knows how the HIV virus is spread and how one can avoid contracting it. However, it has been observed that this knowledge has not necessarily resulted in attitudinal or behavioural change. Although some improvement has been recorded since 1992/93, HIV still remains a severe problem in Malawi and the HIV infection rate in Malawi is still increasing. It has been claimed that in order to bring a positive contribution to the fight against HIV and AIDS in Malawi, any new intervention and support must aim at bringing about behavioural change (Kondowe & Mulera, 1999).

Cultural practice is important for many tribes in Malawi, therefore it is most likely that cultural risk practice continues to influence people's attitudes towards behavioural change and puts people at risk ofHIV infection. Culture is an important element of any nation as it determines, to a large extent, the way people behave and go about their day-to-day lives. It is also one of the major factors influencing the pace of development and the direction that the process of development takes. Experience has demonstrated that the HIV and AIDS epidemic is a complex, multifaceted issue that requires close cooperation and therefore, multidimensional strategies. According to Belgrave, Marin and Chambers (2000), multidimensional strategies have the potential to be more effective than those based on a generic, Eurocentric model and may be an important way to interrupt the trend of the growing rates of HIV and AIDS. Without a systematic analysis of culture, it is difficult to gain a meaningful understanding of why some individuals, communities, and societies operate the way they do (McCrearly et al.,2007).Without a thorough understanding of how the cultural practices impact on the spread of HIV and AIDS, it is difficult

to design preventative strategies for intervention. Consequently, more and more people, especially women, will continue to get infected and die from AIDS(Human Rights Commission, 2005).

Although there has been limited research conducted on the link between cultural practices and HIV infections, hardly any research has been done on the role and implications of cultural practices in promoting HIV infection in indigenous Malawian tribes living in Gauteng, South Africa. It is important to note that cultural practices are unique and distinct aspects of the lives of indigenous Malawian tribes, therefore it cannot be over-emphasised that in developing interventions for HIV and AIDS in Malawi, recognition of these practices is crucial.

Due to economic factors, many Malawians live and work in South Africa. A number of them are members of the Yao, Tumbuka and Chewa tribes. Research studies have revealed that a number of cultural practices that may link to HIV infection among different African groups are similar (Feldman, 2008). Therefore, the link between the roles that cultural practices play in HIV infections is substantial for both Malawi and South Africa.

The proposed research is hoping to make a significant contribution to the knowledge base and practice in the fields of social work and social development, because it will enhance the understanding of social workers and development practitioners about the significant role that certain cultural practices play in HIV infection. Hopefully, they will be more informed and take this into account when they develop and implement programmes or interventions in the fight against HIV and AIDS.

The proposed research also has the potential of making a positive contribution to policy development both in Malawi and South Africa, in that it might influence policy formulation to make provision and to take into account the role that cultural practice plays in HIV infection.

1.3 RESEARCH QUESTIONS

(a) What are the perceptions of Malawians living in Gauteng about the role that cultural practice plays in promoting HIV infection in indigenous Malawian tribes?

(b) What are the views of Malawians living in Gauteng on how cultural risk practice affects the development of preventative interventions?

1.4. AIM AND OBJECTIVES OF THE STUDY

The primary aim of the study was to explore the understanding and perceptions of Malawians living in Gauteng about the role that cultural practices play in promoting high risk behaviour for HIV infection in indigenous Malawian tribes.

The secondary objectives were:

(a) To establish the views of the Yao, Tumbuka and Chewa tribes about whether there is a link between cultural practice and the growing HIV and AIDS prevalence in Malawi.

(b) To explore how cultural practices among the Yao, Tumbuka and Chewa tribes might contribute to the risk of contracting and spreading of HIV and AIDS in Malawi.

(c) To explore ways in which cultural practices of the Yao, Tumbuka and Chewa tribes put people at risk to HIV infection.

(d) To obtain views and suggestions of Malawians living in Gauteng about interventions to prevent the risk of HIV infection that might be caused by the cultural practices of the Chewa, Tumbuka and Yao tribes in Malawi.

1.5 BRIEF OVERVIEW OF THE RESEARCH APPROACH

To explore the understanding and perceptions of Malawians living in Gauteng about the role that cultural practice plays in promoting high risk behaviour that promotes HIV infection in indigenous Malawian tribes, a qualitative approach that was exploratory in nature was employed. The purpose of exploratory research is to gain a broad understanding of a situation, phenomenon,

community or a person (Bless, Higson-Smith & Kagee, 2006).The study was only applicable to members of the Yao, Tumbuka and Chewa tribes from the ages of 30 and older, who had lived in their villages for a period of more than four months. Data was analysed using thematic content analysis. Seventeen people who had lived in their villages for a period of more than two years were interviewed for the research, using a semi-structured interview schedule.

1.6. SIGNIFICANCE OF THE STUDY

HIV and AIDS continue to affect millions of people all over the world**.** It is a fact that sub-Saharan Africa has the highest number of HIV and AIDS infections. Hence the impact of AIDS on the social development of a number of countries in Africa is immensely felt. A number of cultural practices in Africa are identified as contributing to the increase of HIV transmission by promoting behaviour that put people at risk and at the same time inhibit behavioural change. The significance of the study is that it will assist in highlighting the ways in which the cultural practices of the Yao, Tumbuka and Chewa tribes might put people at risk of HIV transmission. Furthermore, the knowledge gained will hopefully assist in the fields of social work and social development, in designing and developing intervention programmes that can influence behaviour that will result in reducing HIV infection that might be caused by such practices. In addition, the study will hopefully lead to the creation of policies that ensure that such practice, that might be putting people at risk of infection, are modified in ways that make them safer, in order to reduce new HIV infection.

1.7. LIMITATIONS AND DELIMITATIONS OF THE STUDY

(a) Research design

One of the weaknesses of qualitative research is that it is too impressionistic and subjective. It is argued that this is so because of the close relationships that the researcher builds with the participants (Leedy, 2005). Although the researcher speaks the same national language as the participants and knew some of the cultural practices being discussed, the researcher attempted to be objective rather than subjective, and was able to present the findings in the way that they were reported by participants. The researcher was professional in her approach, free from bias and

prejudice, and ensured that the focus was on the perspective of the participants and not on the researcher's own perspectives.

(b) Sampling

Possible limitations of the proposed study are worth noting. Some of the participants were very passionate about their culture and were not willing to talk about the negative aspects of the cultural practices. They were also often defensive when it came to the relationship between cultural practice and HIV and AIDS. However, the researcher was able to use interviewing skills such as probing, and conduct herself in a manner that made them feel comfortable, accepted and valued, which encouraged them to express the knowledge that they have on the link between their cultural practice and HIV and AIDS infection.

Most of the participants had lived in their villages for a period of more than two years. Most of them were therefore very knowledgeable about the cultural practice in their areas that put people at risk of HIV infection. This ensured that the criterion of sampling which was targeted at those participants, who had lived in their villages for a minimum period of four months before coming to South Africa, was adhered to.

The research proposed to interview eighteen people, half of whom would be females. Due to work and family commitments, only 17 people were interviewed, of whom three were women. However, because most of the people had lived in their villages for a long time, it was not a challenge to collect information on the practice that involved women, because most of them were knowledgeable about these practices as they have sisters, in-laws and mothers in the villages who follow these practices. This did not limit the data collection process. Due to a small sample, it is difficult to generalise the findings of study to the whole population of members of the different tribes; however, the research results are likely to be transferable.

(c) Research tool

Some of the participants that were interviewed were not comfortable discussing sexual issues and condom use. This was because some were older and some of them shared similar beliefs

about condom use and they feared to be viewed as putting themselves at risk of infection. Secondly, some of the participants found a challenge in understanding the questions that were asked in English and they often asked for clarity. The researcher, however, ensured that the participants were comfortable through the professional manner in which she conducted herself and the use of interviewing skills such as probing, clarifying and focusing, as well as asking open-ended questions that facilitated the process. The researcher also ensured that the participants were told well in advance that she would translate some of the words if they did not understand, as long as they asked for clarity. This made the participants feel comfortable and gave them an opportunity to express themselves effectively, which contributed to a successful and fruitful data collection process.

1.8 DEFINITION OF THE KEY TERMS

(i) Culture

"Culture refers to the ways of life of the members of society or groups within a society. It includes how they dress, their marriage customs and family life, their patterns of work, religious ceremonies and leisure pursuits" (Giddens, 2001, p. 22). According to Tylor (1871,p. 1) in Gauseet, 2001, p. 510) culture is "that complex whole which includes knowledge, beliefs, art, morals, law, custom and any other capabilities and habit acquired by man as a member of a society".

(ii) Cultural practice

"These are behaviours and actions that are common to a particular group of people. But they are salient cultural practices which are not common to the group of people where people do not talk about them" (Jere, 2009, p. 47).

(iii) HIV

This stands for the "Human immune-deficiency virus that causes AIDS" (Van Dyk, 2008, p. 4).

(iv) *Fisi*(Hyena)

Fisi is a man who is invited to come and sleep with a girl during an initiation ceremony, or is a man who sleeps with a sister in-law in order to make the woman pregnant for the sake of helping the infertile brother or cousin (Jere, 2009).

(v) Polygamy

It is a social practice where a man marries more than one wife, often to ensure the continued status and survival of widows and orphans within an established family structure (Parker, 2001).

(vi) Wife inheritance

It is a practice whereby a widow agrees to marry her husband's brother to continue as a member of the family. In the case of refusal, she is expelled and left to care for her children alone (Inuju & Karl, 2006).

1.9 ORGANISATION OF RESEARCH REPORT

The research report is divided into five chapters. Chapter One provides the introduction to the study. It includes a statement of the problem and the rationale for the study, a brief overview of the research approach, limitations and delimitations of the study and a definition of terms. Chapter Two discusses the literature review and theoretical framework underpinning the study. Chapter Three presents a detailed description of the methodology. Chapter Four addresses the presentation and discussion of findings, which have been organised according to themes. Lastly, Chapter Five provides a summary of the findings, the conclusion, recommendations and a concluding comment.

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

HIV and AIDS is a pandemic that is impacting negatively on the lives of millions of people throughout the world. AIDS-related illnesses remain one of the leading causes of death globally and are projected to continue as a significant global cause of premature mortality in the coming decades (UNAIDS Report, 2009). In the context of AIDS, some of the beliefs and practices of specific African cultures have been seen as accelerating the spread of the virus, or at least as barriers to the understanding and prevention of the epidemic (Gauseet, 2001). This chapter will give a brief discussion of HIV and AIDS. This will include the definition, prevalence of AIDS in the world, HIV and AIDS in Malawi and factors that contribute to HIV and AIDS infections in Malawi. This will be followed by cultural practice that plays a role in HIV and AIDS infection in Malawi. Sexual risk behaviours will be discussed briefly.

2.2 DEFINING HIVAND AIDS

HIV is an abbreviation for the human immune-deficiency virus. It is the virus that causes AIDS (Bezuidenhout, 2008). The virus attacks the body's immune system and makes it weak or deficient. It is significant to understand that when one is HIV positive it does not mean that one is suffering from AIDS. The HIV virus enters the body from outside and destroys the immune system that defends the body against infection. The body therefore becomes open to any infection (Magezi, 2007).

AIDS is an acronym used for acquired immune-deficiency syndrome. "Acquired implying that you get it from someone, immune implying the body's immune system, deficiency implying weakness, failure or inadequacy of the immune system, syndrome, a collection of various diseases and symptoms" (Bezuidenhout, 2008, p. 231). It is caused by the immuno-deficiency virus (HIV) which slowly weakens a person's ability to fight off other diseases (Whiteside, 1998).

2.3 THE TRANSMISSION OF HIV

The deadly virus is mainly transmitted through four bodily fluids, namely blood, semen, vaginal fluid and breast milk (Magezi, 2007). Thus one can get infected by simply having any form of unprotected sex with an infected person. It can also be transmitted through blood transfusion, intravenous drug use and needle-stick injury. In addition, HIV can also be transmitted from mother to child during pregnancy, childbirth or breast feeding (Bezuidenhout, 2008). It is argued that saliva, urine, tears and perspiration have low HIV concentrations, therefore large quantities of each have to be available in order for them to infect someone, for instance, seven gallons of saliva (Magezi, 2007).

2.4 PREVALENCE OF HIV AND AIDS IN THE WORLD

Although important progress has been achieved in preventing new HIV infections and in lowering the number of people with AIDS, new infections still continue to grow in different countries. However, there are often large variations in HIV prevalence and epidemiological patterns within countries, as demonstrated below.

2.4.1 HIV IN NORTH AMERICA AND IN LATIN AMERICA

In the United States of America, the HIV prevalence rate is reported as mainly being among African Americans. Their HIV prevalence is 11 times higher than among white Americans (Shambrey-Ebron, 2009). In 2008, the Centres for Disease Control and Prevention (USA) estimated that the annual HIV incidence has remained relatively stable in the USA since the early 1990s, although the annual number of new HIV infections in 2006 was approximately 40% higher than previously estimated. Latin America is primarily home to low-level and concentrated epidemics. In Latin America, HIV seems to be concentrated among high-risk groups e.g. homosexuals, drug users and prostitutes and is not so prevalent in the general population (UNAIDS Report, 2009).

2.4.2 AIDS IN ASIA

According to the UNAIDS Report (2009), Asia is second to sub-Saharan Africa when it comes to the number of people living with HIV and AIDS. The epidemic emerged in several Asian countries in the early 1990s. Since then HIV has been spreading rapidly in many areas of the continent. It is estimated that by 2008, 4.7 million people in Asia were living with HIV. Although there was a recognisable reduction in the annual number of AIDS-related deaths in South and South-East Asia in 2008 as compared to the mortality peak in 2004, it is argued that the rate of HIV-related mortality in East Asia continues to increase. India is the country with the highest HIV prevalence on the continent. Every other country in Asia has an adult HIV prevalence of less than 1%, with the exception of Thailand. The epidemic is concentrated on specific populations such as injecting drug users, sex workers and their clients, and lower-risk populations through heterosexual transmission (UNAIDS Report, 2009)

2.4.3 AIDS IN NORTH AFRICA AND THE MIDDLE EAST

The HIV prevalence rate in the Middle East and North Africa is often represented as low. UNAIDS Report (2009) explains that this is often the case because there is inadequate monitoring of the HIV infection rate among populations at risk such as sex workers, injecting drug users and men who have sex with men. Sudan is the most affected country in the region.

2.4.4 AIDS IN EAST AND CENTRAL AFRICA

HIV prevalence in East Africa has stabilised, and in some settings may be declining. Declines in HIV prevalence reported in Uganda in the past decade appear to have reached a plateau, although these trends may partly be related to the roll-out of antiretroviral treatment programmes. However, reported increases in sexual risk behaviours in Uganda remain a source of concern (Seeley, Malamba, Nunn, Mulder, Kengeya-Kanyondo & Baton, 1994) especially as HIV prevalence has increased in some antenatal clinics. In Kenya, HIV prevalence has increased since 2003 and this may be attributed to the increase in risky sexual behaviour among the population in general (UNAIDS Report, 2009).

2.4.5. HIV IN WEST AND CENTRAL AFRICA

Although HIV prevalence in West and Central Africa is much lower than in Southern Africa, nevertheless, the region is home to several serious national epidemics. While adult HIV prevalence is below 1% in three West African countries (Cape Verde, Niger and Senegal)nearly one in 25 adults (3.9%) in Côte d'Ivoire and 1.9% of the general population in Ghana is living with HIV (UNAIDS report, 2009).

2.4.6. HIV IN SUB-SAHARAN AND SOUTHERN AFRICA

In Africa, sub-Saharan and Southern Africa remain the regions most heavily affected by HIV. In 2008, sub-Saharan Africa accounted for 67% of HIV infections worldwide, 68% of new HIV infections among adults and 91% of new HIV infections among children (Whiteside, 1998). It is estimated that 1.9 million people living in sub-Saharan Africa became newly infected with HIV in 2008 (UNAIDS report, 2009). In a number of countries in the region, HIV is spreading through generalised populations at higher risk, such as sex workers and their clients, men who have sex with men, multiple partners and injecting drug users (Magezi, 2007).It is reported that Swaziland has the most severe level of infection in the world. African women and girls are the most affected population, as compared to their male counterparts. The impact of HIV and AIDS in sub-Saharan Africa is highly felt in the household, community, legal and economic sectors (UNAIDS Report, 2009).

2.4.7 HIV IN EASTERN, CENTRAL AND WESTERN EUROPE

Eastern Europe is the only region in Europe where HIV prevalence remains on the rise. It is argued that 1.5 million people were living with HIV and AIDS in this region in 2008. Countries that are most affected include the Ukraine and Russia. In Western and Central Europe, HIV prevalence has remained stable, with the number of infected men outnumbering that of infected women. In Europe the epidemic is highly concentrated among injecting drug users, sex workers and men who sleep with men (UNAIDS Report, 2009).

2.4.8. HIV IN THE CARIBBEAN

This is one of the regions that are highly affected by HIV and AIDS. Women account for half of the infection in the region. HIV prevalence is mainly concentrated among adolescents and young women. Heterosexual transmissions, sex workers, men who have sex with men, are the primary sources of HIV infection (UNAIDS Report, 2009).

2.4.9 HIV IN OCEANIA

This is one of the regions with the lowest HIV prevalence. Australia has an estimated 0.2% of HIV prevalence. Papua New Guinea and Fiji are the countries with increasing HIV prevalence; the primary means of transmission within these areas is heterosexual intercourse and among sex workers. In Australia and New Zealand, HIV is mostly concentrated among populations at risk such as men who sleep with men, sex workers and injecting drug users (UNAIDS Report, 2009).

2.5 HIV AND AIDS IN MALAWI

HIV and AIDS appeared in Malawi in the 1980s during the time of President Banda's term of office, between 1964 and 1994. During this period, people were scared to discuss anything for fear of being imprisoned without charge or trial. As a result, when the disease appeared, it was prohibited to talk about it in the media (newspapers and radios) (Lwanda, 2005).

This was not strange in Africa because during the early years of the disease, many African presidents refused to acknowledge the existence of the disease and preferred to state that it was the disease of Europeans. This was because of fear that the west would ostracise African nationals and bar them from visiting Europe. Although people in Malawi were aware of the existence of the disease, they were not informed about how to protect themselves from contracting it. Malawi, like South Africa during the time of President Mbeki, lost precious time in focusing on this disease due to government's denial of its existence and rapid growth nature (Kalipeni & Ghosh, 2006).

The first AIDS hospital case in Malawi was diagnosed in 1985. According to Lwanda (2005), this demonstrates that HIV must have arrived in Malawi in 1977. Since then the HIV virus has spread rapidly throughout the country, to such an extent that, at present, Malawi is rated among

countries with one of the highest rates of HIV and AIDS in the world. In Malawi, AIDS has become the leading cause of death among adults from 15-49 years old, a group that makes up 44% of the total population. According to Kalipeni and Ghosh (2006), the HIV incidence is growing fastest among the young people in Malawi.

The fight against the AIDS epidemic in Malawi, just as in any other country facing this challenge, is complex. Although a number of interventions such as behaviour change campaigns have been implemented successfully to reduce the epidemic, AIDS still remains a big challenge to Malawi's social and economic sectors. The National Aids Control Programme (NACP) was founded in 1988 by the Malawian government to coordinate the development and implementation of health education and the prevention of HIV infection. NACP was later replaced by the National AIDS Commission (NAC), an agency that has formulated a national strategic framework of HIV and AIDS prevention and support to guide prevention, care and treatment (Malawi HIV and AIDS Policy Report, 2003).The Information, Education and Communication (IEC) interventions have managed to reach almost every part of Malawi. More than 90% of Malawians are aware of how the HIV virus is spread and how one can avoid contracting it (Kondowe & Mulera, 1999).However, this knowledge does not reflect in the attitudes and behavioural changes of Malawians (Mwale, 2008).

2.6 FACTORS CONTRIBUTING TO THE SPREAD OF HIV AND AIDS IN MALAWI

There are a number of factors that are believed to be contributing to the spread of the HIV virus in Malawi, which will be discussed in more detail.

2.6.1 Lack of Knowledge about HIV and AIDS

Although awareness and general knowledge about HIV and AIDS has reached communities in Malawi in both urban and rural areas, there is still little and limited discussion of HIV and AIDS issues in communities, and between parents and children. One can argue that the silence, secrecy and denial that surround sex and education are a major contributing factor that negatively affects the awareness among people (Kondowe & Mulera, 1999). The Malawian culture is heavily infused with religious beliefs, such as Christianity. In these religious contexts, sex is often

associated with sin, and it is this association that seems to have permeated the Malawian culture. It is considered extremely inappropriate for young women to be educated about practices which, in theory, they should not be putting to use until marriage (Kondowe & Mulera, 1999).

It is undeniable that sex is often a matter that is not discussed openly among members of communities and between parents and their children, in Africa. It is argued that to discuss sex is taboo in Africa as it is something that is not spoken about (Loosli, 2004). This is in agreement with Malawi culture; parents do not discuss sex with their children (Geubbles & Bowie, 2006). In rural Malawi it is taboo to talk to children about sex; this is often left to the elders at initiation. It is this practice of secrecy and denial regarding sexual practice among the youth that has resulted in public support of abstinence and private denial of it, which in turn leads to the rising numbers of HIV infection within the population. It is clear that such cultural values, where elders are not supposed to speak about sex with the youth, contribute to the lack of awareness of HIV and AIDS. This parent-child communication barrier leads to young people learning more from their peers on HIV and AIDS, which may lead them to be misinformed and put them at risk of HIV infection (Poulin, 2005).

2.6.2 Gender inequalities

Gender differences are clearly noticeable in communities in Malawi, especially in rural areas. These derive from cultural constructions of what constitutes appropriate feminine or masculine behaviour in heterosexual relations. It can be claimed that this prescribes male control over their women's bodies, such that they can hardly negotiate safe sex (Scott, 2009). It can be argued that many rural women are financially dependent on men and as a result they have no say in their marriages. Such women cannot question their men should they want to take another wife, or if their men are unfaithful, for fear of being divorced. It is common for many men in Africa to send their wives back to their parent's house and take another wife.

Economic dependence prevents many women and young people from controlling their own HIV infection risk. With little negotiating power, they are often unable to insist on safe sex. Due to poverty, many women have little choice other than to barter sex for survival. As a result, women

do not have control over their own reproductive health rights and reproductive health problems, including HIV (Seeley et al., 1994). Economic dependence is dangerous because it results in making sex a survival strategy, especially for poor women (Kondowe & Mulera, 1999). Hence, sexual decision making lies in the hands of men (Baylies & Bujra, 2001).

2.6.3. Poverty

Promiscuous sexual behaviour by women is commonly believed to be one of the factors responsible for high HIV infection. One can argue that extreme poverty has been one of the contributing factors for women to engage in such risky behaviour. Malawi borders with Tanzania and Zambia and as a result it experiences a lot of commercial sex workers trading, especially in districts that are close to the borders. It can be argued that women can engage in commercial sex at a very young age. It should be understood that were they not living in extreme poverty, most of these women would not be in this position (Smyth, 2000).

2.6.4 Greater sexual freedom among African men

Halperin (1999) asserts that the much higher rate of heterosexually transmitted HIV in Africa than in North America and Europe can be explained by the pervasive pattern among married African men, of having a mistress. Although men from other continents are also most likely to have extramarital affairs, the African culture allows greater sexual freedom for men than for women. In most cases, men's infidelity is accepted as the norm, while women are expected to be faithful (Yoder& Matinga, 2004).

2.6.5. Limited resources and capacity of community-based organisations

Inadequate skills and lack of capacity in community-based organisations for HIV and AIDS prevention activities in the areas of project design and planning, reporting, monitoring and planning, community mobilisation, resource mobilisation and utilisation, leadership, conflict resolution and peace-building have posed a great threat to the acceleration of HIV and AIDS interventions in Malawi (Poulin, 2005).

2.7 CONDOMS AS HIV PREVENTION STRATEGY

Van Dyk (2008) discusses the fact that condoms have not been very popular in many parts of Africa. Previous studies done by Tylor (1990; cited in Van Dyk, 2008) found that people in Rwanda were well informed about AIDS; however, none of them were using condoms. Similarly, a study conducted in Uganda by Green (1995) found that only 3% of the population was using condoms, even though millions of them were distributed.

Condom usage in Malawi still remains a controversial issue between the church and Islam on one side, and the government on the other. Malawi council of churches continues to condemn the distribution and the use of condoms to prevent HIV transmission as immoral and as encouraging promiscuity. According to the churches in Malawi, condoms are not 100% effective in preventing infection. It is argued that the only way to protect oneself from infection is through strict monogamy and abstinence (Kalipeni & Ghosh, 2006). As a result, it becomes a challenge for HIV prevention programmes that encourage condom usage to be effective in such communities.

On the other hand, culture prescribes gender roles where women are viewed as passive and have a lower status compared to men (Kalipeni & Ghosh, 2006). This is even more challenging in patriarchal societies where women have no voice. Due to their position in a given culture, women tend to have little or no control over their sexual lives. As a result, they become dangerously vulnerable in sexual relationships because they don't have the authority to express or to reinforce their needs (Baylies & Bujra, 2001). It is clear that this puts women in a difficult position, especially when it comes to negotiating safe sex practices, as they fear violence and abandonment should they try to do so (Niehaus, 2007).

2.8 BELIEFS ABOUT ILLNESS

It can be argued that in many parts of Africa, people tend to attribute illness to witchcraft. In many cultures any form of illness, misfortune, conflict, accident, death, even loss of a job, are ascribed to witchcraft (Campbell & Kelly, 1995).Malawi is no exception to this. Many Malawians attribute their AIDS to witchcraft. As a result, individuals cannot be held responsible for their actions and this contributes to a lack of behavioural change (Karim & Karim, 2005). This not only has implications for sexual behaviour, but also for the person who takes care of the

sick person. Often, caregivers, especially mothers of the sick young people in Malawi, have contracted HIV from being in contact with infected bodily fluids.

Some communities in Malawi believe that HIV and AIDS can result from magic. This is simply because some of the symptoms of an AIDS patient may be similar to those of other traditional diseases such as *tsempho* and *kanyera*. These are diseases that the communities believe to be those a person suffers from because of the following: *tsempho* the violation of sexual restriction, having extra-marital sex, promiscuity, and having sex with a woman who had a miscarriage. On the other hand, *kanyera* is believed to start when one has sex with a menstruating woman, has sex with a woman who gave birth recently, has sex with a woman who has had a miscarriage or has sex with a person who has had *kanyera* (Poulin, 2005).

2.9 CULTURAL PRACTICES

A number of cultural practices in Malawi have an impact on the spread of HIV and AIDS. In the northern, southern and central regions of Malawi, communities still adhere to these practices which might contribute to the spread of HIV and AIDS. These will be discussed in more detail.

2.9.1 Polygamy (also called *Mitala)*

This is a practice by which a man marries more than one wife, with or without the consent of the first wife. This practice takes place in many countries in Africa, including Malawi. The most common type of polygamy is having two or three wives (Malawi Human Rights Commission, 2005).This practice serves a number of purposes, for instance, in many parts of Africa, children are valued not only for carrying the lineage but also because people can prosper on the land if they have many children and wives. In such cultures, wives and children help work on the land. A man's wealth depends on the growth of his tribe (Gauseet, 2001). This practice is also valued because it is believed to curb infidelity for the reason that the man has more than one wife and therefore he would see no reason to go out with other women (Parker, 2001).However, it is argued that polygamy accelerates the spread of HIV in that if one partner is infected, he or she infects all the partners within the nuclear family and in most cases, the parties involved in such marriages are not tested for HIV (Pelto & Pelto, 2005).

2.9.2 Wife Inheritance (*Kuhara*)

This takes place during the time of mourning, for instance when a husband dies, his brother, cousin, or nephew inherits the surviving wife. Although in some cultures it may be a thing of the past, such marriages still exists in Malawi today, although in fewer numbers (Yoder & Matinga, 2004). In instances where there is more than one brother interested in inheriting the widow, the surviving wife has to choose the brother that she wishes to marry. In some areas of Malawi, the choosing of the brother to inherit the widow involves a ceremony. The brothers are requested to present any symbolic gift to the lady. The lady then chooses the gift of the man who impresses her most. Thereafter, that man becomes her husband (Malawi Human Rights Commission, 2005). This practice has implications where HIV infection is concerned, considering that neither the widow nor the prospective husband is tested for HIV. This becomes problematic if the widow's husband died of AIDS, as it is most likely that the widow is infected. This increase the chance of the person that inherits her of being infected with HIV(Baylies & Bujra,2001).Wife inheritance is blamed for furthering the sexual transmission of HIV in many patriarchal societies in sub- Saharan Africa (Nyazi, Walakira & Serwaniko, 2009).This practice is also common in other parts of Africa, such as in Uganda.

2.9.3 Hyena (*Fisi*)

A hyena, who is usually an identified male, is used in cases where a married woman fails to conceive due to the husband's infertility (Nyerges, 2006). This can be with the husband's consent or not. *Fisi,* or hyena, is also a puberty or pre-marital practice that is practised in some parts of Malawi, among the Senga of Zambia and the Krobo of Ghana (Jere, 2009). This practice often takes place at the initiation ceremonies of young women. The elders or instructors at initiation ceremonies, known as *nankungwis,* educate the women about sex. The young women involved are those who have either recently incurred their first menstruation and are often virgins, or are soon to be married. In this case, the hyena is an unidentified male who comes to each woman individually under the cover of night and has sex, often without protection (Malawi Human Rights Commission, 2005). The purpose is to test the girl to ascertain if she is sexually ready for marriage. However, the hyena is not tested for HIV, nor is the other party. This therefore has implications for HIV in that both parties can infect each other. In the case of married women, they can also infect their partners (Nyerges, 2006).

2.9.4 Replacement of a deceased wife (*Chimetamasisi, Chidzutsa nyumba)*

This is a practice by which a widower marries a younger sister or niece of his deceased wife. The young sister or niece is usually encouraged by her parents to marry the brother-in-law. This practice serves a number of purposes. In cases where the *lobola* (bride price) was paid by the widower's family to his deceased's wife family, the parents of the deceased wife may be afraid that the husband's family may want the *lobola* back. The younger sister may be given to the widower to avoid this payment. In some instances, the widower might be wealthy. The younger sister of the deceased wife may be given to the widower for marriage to ensure that her family still has access to the wealth of the husband (Malawi Human Rights Commission, 2005). It is argued that most of the young girls who are part of such marriages are found in extramarital relationships with men/boys of their own age, not only because they would like to run away from a loveless union, but also because they do not get sexual satisfaction from such a union due to the big age difference. In some instances, the young sister or the niece who is chosen can be as young as fifteen years old. Just like the cultural practices previously discussed, the girl or the husband is never tested for HIV. As a result, there is a risk of HIV infection (Malawi Human Rights Commission, 2005).

2.9.5 Bonus wife (*Hlazi, Mbirigha, Isakulwa, Nthena)*

In this practice, a husband is given a younger sister or niece of his wife to take as his second wife. This is done for a number of reasons. The parents of the wife may offer their young daughter as a sign gratitude to the son-in-law for taking good care of their daughter and her family. The wife can also ask the younger sister to marry her husband as a second wife in cases where she cannot bear children. The younger sister is therefore, encouraged by her parents, her sister and aunties, to marry the brother-in-law. In some instances, the younger sister may be as young as fifteen years old. (Malawi Human Rights Commission, 2005) This practice takes place in parts of the southern region in Malawi. It can be argued that this practice has implications for HIV infection, since neither party is tested for HIV.

2.9.6. Offering a girl-child as payment for debt (*Kupimbira /Kupawira*)

This is a practice whereby the parents of a girl-child offer their daughter as payment for a debt that they fail to pay to the creditor. The creditor takes the girl as his wife. In some instances, the girl can be as young as nine years old and the man could be as old as 40 years. It is argued that often, the girl ends up attaining puberty while married to the older husband. The girls in such unions are often threatened that they will be cursed if they run away from their marriages. This is one of the reasons that make them stay in such marriages. There is a high chance that the girl-child may be infected with HIV at a tender age, considering that the man who marries her is never tested for HIV (Malawi Human Rights Commission, 2005).

2.9.7 Marriage by Proxy (Marrying the wife of a brother in the brother's absence)

In some parts of the northern region of Malawi such as Mzimba, many men leave for greener pastures to work in South Africa. In olden times, they would work in the mines. In their absence, the husbands' brothers are asked by the elders to look after their sisters-in-law, including having conjugal relations with them. Sometimes it is the fathers-in-law that take on the responsibility of proxy husbands. Until the husband returns, the women are not given a chance to refuse since they are in a new environment and they are usually young and naive. The husband can take over his family when he returns. This has implications for HIV infection considering the parties involved are never tested for HIV; therefore they can all become infected (Malawi Human Rights Commission, 2005).

2.9.8. Sexual cleansing (*Kulowa Kufa/Kupita/Kufa*)

This is a practice whereby a man is chosen to have sexual intercourse with a woman whose husband has passed away, in order to put to rest the spirit of the deceased husband (Jere, 2009). According to a number of cultural beliefs in many parts of Africa; the widow becomes unclean after the burial of her husband. The widow therefore has to be cleansed to be able to marry again (Loosli, 2004).This practice is conducted for a number of reasons, such as to remove the spirit of the dead so that the living spouse can start a normal life, to liberate the marriage partner from the bond of marriage so that she is able to marry again, and as a purification rite that symbolises that the mourning period is over (Jere, 2009). This practice often takes place three days after burial of

the widow's husband. After the sexual cleansing is conducted, the widow can become normal again and mix freely with other members of the community. The practice is common in many countries such as Malawi, Zambia and Zimbabwe and Kenya (Gauseet, 2001).

One can argue that there's a high chance that both the widow and the cleanser could be HIV positive. The cleanser is often involved in the sexual cleansing of a number of widows. Often, he is not tested for HIV (Ayikukwei, Ngare, Sidle, Ayuku, Baliddawa & Greene, 2008). On the other hand, the widow's husband could have died of AIDS which increases the widow's chances of being infected. Such practices put both parties at risk of HIV infection, as they are never tested for HIV(Gauseet, 2001).It is in this view that efforts are being made to encourage sex cleansers to use condoms while performing the ritual (Loosli, 2004).

2.10 CULTURAL PRACTICES ASSOCIATED WITH RITES OF PASSAGE

Traditional initiation is described as the counseling of boys and girls by elders on how to behave as adults (Jere, 2009). The main purpose is to teach the children about the values and norms which are highly regarded in their society. The cultural practice of initiation takes place when girls and boys reach puberty. Initiation is important for many societies as the child can only be fully integrated into his/her society after going through extensive rites of initiation (Spark-du Preez, Zaba, Nyamukapa, Mlilo & Gregson, 2004). This period is viewed as marking the end of childhood and the beginning of adolescence or adulthood (Jere, 2009). Many African cultures have initiation ceremonies for girls and boys. The following are cultural practices that are associated with the rites of passage in Malawi:

2.10.1 Girls initiation practices (*Chinamwali cha atsikana*)

This practice takes place when young girls reach puberty and have started experiencing menstruation. This practice marks the transition between childhood and adulthood. The main principal purpose of *chinamwali* is to give instruction or to counsel the girls on good manners, especially when interacting with adults (Malawi Human Rights Commission, 2005). It is

important to note that this practice is also common in Zambia, where it is called *cinamwali* (Jere, 2009).

The following are different types of initiation that some girls go through in the different regions of Malawi.

(a) A type of girls initiation (*Msondo, Zoma* or *Chidototo*)

Msondo or *zoma* or *chidototo* are names given to a type of initiation that takes place among girls in some areas of the southern region of Malawi. Girls from six years of age are taken to an isolated place, which is usually a house within the village, for a period of two to four weeks. At the initiation, the girls are given a number of advices by elders or instructors, known as *namkungwis*, and who are women/girls who have already undergone this initiation (Mwale, 2008). The girls are taught how to conduct themselves respectfully as adults, how to respect elders and about sex. For instance, the girls are taught how to offer the best sex to men or their future husbands. It is argued that the women who instruct the girls perform a dance that imitates the process of having sex. As they do this, people from the community are free to watch. The girls are instructed and given advice through talks, dance and song from the elders. The songs are usually in obscene language. It is argued that each of the songs has a particular message to convey to the girls. The songs are therefore used as channels through which advice is given to the girls (Malawi Human Rights Commission, 2005).

Although *msondo* is very common among the Yao from the southern region of Malawi, in other regions such as the central and northern regions, girls are given similar advice at their initiation ceremonies, often known as *chinamwali* in the central region among the Chewas. At such initiation ceremonies, girls are put into isolation for a period of four weeks. After completion of the initiation ceremony, a ceremony is organised for the girls at the chief's house. It is argued that the initiates perform a dance while naked and everyone is allowed to watch the dance. Any person who gives a gift, for instance in the form of money, to one of the dancers is free to touch her breast. At the end, the girls are advised to identify any boy to have sex with to avoid *kutuwa* (getting pale) and they call this practice *kusasafumbi or kuchotsa fumbi* (wiping dust). One can

argue that the practice of female initiation teaches the young girls about sex at a tender age, which may encourage them to be promiscuous. In addition, the girls are encouraged to have sex with boys who may put them at risk of HIV infection, especially in situations where both parties have not tested for HIV (Malawi Human Rights Commission, 2005).

(b) Other types of girls' initiation (*Chindakula, Maseseto* or *Masosoto)*

Chindakula (in the Mangochi district) or *maseseto* (in the Nsanje district) or *masosoto* (in the Mulanje district) is the practice that girls go through during initiation. Like the initiation ceremonies discussed previously, this takes place when the girls begin menstruating for the first time. The girl is given advice on personal hygiene, especially when experiencing monthly periods, how to respect elders, and on sexual matters. For example, the girls are taught not to deny their husbands sex when they get married, except for when they are having periods. The girls are also taught how to please their husbands sexually. The Malawi Human Rights Commission (2005) reports that the girls are taught what is called *kunyekulira* or *kudikulira* (swinging or wriggling around the waist) to assist men during intercourse. One can argue that this knowledge about sex can encourage promiscuous behaviour among young people who might not yet have known about sex, and therefore increase the spread of HIV and AIDS (Malawi Human Rights Commission, 2005).

(c) Pulling of the girls labia (*Kukuna/Zokoka, Kuthuna/Makuna*)

This is a practice where young girls are encouraged to pull or stretch the inner lips of their vagina, known as labia, for future sexual pleasure. The young girls from the ages of seven or eight years are given instruction on how to pull their labia so that in time the labia elongates into something like small fingers attached to the vagina (Human Rights Commission, 2005). In other parts of Africa such as Zambia where the practice takes place, the aim is to ensure that the labia measures up to 4cm long so that the husband can play with it during foreplay (Van Dyk, 2007) in (Jere, 2009). During the girl's initiation, the elders, known as *nankungwis* can also check the girls physically to see if they have pulled their labia. The girls are paired and each girl pulls the labia of the other gently for a certain period, as instructed by the elders. The purpose of this

practice is to ensure that the girls are able to give their partners maximum pleasure during sexual intercourse. It is often believed that a woman whose genital parts are not pulled does not arouse a man during sexual intercourse because the man has nothing to caress during foreplay. The implication of such practice to HIV infection is that girls are taught at a young age about sex and about pleasing men in bed. As a result, the girls can become sexually promiscuous at a tender age, which may put them at risk of HIV infection (Malawi Human Rights Commission, 2005).

2.10.2 Boy's initiation

(a) Circumcision for boys (*Jando*)

According to van Dyk (2007, p. 127) in Jere (2009), circumcision "symbolises a separation from childhood to adulthood". *Jando* refers to circumcision for boys among the Yao in the southern region of Malawi. In such cultures, boys can go for initiation at as young as six years old (Malawi Human Rights Commission, 2005).The boys are often taken to a secluded area where the initiation takes place for a certain period. At the initiation, the boys are given instruction and advice on how to respect elders, how to conduct themselves as adults and about sex in general, For instance, they are taught about new ways of having sex with a girl without making her pregnant until they are married (Van Dyk, 2007) in Jere (2009). The boys are also provided with adequate information about girls. For instance, they are taught about girls' menstruation. The instructions are usually given through songs that are characterised by obscene language (Malawi Human Rights Commission, 2005). Once the boys undergo circumcision they are considered mature and are actually advised and encouraged to have sexual intercourse upon completion of initiation and on return to their homes (Mwale, 2008). It is believed that having sexual intercourse prevents the boys from experiencing misfortune and from experiencing serious back ache. There is also a strong belief that if the boys do not have sex after initiation, their penises will shrink and become too small for sex. One can argue that this practice puts the boys at risk of HIV infection since it encourages promiscuous and risky behaviour (Malawi Human Rights Commission, 2005).

2.10.3 Dry Sex

This is mainly practised in a number of communities in sub-Saharan Africa, Latin America, the Carribean and South East Asia. “It refers to vaginal penetrative sex with non-lubricate genital contact” (Loosli, 2004, p. 32). Women insert herbs, dry cloths, chemical substances such as tooth paste, Dettol, soap powder etc. into the vagina to facilitate the dryness. This is often conducted before the process of sexual intercourse starts (Loosli, 2004). It is argued that women can use up to thirty different substances, mostly leaves and powders, to ensure that they achieve the appropriate dryness (Feldman, 2008). The aim is to ensure that the vagina is tight, dry and hot (Loosli, 2004). It is believed among some women in many parts of Africa, that men will like them more if they have a dry and tight vagina. The purpose of this practice is to ensure that their men enjoy the process of sexual intercourse. This is also based on the idea that women are not supposed to be sexually excited before meeting their partner. When a woman has a moist vagina before starting intercourse it could be seen as a sign that she has had sex previously with other men. However, this practice can cause internal abrasions, breakages in the skin and mucous membrane, which may facilitate HIV transmission (Gauseet, 2001).

2.11 THEORIES ABOUT HEALTH BEHAVIOUR

The different theories describe specific forces that shape sexual behaviours, of which the following are the most important: The health belief model, social cognitive learning theory, the theory of reasoned action, the theory of self-regulation and self-control and the theory of subjective culture and interpersonal relations. These theories focus on personal and interpersonal factors influencing behaviour. However, it is argued that change in behaviour is most likely to occur if the individual has a strong positive intention to perform the change, is not impeded by constraints, either external or internal to the person, perceives more social or normative pressure from relevant referents to perform the behaviour rather than change it, believes the perceived advantages outweigh the costs and believes the performance of the behaviour to be consistent with his/her self-image (Karim & Karim, 2005).

Karim & Karim (2005) argue that explanations of sexual behaviour should be extended to broader contextual factors of structure and environment and the way these shape the possibility for safe sexual behaviour. These are discussed below:

(a) Personal Factor

Personal factors are those that reside within the individual person, such as cognition and feelings related to sexual behaviour and thoughts about oneself. Personal factors influence sexual behaviour and HIV risk. For instance, low self-esteem is associated with having a negative attitude towards condom usage (Karim & Karim, 2005).

(b) The Proximal Context

The proximal context encompasses features of relationships and the environment that intimately impinge upon an individual. Proximal factors include those related to interpersonal relationships such as negotiating condom use, coercive male-dominated sexual relationships and peer pressure to be sexually active. For instance, gender inequality is an important feature of many sexual relationships and one that is associated with sexual risk. Proximal context also embraces the physical and organisational living environment: where one lives (urban or rural), on the streets, in prison etc, the quality of health services, access to condoms, to the media and recreational facilities (Karim & Karim, 2005).

(c) The Distal Context

This includes the less immediate elements of a person's environment. An example of the distal context includes cultural factors such as traditions, the norms of the larger society, the social discourse within a society and shared beliefs and values and structural factors such as legal, political, organisational elements of a society. Karim and Karim (2005) further argue that discourse that supports the unequal distribution of sexual power between men and women and the subordination of women's needs and rights has an important influence on sexual behaviour and HIV risk. For instance, ideas about masculinity, risk taking and sexual conquest increase men's HIV risk behaviours. Norms around intimate partner violence make women vulnerable to HIV infection through coercive sex and sex without a condom (Karim & Karim, 2005).

2.12 SUMMARY

Chapter 2 gave a brief discussion on HIV and AIDS and included the prevalence of HIV and AIDS in Africa and the rest of the world. It also included a focus on factors that contribute to the

increase of HIV infection in Malawi. The cultural practices that might put people at risk for HIV infections were discussed thoroughly. These included the practice of initiation for young girls and boys, the practice of polygamy, and the practice of wife inheritance, the practice of sexual cleansing and the practice of dry sex. It was discussed that such practices may put people at risk of infection because the parties involved are never tested for HIV. In the case of initiation ceremonies, it was discussed that the young girls and boys are taught and encouraged about sex at a tender age and this encourages promiscuous behaviour that may lead to HIV infection. Lastly, theories of health behaviour were discussed, which brought about an explanation on the reasons that may contribute to people behaving in a manner that puts them at risk of infection.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter presents the research methodology that has been used in this study to explore the understanding and perceptions of Malawians living in Gauteng, South Africa, about the role that cultural practice plays in promoting HIV infection in indigenous Malawian tribes. This research utilised a qualitative approach. Qualitative research deals with data that is primarily verbal and derives meaning from the participant's perspective, and also aims to understand the meaning that people attach to everyday life (Bless, Higson-Smith & Kagee, 2006).

3.2 RESEARCH APPROACH AND DESIGN

A qualitative approach was applied to gather in-depth information about the role that cultural practices play in promoting HIV infection in indigenous tribes in Malawi. De Vos, Strydom, Fouche, Poggenpoel and Schurink (1998) explain that one of the strengths of qualitative research is that the information that is collected reflects what the participants experiencing the phenomena believe to be important, rather than what the researcher believes to be important. The researcher is involved rather than detached and takes an insider perspective (Leedy, 2005). Miles and Huberman (1994; cited in Muganwa, 2005) note that qualitative data is attractive, and a source of well-grounded rich description and explanation of processes occurring in a local context. Muganwa (2005, p. 4) argues further that "Qualitative research data are more likely to lead to unanticipated findings and to new theoretical integration leading researchers to go beyond initial preconceptions and frameworks". Therefore, the research was exploratory in nature. As Bless, Higson-Smith and Kagee (2006, p. 49) argue, "The purpose of exploratory research is to gain a broad understanding of a situation, phenomenon, community or person".

Babbie and Mouton (2002) further outline that the qualitative approach to research is uniquely suited to uncovering the unexpected and to exploring new avenues. The qualitative approach puts emphasis on people's lived experiences and locates the meanings people place on events,

processes and structures of their lives, their perceptions, assumptions, prejudgments, presuppositions, and connects these meanings to the social world around them. This approach was appropriate for the study because it allowed the researcher to collect in-depth data that focused on the participant's subjective experiences on living in the villages that practice cultural practices that impact on HIV and AIDS infections. It also focused on their understanding of the role that cultural practice plays in promoting HIV and AIDS in indigenous Malawian tribes.

Mouton and Marais (1990, p. 193) define a research design as "an exposition or plan of how the researcher decides to execute the formulated research problem. The objective of the research design is basically to plan, structure and execute the research project in question in a manner that maximises the validity of the findings" (Mouton& Marais, 1990). The study employed a case study research design. A case study can be defined as "a method of studying social phenomena through the thorough analysis of an individual case; the case may be a person, a group, an episode, a process, a community, a society, or any other unit of social life"(Punch, 2005, p. 145). It can also be defined as "a phenomenon of some sort occurring in a bounded context, thus a case can be individual or attributes of an individual's actions and interactions, residues and artifacts of behaviour, settings, incidents and events, and collectivities" (Punch, 2005, p.144). The basic idea behind a case study is that a small number of cases will be studied in detail using whatever method that seem appropriate. The general objective is to develop a full understanding of that case as much as possible (Yin, 2003).

The advantage of using a case study is that it has a holistic focus which aims to understand the wholeness and unity of the case. Case studies are a good source of ideas about the case under study and they provide a good opportunity for innovation and a good method to challenge theoretical assumptions. Another advantage of the case study is that it can provide understanding on a new or persistently problematic research area (Yin, 2003). The case study therefore gives an opportunity to the researcher to understand the case in-depth, in its natural setting and its context (Punch, 2005). The research study used a multiple case study approach which was beneficial in that it gave an opportunity to provide valuable and in-depth understanding on cases that were not yet understood.

However, a common criticism with case study concerns its generalisability. It is argued that often the study is based on one case which makes it difficult to be generalised. However, this was not the case with the current research study as it involved the use of multiple cases. In addition, the intention of the research was not to generalise, rather to understand the case in its entirety as well as in its context. The researcher was also aware that the findings of the research can be found as being potentially applicable to other contexts, depending on the theoretical grounds that were used. Another challenge with the case study is that it can result in possible bias in data collection and interpretation since only one person gathers and analyses the information. The researcher was able to avoid this by ensuring that she was not subjective but objective, and was able to ensure that the results were not influenced or tainted by any bias, but rather by the facts themselves. The researcher presented the facts the way that they were (De Vos et al., 1998).

3.3. SAMPLING PROCEDURE

Bailey (1998) explains that purposive sampling requires that the researcher use his or her own judgment in selecting participants who meet the needs of the study. Purposive sampling therefore allows the researcher to purposively select informative participants. The study focused on three Malawian tribes, namely the Chewa, Tumbuka and Yao tribes. A total of six participants from each tribe were selected. However, due to unforeseen circumstances, the researcher was able to interview six participants from the Yao tribe, six from the Tumbuka tribe and five from the Chewa tribe. The research mainly involved three women, one from each tribe, as it proved a challenge to secure male participants due to work and family commitments. Leedy and Ormrod (2001) point out that in a qualitative research it is appropriate to select a few participants who can best shed light on the phenomenon under investigation. The participants were purposively sampled using the following criteria: they should be a member of one of the three tribes, they should have knowledge of cultural practices that are practised in their villages and they should have lived in their village for a minimum period of four months. The advantage with this approach was that it allowed for the collection of a lot of information that was rich and in-depth on the subject matter, considering that the participants already had knowledge on the topic under study. The limitation of having a purposive sample is such that it becomes a challenge to generalise to a large population (Bless, et al., 2006).However, the researcher is of the opinion that the results of the research can be transferable to a similar context based on the similarities in

the findings from the different cases that was studied and on the similar literature that was reviewed.

3.4 RESEARCH TOOL

A semi-structured interview schedule was used to collect data (Appendix D). Bless,et al. (2006) argue that an interview schedule is beneficial when conducting a research as it gives the researcher room for probing, for clarification and further discussion of important and relevant issues that will arise during the interview. The use of the interviews as a method of data collection is motivated by a number of variables. Muganwa (2005) argues that the advantage of using interviews is that interviews give the opportunity to the researcher to meet the subjects of the study. Interviews also provide both detailed information that was set out to be collected and some contextual or other information. The interview schedule makes it possible to reduce misinterpretations of questions because the subject can ask for some clarification of the questions or can recheck what he/she understands from the interviewer after he/she has been given information. However, besides the strength of using interviews as a method of data collection, the study also recognises that this method has some limitations (Leedy, 2005). The interviews can be time consuming, which affects the availability of subjects and number of questions to be used. However, the study took this into account to make sure that there was less influence in the process of data collection. For clarification where necessary, some English words were described in Chichewa, the national language of Malawi.

3.5 PRE-TESTING OF THE RESEARCH TOOL

Pre-testing of the research tool was conducted, where the researcher interviewed each member from each of the tribes under study who did not participate in the final study. According to Leedy (2005), the purpose of pre-testing is to find out how long it takes to complete the semi-structured interview and to get feedback from the participants regarding any problems in the interview schedule, such as unrelated questions. The researcher was able to identify through feedback from participants that some of the language that was used as part of the research questions was difficult for some of the participants to understand. The researcher had to translate and clarify some of the questions during the interview in Chichewa, which is Malawi’s national language.

This made it easier for the participants who did not understand how to express themselves clearly during the interview. Therefore, it contributed to easier and faster collection of meaningful data.

3.6 DATA COLLECTION

Data was collected through face to face individual interviews. Muganwa (2005) argues that the face to face technique of data collection is appropriate when dealing with complex issues where there is little or no available information. According to Leedy (2005) interviewing is the most important data collection method. It is the responsibility of the interviewer to create an atmosphere in which participants feel comfortable enough to talk freely and openly. This was achieved by allowing participants to take part in choosing an appropriate and conducive venue for the interviews. Most of the interviews were conducted at a neutral venue chosen by the participants, to ensure that they were comfortable with the interview. A tape recorder was used so that all the information could be captured without missing any important information. The interviews were later transcribed.

3.7 DATA ANALYSIS

The researcher conducted face to face interviews in English with 17 participants from the three tribes under study. The data was tape recorded and transcribed. The study involved the use of thematic content analysis. It involves “organising what you have seen, heard and read so that you can make sense of what you have learnt” (Glesne and Pestikin 1992, p.127). Different facts from the data collected were identified and grouped together into categories. This made it possible for meaningful groups of data to be put together and to be organised into themes (Leedy & Ormrod, 2005). The researcher identified common themes that were relevant to the study, and classified sub-themes that emerged in the data. This made it possible to reduce and categorise large quantities of data into more meaningful units for interpretation (Grinnell, 2005). The researcher was able to identify perceptions, feelings, attitudes, understanding and suggestions from the data collected. Similarities, differences and patterns that emerged from the data collected from members of the different tribes interviewed were also identified which gave the researcher a broader understanding of the case under study (Leedy & Ormrod, 2005). The use of thematic content analysis made it possible for the researcher to draw meaningful conclusions from the study.

3.8 TRUSTWORTHINESS AND RIGOUR

When conducting qualitative research the key issue is trustworthiness. A trustworthy study is one that is carried out fairly and ethically and whose findings represent as closely as possible the experiences of the respondents (Glesne & Pestikin, 1992).De Vos et al., (1998) explain that all research must respond to canons that stand as criteria against which the trustworthiness of the project can be evaluated, in order for the research to be valid. They are a number of threats to the credibility and trustworthiness of qualitative research. These include reactivity, research biases and respondent biases (Leedy, 2005). The research was evaluated in terms of:

(a) Credibility

Credibility refers to truthfulness, believability and value of the researcher's findings as perceived by participants. It also looks at whether the researcher is answering the research question in a realistic manner. The qualitative approach used in the study allowed for validity and credibility in that the researcher ensured that the findings were objective and reflective of the participant's experiences, values and feelings, and not of the researcher's prejudices and biases. This made it certain that the research findings are believable and not subjective (De Vos et al., 1998). In addition, the researcher would submit the findings of the research to the participants to ensure that the researcher understood their attitudes, feelings and perceptions.

(b) Transferability

Transferability involves assessing the applicability of the findings to another context. It looks at whether the research can be repeated to be able to yield similar results. The sample consisted of 17 participants, which may not make it possible for the research findings to be representative of the entire population of the Yao, Tumbuka and Chewa tribes living in Gauteng, South Africa, however, the research would hopefully be able to yield similar results if data were gathered from a larger population sample based on the theoretical grounding of the research that was looked at (De Vos et al, 1998).

(c) Dependability

Dependability looks at how dependable the collected data was. This data was obtained by looking at the repetitive themes that the researcher identified in the interviews that were conducted, as well as by looking at literature and previous studies conducted that were similar to the findings (Maxwell and Sarake, 2006). The researcher ensured that complete records of all phases of the research were kept in an accessible manner and at all levels, from problem formulation, selection of research participants, interview transcripts to data analysis decisions (Bryman & Bell, 2007).

(d) Comfirmability

Confirmability focuses on "whether the results of the research could be confirmed by another person to ensure that the findings were not biased and places the evaluation on the data themselves" (De Vos et al., 1998, p. 351). The researcher was able to achieve this by ensuring that her values did not interfere with the findings of the research. Therefore she was objective in her conduct throughout the research process (Bryman & Bell, 2007).

3.9 ETHICAL CONSIDERATIONS

When conducting a research study the following ethical considerations have to be taken into account. These include avoidance of harm, voluntary participation, informed consent and confidentiality. These are discussed below:

(a) Avoidance of harm

As cited in Bless, et al. (2006), conducting any social research may be intrusive upon the lives of subjects; hence care will be taken to ensure no malfeasance. It is noted that harm may occur unintentionally or intentionally during the course of a research study; however, it is the role of the researcher to ensure that there is no harm. The research was not a sensitive topic so there was no possibility for harm caused through participation in this research.

(b) Participant information sheet

In the participant information sheet which was discussed with the participants, the researcher gave a detailed explanation of what the study was about (Appendix A). Participants were informed about the right to participate and not to participate in the study if they so wished,

therefore, they were informed that their participation was solely voluntary. Participants were given every assurance that they were free to discontinue their participation at any time without being required to offer an explanation and this wish was respected. The participants were informed that their participation in the research was solely voluntary, they were at liberty to withdraw from the investigation at any time if they so wished. The participants took part in the study without any coercion or force and out of their own free will. Hence the researcher asked the participants for their voluntary participation.

The participants were informed about the confidentiality clause in order for them to have no doubt that any identifying information that was provided was regarded as confidential (Leedy, 2005).The participants were informed that the confidential information will be accessed by the researcher and her supervisor; they will not be required to provide any identifying information so the transcripts and the final report will not reflect the subjects identifying information such as their names. Bless, et al., (2006) note that participants' data must not be associated immediately and obviously with identifying information such as their names. The researcher achieved this by ensuring that sensitive and personal information obtained from the participants was protected.

Bless, et al., (2006) argue that it is the right of participants to be informed of the results of the study. The researcher will achieve this by presenting the results of the study to the research participants in the most easily understandable form. The researcher will consider the participants' language competence and their educational level to ensure that they get a clear understanding of the findings.

(c) Informed consent

Informed consent implies that participants are given adequate information on the investigation, procedures to be followed, the possible benefits and costs and dangers to which they may be exposed, what is required of them in terms of participation and the fact that they have the right to decline to participate. The participants were given as much information as possible to make an informed decision about whether or not to participate in the study. The participants were asked to sign the consent form in order to grant their consent (Appendix B). This was ensured through detailed explanation of what the study entailed. The participants were given a consent form to sign both for the interview and the tape recording. Informed consent was therefore sought (Bless, et al., 2006).

(d) Consent for tape recording

Participants were requested to sign a form to consent to the tape recording of the interviews (Appendix C). Participants were informed that after transcribing, the tapes would be kept in a safe and confidential place for a period of six years if no publications emerge from the proposed study or for two years if any publications arise from the study. The principle of anonymity is linked with confidentiality. The researcher achieved this by ensuring that participant's identities were not reflected on the tapes (Bless, et al., 2006).

(e) Social and scientific value of the research

According to Schuklenk (2004) for research to be ethical it must have social or scientific value or both. The proposed research will provide knowledge and awareness on the cultural practices that play a role in the spread of HIV amongst the Chewa, Tumbuka and Yao tribes which will hopefully lead to the creation of interventions programmes and to the creation of alternative, safer cultural practices. Ethics clearance to conduct the research was obtained from the University's non-medical ethics committee. The ethics clearance certificate protocol number is H100 1106 (Appendix E).

CHAPTER 4: PRESENTATION AND ANALYSIS OF FINDINGS

4.1 INTRODUCTION

A multitude of literature in Africa has put traditional cultural practices as having implications for HIV infection and inhibiting risky behaviour change (Nyerges, 2006). A number of cultural practices were identified in the study as contributing to HIV infection such as wife inheritance, polygamy, initiation practices, bride price, traditional marriages and circumcision. This chapter presents the demographic profile of the participants and findings of the study according to the three groups, namely the Tumbuka tribe, the Yao tribe and the Chewa tribe. Some of the data are analysed in terms of Tables and in terms of the major themes that were identified.

4.2 DEMOGRAPHIC PROFILE OF PARTICIPANTS

Table 4.1: Gender of Participants by Ethnic tribe (N=17)

	PARTICIPANTS' GENDER		
ETHNIC TRIBE	MALE	FEMALE	TOTAL
Yao	5	1	**6**
Chewa	4	1	**5**
Tumbuka	5	1	**6**
TOTAL	**14**	**3**	**17**

Table 4.1 demonstrates the gender ratio among the participants in the current study. Seventeen participants were interviewed. Fourteen of the participants from the three tribes were men. Three of the participants interviewed were women from each of the tribes under study. Of the participants, 83% were men and 17% were women.

Table 4.2: Age distribution of participants by Ethnic tribe (N=17)

	PARTICIPANTS' AGE GROUPS							
ETHNIC TRIBE	**30 - 35**	**36 – 40**	**41 - 45**	**46 – 50**	**51 - 55**	**56 - 60**	**61 - 65**	**TOTAL**
Yao	4	2	-	-	-	-	-	**6**
Chewa	5	-	-	-	-	-	-	**5**
Tumbuka	4	-	-	-	-	2	-	**6**
TOTAL	**13**	**2**	**-**	**-**	**-**	**2**	**-**	**17**

In Table 4.2 the age distribution among the participants interviewed is displayed. Of the participants, 13 were between 30 and 35 years of age, two were between 36 and 40 years old and two were between 56 and 60 years of age.

Table 4.3: Years participants lived in the village (N=17)

	YEARS PARTICIPANT LIVED IN THE VILLAGE				
ETHNIC TRIBE	**4 - 6 MONTHS**	**6 - 12 MONTHS**	**1 - 2 YEARS**	**OVER 2 YEARS**	**TOTAL**
Yao	-	-	-	6	**6**
Chewa	-	1	-	4	**5**
Tumbuka	-	-	-	6	**6**
TOTAL	**-**	**1**	**-**	**16**	**17**

Table 4.3 illustrates the years that the participants had lived in their villages. All the members of the Yao and Tumbuka tribes that were part of the current study had lived in their villages over a period of two years. Among the Chewa, four participants had lived in the village for more than two years. One participant had lived in the village for a period of less than twelve months. Of the participants, 89% had lived in the village for more than two years and 5% of participants had lived in the village for less than twelve months.

Table 4.4: Educational level of participants (N=17)

	PARTICIPANTS' EDUCATION LEVEL				
ETHNIC TRIBE	BELOW GR 10	GR 10 - 12	COLLEGE DIPLOMA	UNIVERSITY DEGREE OR HIGHER	TOTAL
Yao	-	5	-	1	**6**
Chewa	1	3	1	-	**5**
Tumbuka	-	2	4	-	**6**
TOTAL	**1**	**10**	**5**	**1**	**17**

Table 4.4 illustrates that one of the 17 participants' education level is below grade 10, ten participants completed grade 12 and have a Malawi School Certificate of Education (M.S.C.E) five of them have a three-year college diploma and one of the participants has a Master degree (University Degree or Higher).

4.3 FINDINGS FROM THE TUMBUKA GROUP

4.3.1 The Tumbuka group in Context

The group comprised six participants, five male and one female, who originate from the Northern region of Malawi; three participants originate from Mzimba district, two from Karonga district and one from Rumphi district. The participants' ages were from 30-65. Three of the participants have college diplomas and three of the participants have grade 12 (known as M.S.C.E.). Most of the participants had lived in a village for more than two years. When reflecting on the meaning of culture, Giddens (1990, p. 31; cited in Jere, 2009, p.52) states that "Culture consists of the values the members of a given group hold and the norms that they follow. Culture has a powerful influence over the lives of the people through the beliefs and practices that govern their daily behaviour and the conduct of life". According to the current study, all the participants (6 of 6) reported that culture is very meaningful among the Tumbuka tribe**.** Most of the participants mentioned that it is important because it preserves values and knowledge that can be transferred from adults to children. Furthermore, one participant reported

that *"culture creates dignity, it makes you who you are and it gives you values and principles. It also improves day-to- day lives"*. All participants (6 of 6) acknowledged that culture has both a good side and a bad side.

4.3.2 Significant cultural practices that contribute to HIV and AIDS infections

All the six respondents reported that there are a number of practices that are significant in the Tumbuka culture. These are the practice of wife inheritance known as *kuhara*, the practice of polygamy known as *mitala*, the practice of bride price known as *lobola* and the practice of initiation. They reported that all these practices to some extent have implications where HIV and AIDS are concerned.

4.3.2.1 Wife inheritance (*Kuhara*)

In Malawi, wife inheritance takes place amongst the Tumbukas. According to the current study, most respondents (4 of 6) reported that wife inheritance is not a practice of the past but that it is still practised among the Tumbukas in Malawi, in areas such as Mzimba and the Karonga district. In addition, the respondents reported that wife inheritance takes place when a woman's husband passes away. The husband's brother is asked to marry the widow. The participants reported that this practice serves a purpose, which is to avoid the widow and her children from becoming destitute. Furthermore, the participants reported that this practice is also conducted to ensure that the property of the late brother remains in the family because they do not want the widow to take the property with her once she leaves her husband's village. One participant mentioned that *"It is like if I am married, it comes a time when I am no longer there, then my younger brother will take over if I am gone. They don't force, but ask the brother to take responsibility of the widow. They go and make kids again; they are doing it even now. My father-in-law is into that, he took over his brother's wife, he has two wives now and I am sure he did not even go for an HIV test"*. This corresponds with the discussion that in many sub-Saharan African countries where wife inheritance is common, the husband's family asks the widow to choose one of the members of the husband's family as her husband. In most instances, it is the husband's brother who inherits the widow (Inugu & Karl, 2006).In many African countries the practice takes place for a number of reasons, such as to provide protection to the deceased's family and to ensure that the widow remains in the husband's family, since the *lobola* was paid.

Therefore it is viewed as normal that the wife should be inherited as an asset of the husband (Loosli, 2004).

Another participant mentioned that *"although culture does provide meaning in my life, sometimes it is not that good because of the old things that they continue to practise such as* kuhara*, you have to take someone else's wife and it is not safe"*. This is confirmed by Geubbles and Bowie (2006) who argue that compared to married people, divorced or widowed persons have an increased risk of being HIV positive according to the community study conducted in Karonga district, Malawi. It is argued that the increased prevalence in widowed people can be explained by the fact that their husbands had probably died of AIDS. Corresponding to this statement, it is reported that mostly widowed, divorced or separated women have the highest HIV infection in many countries in sub-Saharan Africa (UNAIDS Report, 2009).

It was clear from the data collected that most of the participants acknowledged that the practice of wife inheritance (*kuhara*) exists and they identified the significant value of the practice, regardless of the risk of HIV infection. One participant argued that there is value in the practice of *kuhara*. He stated *"in a practice such as* kuhara*, people feel that they are raising their brother's children with the wife; it is part of helping the widow, so they cannot stop it. However, practices such as* mitala *(polygamy) do not help at all, they are just stupid"*.

Furthermore, another participant mentioned that "*It happens when the brother dies and* "ngati kumwalira kwake kunalikooneka bwino" *(if the deceased did not display any signs of AIDS and the death looked well) and people in the villages were not suspicious, then you can marry the woman. Meaning when you die from AIDS you suffer for a long time, then you cannot marry the woman (widow) off as people are able to tell that it was AIDS. This means that if the death didn't look well then it is discouraged to marry the woman. If there is someone who still loves the woman and if he is willing, there are a lot of organisations and doctors who move from village to village to test, then the people can go for test if they want. But it is mainly up to the person marrying the woman to go for test or not. If he does not suspect then he lives it out. It is a personal choice and often people do not test. In most cases what they do is to see if the husband is sick or if he suffered for a long time"*.

This is confirmed by Geubbles and Bowie (2006) that in a study conducted among sex-workers (1990) in Dedza, Mchinji and Dowa districts in Malawi, nearly all participants were aware of HIV transmission, however, it was found that the participants (sex workers) identified the necessity of using a condom with the physical appearance of their male client. Similarly, Loosli (2004) argues that physical appearance determines whether a man or woman perceives the need to use a condom in Africa and Asia, where previous studies have been conducted.

It is well established that there is still a high chance of HIV infection regardless of whether or not the person has suffered for only a short time or whether or not he/she looks healthy, as long as the person is infected with the virus. The statement that *"only if the person that died did not display any signs of AIDS and did not suffer for a long time then they can marry"* is problematic. It clearly demonstrates the low levels of understanding among the villagers about HIV and AIDS, and this seems to be what puts them at risk of HIV infection, especially where this practice is concerned. It is well known that one cannot diagnose HIV by merely seeing the person and concluding whether a person is positive or not, without conducting the actual HIV test. Mwale (2008) argues that there is a mismatch between awareness of HIV and AIDS transmission and behavioural change in Malawi. Nyerges (2006, p.49) argues further that "individuals' lack of adequate understanding of HIV and AIDS is contrary to findings in the literature that suggest that high percentages of the population have the requisite knowledge about HIV and AIDS. This may suggest that individuals can regurgitate information provided, but do not really understand the message and fail to translate it into behavioural change".

Most of the participants (4 of 6) acknowledged that this practice puts people at risk of HIV infection, as most of them do not test for HIV. One participant stated that *"you inherit your brother's wife when you don't know what killed him and this is still practised because it is something that they have been practicing for a long time, regardless of being aware of the risk"*. This corresponds with findings from a study conducted by Ayikukwei, Ngare, Sidle, Ayuku and Baliddawa (2007) in Uganda, where a significant number of participants discussed that the use of condoms is mainly not acceptable in wife inheritance. The reasons given were that intercourse should be carried out the same way as it was done with the late husband, since the widow is taken as the wife of the brother. For this reason, the use of condoms was viewed as making the practice incomplete; it was viewed as cheating and against their tradition. Another refusal to use

condoms was because condoms were viewed as preventing procreation because the semen is discarded. By doing so it is viewed as getting rid of the baby. As demonstrated, this practice is not unique to the Tumbuka in Malawi. Therefore, the risk of infection exists in all areas where it is practised.

Inugu and Karl (2006) argue further that wife inheritance is among the cultural practices that are blamed for furthering the sexual transmission of HIV in a number of patriarchal societies in sub-Saharan Africa. For instance, it is considered by some that the highest rate of HIV in certain areas of Kenya can be put down to the fact that wife inheritance is popular in that area. Although such practices are favoured by some cultures, not all women are in favour of them. For most women, it becomes extremely difficult to challenge such practices in view of the fact that a widow can be isolated and can become an outcast in her community for refusing to be inherited (Ayikukwei et al., 2007).

In addition, a few participants (2 of 6) reported that such customs should be abolished. However, the participants acknowledged that it is a challenge to stop such practices when they are viewed as helping the widow and her children from becoming destitute. One participant stated that *"we do not want to stop. Why should we, we started this a long time ago, our elders, our parents did this so why should we stop"* another participant reported that *"elders actually say you should marry this woman with kids, you should support her, so you listen to them and do it because you do not want to disappoint them"*. Ayikukwei et al., (2007) confirm this statement by discussing that many cultural practices continue to be practised due to the expectations of family and community members. They argue further that refusal to follow cultural norms that members of the community are expected to, has a number of negative outcomes. For instance, it can lead to isolation on the part of the person refusing to follow the practice and families may stop interacting with one another, regardless of the implications it has for HIV transmission. It can be argued that given the ignorance that surrounds the link between HIV and AIDS and wife inheritance in some cultures, the continuing practice of wife inheritance has contributed to a number of lives being lost to HIV and AIDS.

Contrary to the statements made by most participants, two participants reported that cultural practice such as wife inheritance is not commonly practised among the Tumbukas in Malawi. They mentioned that such practice occurs in selective cases. Furthermore, they explained that

wife inheritance has declined because of the western and Christian values that most people have adopted. The respondents also attributed the decline of the practice to the awareness of the link with HIV infection. One participant stated that "*Wife inheritance is not common anymore because people move from villages to town; most of the people are becoming more and more educated, especially about HIV and AIDS*". The extent and rate to which such practice occurs is therefore not known (Scott, 2009).

4.3.2.2 Polygamy (*Mitala*)

Nyerges (2006, p. 44) describes polygamy as "a culturally determined, socially acceptable and legally recognised form of permanent marriage, where a man has more than one wife at a time". It is argued that in most polygamous cultures, having more than one wife is seen as a thing of pride, recognition, wealth, status and respect.

In the current study, all participants (6 of 6) confirmed that this practice is still common among the Tumbukas in Malawi in areas such as the Mzimba and Koronga districts. One participant stated that many of the men in his village have more than one wife and that other men have three wives. In addition, the participants reported that polygamy (*mitala*) serves a particular purpose which is bearing children, especially in cases where the first wife cannot have children. One participant reported that "*It is done because God says that a wife should bear children but sometimes it happens that the entire children die or the wife cannot bear the children. Then the man decides to marry another wife to see if he can have chance with that woman*". Furthermore, most participants (5 of 6) reported that this practice cannot stop because it has a lot of value for the Tumbukas, as discussed. These sentiments are also held by the Tonga of Zambia as discussed by Gauseet(2001) who sees the intrinsic value in the practice. The participants reported that people are still having more than one wife because of their culture, which gives them the privilege to take on another wife. The respondents reported that most of the Tumbukas who do not practise polygamy are mainly influenced by education and Christian values.

However, the participants acknowledged that it poses a challenge to abolish such practices as it is part of the culture. One of the respondents mentioned that even the church has recognised and accepted this practice as part of the Tumbuka culture. He reported that "*Even now in the church, things are changing. Previously in the Roman Catholic Church in Mzimba they never used to*

allow a person with a second wife to go to church and take part in church activities, but now they can all go and even join church organisations. The church even takes part at the funeral proceedings if one of them passed away. This was not the case before; they would refuse to take part at the funerals".

When it came to the link with HIV and AIDS, all respondents (6 of 6) acknowledged that polygamy has implications for HIV infection. The participants identified that the danger of getting infected exists because most people do not go for HIV tests for *mitala*. Struensee (2004) argues further that the drawback with such behaviour is that when one member of the family is infected or misbehaves, or if a man marries a woman who is HIV positive, then all the wives will be infected, since condoms are not used in such marriages. This practice also becomes risky if one wife is unfaithful and has extramarital affairs because the whole group is then at risk of becoming infected (Gauseet, 2001). Although it is unquestionable that there is a positive relationship between polygamy and HIV, it is important to note that the argument that HIV prevalence rates are higher among women and men in polygamous relationships compared to those in monogamous relationships is rather premature, as argued by Reiners and Tfaily (2008).This is so because in many countries with high HIV infection rates, the HIV prevalence is concentrated in urban areas where polygamy is not practised as much. For instance, in countries like Malawi, Swaziland, Zimbabwe and South Africa where HIV prevalence is high, polygamy is not practised at a high rate, especially in urban areas. In connection with this statement, 2 of 6 participants mentioned that there are two reasons why polygamy has declined in their areas. One is the fear of contracting HIV and AIDS infections and the other is that people do not have enough money to sustain many wives and children. One participant stated that *"people have realised that you need money to be a polygamist or to inherit someone's wife".*

4.3.2.3 Traditional Marriages

Most participants (4 of 6) acknowledged that marriage contributes to HIV infection due to infidelities that occur between some married partners and the lack of condom usage in marriages. Scott (2009) confirms this by explaining that in some parts of Africa, marriage itself is strongly perceived to be a risk factor for HIV infection. It is argued that most women cannot take preventative measures, for instance through condom usage, due to their culturally prescribed roles which prevent them from challenging or refusing their husbands for fear of violent

consequences or divorce. Nyerges (2006, p. 18) explains that in Zambia "a woman would be beaten if she told her husband to wear a condom. Women in long-term relationships are prevented from demanding condom usage or denying dry sex due to social norms". As a result, they continue to be infected and re-infected in the matrimonial home.

The situation is worse for those women who are financially dependent on their husbands for their survival. This results in many women enduring abusive relationships that put them in a vulnerable position where HIV infections are concerned (Nyerges, 2006). It is incontestable that most of the women in rural areas are economically dependent on their partners; hence it becomes difficult for them to question their husbands or to merely ask them to use protection, even though they are aware of their husbands' infidelities (Scott, 2009). Most participants expressed concern that poverty and financial dependency on the part of the rural women is contributing to HIV infection in marriages. This is confirmed by Saayman (1999) in Jere (2009)that the hierarchical and patriarchal structures embedded in the culture and traditions that govern African society place women in an inferior, voiceless and powerless position which contributes to them being vulnerable to exploitation by men. It is argued further that such structures limit women's rights and their ability to insist on the use of condoms during sex. This is what makes them vulnerable to the risk of HIV infection (Niehaus, 2007).

This is inconsistent with Scott (2009) who wrote that in Malawi, the condom is often considered an 'intruder' in marriage because it limits the natural sexual act that is linked with marriage. In most marriages when condoms are used, it is believed that the marriage is not a proper marriage. This is often the case because the use of condoms is associated with the issue of trust. Scott (2009) explains that in most marriages, requesting the use of condoms provokes suspicion that one party is infected or is being unfaithful, hence portraying a lack of trust in the relationship. It is in this light that condom usage is often discussed in terms of extramarital relations or casual relationships and not within marriages. It is clear that the lack of condom use in marriages where one party is unfaithful poses a high risk of HIV infection (Baylies & Bujra, 2001). This is congruent with what most participants reported. They discussed that it is often the case in marriages where people trust each other for one to get infected with HIV, if one party is unfaithful. The participants attributed the lack of condom use to the perceived trust that exists within such marriages. A number of the participants reported *"people are infected because they*

trust each other and they do not use condoms because they are married". This is in agreement with Loosli (2004), who argues that married or regular partners are more exposed to the risk of HIV infection than single people in Africa. It is argued that between 50% and 80% of all HIV infected women in Africa have had no sexual partners other than their husbands. For instance, according to Loosli (2004) a study conducted in Kigali, Rwanda, found that women with no other risk factor except from their long-term partner formed the largest proportion of women with HIV and AIDS.

Another participant attributed the infidelities that occur within marriages to the failure of husbands to take care of their wives. He reported that "*a woman leaves her parents because of me, I leave my parents because of her to get married and then I am her father and mother. I should be able to take care of her so if am not looking after my wife, then my wife can think 'what should I do', then she get a problem and that problem she gives to me, which is HIV. Then both of us, we are infected"*. Contrary to these statements, Struensee (2004) argues that in terms of sexual behaviour, being in a formal marriage is thought to reduce the probability of HIV infection. However, marriage may be a risk factor to infection in regions with high HIV prevalence. Most of the participants reported that the culture encourages early marriages among the young girls and boys. They mentioned that girl-children are groomed for marriage at a tender age and this is what puts them at risk of HIV infection once they get married, as they do not have the power to initiate safe sex.

4.3.2.4 Initiation ceremonies

Most participants reported that the Tumbukas, like many cultures in Malawi, send their children to initiation when they are close to adolescence. Most participants described the practice of initiation as the coming of age that teaches young girls and boys how to live as people, how to be cooperative and respectful. The participants mentioned that boys and girls as young as 8 -14 go to a special (secluded) place where they are taught about raising children, how to look after a family, knowledge of how to be a man or a woman, and sexual life. All participants reported that the practice is significant because it prepares the young boys and girls to become responsible adults and how to become good husbands and good wives. *One respondent stated that "You feel proud that you are a man, as a man you can be independent and do things on your own because as soon as you get home from initiation you are treated differently, you are now given*

responsibility. Even though you are as young as fourteen, you learn to be responsible, how to take care of yourself, to have mentality that you can stay on your own. Such sentiments are not only unique to Malawian tribes such as the Tumbukas but are also common in other African countries such as in Zambia. Jere (2009) explains that traditional initiation rites are significant because they represent the symbolic stages in a person's life, a transition from one stage to another which is celebrated with rituals. He argues further that the significance of the rite of passage is that it provides a platform for training young people in the skills of living a productive life in society.

However, most participants acknowledged the risk that initiation practices pose for HIV infection. Most of them expressed concern that initiation ceremonies encourage promiscuity. One participant explained that "*everyone feels that as a man I want to have a lady. That is the down side of it*". Another participant stated that *"I would not want my child to go for initiation because when you come from there you start feeling proud that you can do anything and this feeling is what makes one become promiscuous"*.

In addition, one of the participants mentioned that "*at the mountains they ask you to go to girls, they ask you to test the girls; they tell you to sleep with girls to prove your manhood. They tell you how will we know if you can make it or not or if you can make it as a husband. They do not teach you about HIV. All you are taught is how to be a man, for instance so that you should not be weak but you can make yourself strong sexually and how you can handle a lady, but no preventative measures for HIV"*.

Geubbles and Bowie (2006) confirm the above statement in a study that was conducted in Mulanje Malawi where girls were encouraged to practise sex after initiation to make sure that they will be good wives. He further argues that previous studies conducted estimated that over80% of women and 60% of men who had gone through initiation ceremonies are encouraged to undergo sexual cleansing after initiation. Although some of the respondents argue that such practices have decreased, Geubbles and Bowie (2006) argue that the degree to which harmful sexual practice still persists is not really well known. Furthermore, they argue that in many communities in Malawi, sex is seen as a cleansing agent that has the power to combat evil. Hence it puts people at risk of HIV infection.

Other participants reported that some practices have been modified to reduce the impact that such practices might have on HIV infection. One female participant reported that a lot has changed from the time her older siblings went for initiation to that of her time. She explained that she did not go to a secluded place for initiation but was just sent to her uncle's place after her first menstruation. The participant reported that she was taught by aunts about respecting elders, how to behave in marriage, for instance preparing food for the husband, dishing food for him and preparing a hot bath for him when he came from work. Furthermore, she was taught about how to please a husband in bed so that other women would not take him away from her. She reported that "*these days it's different; you do not have to go somewhere else to be given advice by people you do not even know. Like myself, I only went to my aunt's place and she taught me everything including sex things so that my man should not go to other women*". The researcher is of the opinion that what has changed is not the message itself, but the place where the initiation takes place and the involvement of family members in giving advice to the child, as opposed to a number of village elders who are not related to the child. The risk of influencing risky behaviour in the child that could lead to HIV infection and as argued by other respondents, still exists, as the initiates are continually taught about sex.

One of the six participants mentioned that the practice of circumcision takes place at initiation. However, this was not reported by the other participants. He reported that the practice of circumcision is a safe one. He attributed this to the fact that people are educated about the risk of HIV infection when using one razor blade, and the involvement of parents in educating their children about the risk. He explained that "there *is a lot of information about the risk of using one razor blade. Parents are aware about this and they make sure that their children take their own blades when going for initiation. Even the children themselves are aware, so there is no risk anymore when it comes to circumcision.* Special sharp knives are used to do the cutting and one or two knives can be used to cut many boys; this is where fear of contracting the HIV virus can be possible because no one knows the status of each child involved (Auvert, Buve & Lagade, 2001).

4.3.2.5 Bride price (*Lobola*)

"In a typical African setting, bride price consists of a contract where marital items such as cows or money are paid by the groom to the bride's father in exchange for the bride, her labour and her

reproductive capacity" (Struensse, 2004, p.133). All the participants (6 of 6) recognised *lobola* as one of the most significant practices among the Tumbukas in Malawi. They reported that *lobola* plays a significant part in Tumbuka marriages, as it makes the marriage a respected one. The participants mentioned that it conveys gratitude to the parents of the bride-to-be for raising their daughter well. Furthermore, they argued that *lobola* helps to bind the marriage together. One participant reported that couples cannot just break up because a lot of people (such as uncles) are involved.

In addition, most participants (5 of 6) reported that poverty has influenced a number of parents who practice *lobola* in rural areas to encourage their children to be married at a young age. They argued that this is one of the down-sides of bride price. One participant stated *"because of poverty, people want to leave home early for better opportunities and this is through their husbands, however, they do not test each other for HIV*". Another participant mentioned that "*lobola, although it is a traditional practice, it is like* kugulisana *(selling). You have paid for something, now it is yours"*. Furthermore, they explained that *"the down-side of this practice is that parents, especially in poverty stricken areas, take advantage to sell their girls"*. One participant argued that *"most of the time if a man is poor and he wants to marry your daughter, you can refuse because he is not able to pay the money that you have charged him and if someone richer comes along you will accept him because he is able to pay. It has become so expensive. There are different charges for those who have been to university, those who have not been, those who have babies and those who do not have, which shows that it has become like a business"*. This is also confirmed by a study conducted by Libindo (2004;cited in Reiners & Tfaily,2008) which explains that early marriages take place in Uganda and Ghana, where destitute widows find themselves searching for husbands for their young girls so that they can acquire the bride price of cattle.

Although all participants acknowledged the significance of the practice, most of them were concerned that the practice makes husbands take advantage of their wives because they feel that they paid for them, therefore they own them. One participant (1 of 6) stated that in most cases "*they say 'I paid for you, you are mine, you must do as I say'. They can even beat the woman"*. It is in light of this that the Domestic Bill of Uganda, according to Struensee (2004) is advocating the abolishment of the bride price. It argues that the bride price is a major contributing factor to

violence and abuse in the home as it gives the husband proprietary rights over his wife, allowing him to treat her like his possession. It is argued further that the bride price undermines a woman's status since a woman's status in marriage is measured by the amount of bride price exchanged and not by her capacity and skills and abilities.

Most of the participants linked the practice to promoting risky behaviour that can promote HIV infections. The participants argued that the relationship between the practice of *lobola* and HIV is that it encourages promiscuous behaviour among men because such behaviour is condoned in marriages. Most of the participants (4 of 6) explained that if the wife leaves the husband because of his infidelities and goes to her parent's house, her parents could send her back for fear of being embarrassed when the man's family asks them to give back the *lobola*. This is confirmed by Struensee (2004) that if a bride wants a divorce, the money or items that were paid for her must be paid back or returned to the husband. In cases where the wife's family is unable to pay the husband, the wife cannot get a divorce.

The participants reported that the bride price is often favoured because it is often a matter of pride for the woman's family when their daughter gets married in the right way, and often it is known in the village that their daughter had been married properly. The participants reported that it therefore, poses a challenge for the parents to welcome back their daughter, as this would be an embarrassment to them in the village that her marriage failed. As a result, most of the women are encouraged to overlook the infidelities and go on with their lives. Furthermore, one participant reported that *"this practice makes people feel that they cannot go back home. If their husbands paid* lobola, *how can they go back?"* Participants (4 of 6) argued further that this practice is burdensome on the women concerned because they live in marriages where they are unhappy but continue to stay because the husband paid *lobola* for them. Another participant stated that "*in rural areas they take it as a business. 'I sold my child, I have been given something so I cannot return it' and as a result the women continue staying in such marriages and can be infected with HIV*". Struensee (2004) argues that the bride price is therefore a key to domestic violence issues as the woman is trapped in a marriage that puts her at risk of HIV infection until she is able to pay back the bride price. For a poor African woman living in a rural area, paying back might be something that could never happen.

4.3.2.6 Culture, Christianity and Education

Most participants reported that education and Christianity make a difference when it comes to cultural practices. One participant stated that *"I used to follow most cultural practices, but since I became educated and learned about Christianity, I decided to stop. I am no longer doing that although I did go to the mountains for initiation"*. One participant stated *"as Christians, it is impossible to follow such stuff. Behaviour changes once you truly know God. Christianity is the only answer that can solve such problems. Even the old people, if they can understand who exactly they are, where they come from and what makes them be as they are, it can be so easy to understand that what were are doing is wrong-for instance the practice of* mitala*"*. Nyerges (2006) argues that the daily function of traditional Africans is fundamentally a religious function and religion influences all levels of their lives.

One participant explained that Christianity has led to the dropping of some of the cultural practices such as *mitala* and *kuhara*. He stated *"Christianity states 'one wife for one man' however, not all understand the bible this way, and others understand the bible differently*". Furthermore, a few respondents reported that the church has affirmed the significance of cultural practices and it has decided to include them instead of excluding them. The respondent reported that "*Christianity is allowing people to have their own culture as it is aware that people value their culture"*.

One participant stated "*Priests invite elders in the villages to learn about their culture and ask people who have been married for a long time in the villages how they have managed to stay together for such a long period, and they are able to tell and teach other"*. Most participants recognised that people combine culture and Christianity. Another participant mentioned that the Catholic Church in Mzimba district where he comes from "*has allowed people who are part of polygamous marriages to take part in church activities, which did not happen before"*.

4.3.2.7 High Prevalence Rate in Malawi

Most participants reported that HIV infections continue to increase in Malawi despite the knowledge of the link between cultural practice and HIV and AIDS. The participants identified a number of factors that play a role in increasing the infection such as poverty, high unemployment and strong cultural beliefs that make people resistant to change. One participant mentioned that

"cultural practices are contributing to an extent to HIV and AIDS. When it comes to HIV you are advised that you have got to stick to one wife or one husband, to have more than one partner is risky and not reasonable. Polygamy and wife inheritance is therefore risky behaviour as they can contribute to HIV infection". It can be argued that people continue to value and practice such cultural practices because they fear that they may encounter misfortune and illness if certain cultural norms are violated and if they do not follow their elders (Jere, 2009).

All respondents expressed concern at the high unemployment rate among the youth which is viewed as contributing to risky behaviour. One respondent from the Mzimba district stated that most of the youth in rural areas are sitting at home doing nothing and this is what contributes to high risk behaviour. He further argued "*the youth of today are doing things their own way and HIV is increasing because of their carelessness"*. This corresponds with a study conducted in the copperbelt in Zambia (Nyerges, 2006). It was viewed that continued unemployment in the area had increased the tendency of young people to seek immediate gratification. According to the findings of the study, it was concluded that individuals who have no real hope of future prosperity feel that there is no reason to practise safe sex.

Most participants identified the lack of education among the population in rural areas as contributing to HIV infections, especially where cultural practices are concerned. One participant stated that "*HIV is high in Malawi especially in rural areas because people still follow cultural practices of their parents that put them at risk for infection, such as* kuhara, mitala *and initiation"*. Mwale (2008, p.298)confirms that "another reason for the contradiction between knowledge of HIV and AIDS transmission and preventative dynamics and risk-aversion with subsequent behavioural change as unveiled by the study, is the fact that AIDS messages are wholly or partly disbelieved". According to the study by Mwale (2008) the respondents mentioned that AIDS is not real; other respondents claimed that there are already cures and/or there is the tendency of the western media to exaggerate the dangers and implications of HIV.

In addition, another participant reported that "*When I went home in November 2010, I was shocked to see how kids are being pushed to do things that are wrong. A 13 year old was married to a 17 year old boy. The parents could not say anything and they accepted it because they love each other and because in the olden days it used to happen. But by parents allowing such it is dangerous. If a 17 year old and a 13 year old marry, what do you think will be in the*

man's heart when he is becoming a man at 24, 26, and 30? Is he still going to be with the same lady, no he will be involved with other women". Furthermore, another participant reported that culture is allowing people to get married at a young age just because parents want the *lobola* and in most instances they do not test for HIV.

All participants (6 of 6) reported that HIV continues to increase despite the knowledge of how one can get infected, because people do not use condoms. One participant stated "*when it comes to using condoms, people are still blind. We say that I am tired of that, I cannot eat a sweet in a paper*." Scott(2009) argues that such reluctance to use condoms, where men prefer the feeling of natural sex and getting what is known as maximum pleasure (cannot eat the sweet in the paper) is resulting in failure to change behaviour. Another participant argued further that "*a lot of people are ignorant. They say 'I cannot use a condom; I cannot eat a sweet in a paper'. Or 'if I find myself positive, I don't want to use a condom because I am already infected'. 'Sweet in a paper' is part of carelessness. People have this feeling of invincibility. They feel that it cannot happen to them. Some don't believe in HIV. My friend says 'why should I use a condom,* kulibe *AIDS' (there's no AIDS) he is very promiscuous and I am sure he is positive"*. Mwale (2008) confirms the statement in a study conducted, as he argues that acceptance of death and the culture of silence is contributing to a lack of change of behaviour, regardless of the knowledge about HIV and AIDS transmission. In the study conducted by Mwale (2008) in Zomba, Malawi, it was found that most of the people interviewed (65%) reported that death is inevitable and that people can die from an accident or any other disease and not just from AIDS, hence they did not see the need to fear AIDS. Of the participants in that study, 55% believed that there is little evidence of the existence of HIV and AIDS and they claimed AIDS is just a Eurocentric endeavour to discourage sexual intercourse.

In addition, most participants reported that HIV is increasing because the youth are getting sexually involved at a younger age and they get themselves involved with a number of partners. One participant argued that "*once people sleep with a girl more than twice, they feel that they know the person and they stop using condoms*". Additionally, most of the participants (5 of 6) reported that HIV is still high because of infidelity among partners which is putting them at risk of HIV infection. Geubbles and Bowie (2006) explain that the risk of HIV increases with a higher number of sexual partners, especially if the partners are from a high risk group such as bar

girls. In addition, societal norms enable Malawian men to engage in multiple sexual relationships, either formally in polygamist unions, or informally through extramarital sex. However, women are represented as being ideally faithful. This corresponds with Nyerges (2006,p.18) on previous studies conducted in Zambia that "most Zambian men perceive manhood in terms of multiple sexual relationships as a way of reinforcing traditional beliefs that men must be sexually vigorous and demonstrate virility".

One respondent reported that "*previously when one got married to a wife, one was sure that the wife would not go anywhere else, but it is not the case these days. These days' people are found with HIV because the way our elders used to live has changed. These days if the husband does not have money, the wife can go somewhere else"*. They argued further that HIV is increasing because of eroding cultural values. They expressed concern that the youth has adopted the modern culture, they live differently and that they do not listen anymore to the elders. One participant from the Mzimba district mentioned that "the *culture of villagers has changed, especially among the youth. In Mzimba these days, people are brewing their own wine. These days everyone is drinking, even women. The young are not focused on how they should live anymore. Men and women are not being faithful. Boys are just drinking alcohol without looking for jobs. As a result, HIV is high. There is nothing to help women, the men leave as early as 5 a.m. and come back at 9 p.m. and they never stop drinking. Women are left with no choice but to get involved with other men. For instance in my village the T.A. (Traditional Authority)had to get involved and banned the making of wine because someone was killed in the area where the wine was being brewed*". This is confirmed by the study conducted by Nyerges (2006) in the copperbelt in Zambia. The study concluded that alcohol abuse was one of the obstacles to behavioural change. Loosli (2004) describes that in many African villages people have facilitated access to alcohol and light drugs. Alcohol brewing has become an income generating activity in many African villages which has contributed to people abusing its consumption. Previous studies have shown a link between substance abuse and unsafe sex. Substance effects may induce cognitive release which in turn leads to risky behavior (Loosli, 2004).

One participant (1 of 6) reported *"a lot of men do not get satisfied with their partners. They always want to sleep with other women"*. Another participant stated *"sometimes you work in Johannesburg like me, while your wife is in Malawi, I don't know what is happening there and I*

can be infected". Further, the belief that males cannot have one partner is consistent with the views of Mitsunaga, Powell, Nathan, Heard and Larsen (2005) who argue that the belief that males are biologically programmed to need sexual relations with more than one woman is widespread, perhaps universal, across all sub-Saharan African cultures and held strongly by women, as having several partners is seen as a sign of masculinity.

Besides the factors already discussed, two participants identified prostitution as a contributing factor to the increase in the HIV infection rate in Malawi. Geubbles and Bowie (2006) confirm that prostitution is illegal in Malawi but that commercial sex is widespread in the form of food handlers, bar girls and cleaners offering sex in rest houses and bars. It is a fact that some women depend on commercial sex for their livelihood and they are often disadvantaged and socially stigmatised in many countries, including Malawi. This, together with high sexual partner turnover renders them at risk of HIV infection, which contributes to them being an important group in HIV and AIDS transmission.

In Malawi, as in many African countries, some girls get involved in sexual relationships with older men known as 'sugar daddies' who obtain sexual favours from girls in exchange for money, clothes and other gifts, as stated by participants. Loosli (2004) explains that in Kisumu, Kenya, girls' between15 and 19 years were infected by HIV. It is therefore undeniable that transactional sex is one of the reasons for this high HIV rate in many countries, given that the youth culture is strong and that in some cases older men prefer to have sex with young girls (Scott, 2009). In light of this statement, the participants reported that poverty is contributing to high risk behaviour such as prostitution and that young people are being involved in prostitution. One participant argued *"young girls are selling themselves. Most clubs have under-age prostitutes and such clubs are making money through them. People have lost their culture because of poverty and this is what is increasing HIV infection"*, was mentioned by another participant. This statement also confirms findings documented by research done in Mwale (2008) that obstacles to behavioural change as identified in the study were the adherence to the present sexual culture among adolescents, the refusal of leaders to recognise and come to terms with the situation, the acceptance and attitude towards death and the limited number of relationships in which condoms are acceptable.

4.3.2.8 Awareness of the Link between HIV and AIDS and Cultural Practice

Most participants mentioned that people are aware of how HIV is transmitted, but most of them do not want to change their behaviour. One participant mentioned *"there are groups in my village that give out condoms, they teach people about AIDS but people take condoms and don't use them. Most of them say that they cannot eat a sweet with a plastic outside. So although the education is there, many people make the personal choice not to use condoms"*. Another participant stated *"there are tribes in Malawi with strong cultural practices and I don't see the day that such practices will come to an end. Some customs in villages will go on for a long time, regardless. People are very passionate about their culture; they do not want to change"*.

Furthermore, most participants established that the challenge in understanding the link lies in the lack of education among a number of villagers. One participant stated *"people are not aware of the risks, especially the illiterate. Moreover, people with no education are scornful of any advice that goes against polygamy or wife inheritance. This lack of awareness and the low levels of understanding have made others go to the extent of saying AIDS is just like any other disease, it is just like cancer, or it's no worse than cancer"*.

One of the participants reported that the people who are in charge of HIV campaigns also contribute to the reluctance and unwillingness of people to change their risky behaviour. He stated *"Most of these people are well known in the village for their promiscuous behaviour and then they come and teach people to abstain. No one is willing to listen; they say what can they tell us'? People feel that they are losing what is nice when they are told to use condoms, so they do not listen."* One participant mentioned that the young people in his village are destroyed.

Another participant reported *"the erosion of cultural, values is visible in my village since things that never used to happen are now happening and putting people at risk for HIV infection"*. He explained that in his village, married women come from the neighboring villages and ask for friends to dance with at night and this leads to sexual encounters which put them at risk of HIV infection.

In addition, one of the participants reported *"people are aware that* kuhara *can cause AIDS since there is sex education in the villages. In my village there is adult education where elders are educated about HIV. This is called* school ya Kwacha. *However, people see value in their*

culture, they see that it has meaning and they would rather continue than stop". One participant reported on the significance of *kuhara,* which is to assist the widow and her children. He mentioned "*It would be difficult to abolish such a practice that is viewed as assisting the poor, otherwise who would assist them?*" Another participant stated "*70% of people stick to their culture but 30% do understand"*. The participants identified this gap as being contributed by the poor levels of education among a number of people in rural Malawi who are often illiterate.

Furthermore, one participant reported that all cultures in Malawi are aware of the link of cultural practice to HIV infection, however they continue with most of the practices regardless of the risk. The participant expressed concern with the practice of *fisi* (hyena) which he reported as taking place across all cultures in Malawi. He reported "*the practice of* fisi *is still happening in many areas in Malawi where they get someone to make a child for the husband and wife if they cannot bear children. In most cases the man is given permission to sleep with the wife and the man is paid a cow"*. This practice is not unique to Malawians. Nyerges (2006) argues that this practice takes place amongst the Senga people of Zambia. When a husband is impotent they allow another member of the family to make children for him. It can be argued that the wife can be infected if this man is positive, and she can in turn infect the husband.

Similarly, amongst the Ngonies and Tumbukas of Zambia, if a man cannot have a child, a *fisi* (hyena) is introduced to sleep with his wife until she conceives. In cases where the *fisi* cannot make her pregnant special arrangements are made for another *fisi* to produce on the husband's behalf (Jere, 2009).It is argued that by having unprotected sex without knowing the HIV status of both the *fisi* and the married woman, either of them could be infected. What's more, the participant in the current study reported that this is an expensive practice because a human being is being created. He also reported that this practice is contributing to HIV transmission and it still exists across all tribes in Malawi. In relation to the statements above, all the respondents acknowledged the lack of education and knowledge and the strong cultural beliefs that are contributing to the continuous practising of cultural practices that promote high risk behaviour for HIV infection, at the same time as contributing to people's resistance to change.

Besides the statement discussed by other participants, one respondent reported "*people are aware of the link between cultural practice and HIV and AIDS and they have put things in place to prevent people from being infected"*. The participant stated *"in the case of* mitala *or* kuhara,

the elders observe the young ones and how they live. Let's say if I get infected in Jo'burg people will know that I am not okay and if other people want my wife, they tell you that you cannot marry the wife, which the husband passed away from AIDS. But sometimes anthu amati ndizaboza *(people say it is all lies) then they marry that person and get infected. It is mainly a personal choice when it comes to such practice".* It is evident from this statement that the level of understanding of HIV and AIDS transmission is limited. This is confirmed by a study done by Loosli (2004) in Ghana, which demonstrated that regardless of the HIV prevalence being high, HIV prevention campaigns had not achieved the desired results due to apathy and disbelief about the existence of the disease. It is argued that for such people, it becomes a challenge to encourage them to change risky behaviour when they do not believe about the existence of the virus. Similarly, studies have indicated that a majority of the Zambian population is well informed about HIV transmission, although no behaviour change seems to be occurring (Nyerges, 2006).

One participant mentioned that it is due to strong cultural beliefs on the part of parents and elders that HIV infection continues to be high. The participant further explained "*In most cases children are forced by their elders and parents to continue some cultural practices, such as wife inheritance. For instance, during wife inheritance they will tell you 'who will look after the kids, the woman is poor, she cannot take care of herself' so because of culture people respect their elders, then they marry that woman in fear of displeasing the parents and the elders and as a result, they can get infected".*

One participant reported that *"everyone is aware about AIDS. People have seen others die of AIDS, but they say people are dying from many diseases and not just from AIDS, and most of them are linking AIDS to witchcraft".* Overall, most participants linked the lack of education, lack of Christian values and strong cultural beliefs as encouraging people to continue with the high risk behaviour that puts people at risk of infection, therefore leading to an increase in HIV infection in Malawi.

4.3.2.9 Witchcraft

Pelto and Pelto (2005) explain that all people, whether bio-medically trained professionals or rural villagers, have cultural belief systems about the causes of illness and their remedial

measures. It is argued that in many African countries, death or sickness is often associated with witchcraft or that the living dead (ancestors) are not happy with something which was not done accordingly. Most traditional Africans believe that one has been bewitched if one is suffering from AIDS (Van Dyk, 2008). It is argued that many people do not believe that the disease exits, such as a number of people in Nigeria who often attribute AIDS to witchcraft or a curse (Loosli, 2004). This situation also exists in Malawi, as reported by participants. It is undeniable that cultural beliefs about the causes of HIV and AIDS have an effect on sexual behaviour choices and the way that people measure or perceive their risk of HIV infection. Since many cultures believe that AIDS is caused by witchcraft, safe sex is not viewed as necessary, nor is it perceived as appropriate against HIV and AIDS(Scott, 2009).By attributing the illness to witchcraft, it becomes a challenge to motivate people to change their behaviour (Gauseet, 2001). Such beliefs therefore, have negative implications for HIV prevention programmes, education and counseling. It is argued that they are obstacles to a good understanding of how the virus is spread, which is significant if people are to change their behaviour (Peltzer et al., 2006). This not only has implications for sexual behaviour but also for the person who takes care of the sick person. Often caregivers, especially mothers of the sick young people, have contracted HIV from being in contact with infected blood and other bodily fluids. A widower or widow can remarry without being concerned about his or her HIV status simply because they feel that their deceased partner did not die from AIDS, but was bewitched (Green, 1994).

This was confirmed by most participants who acknowledged that one of the challenges to curbing HIV infection in rural areas exists because of this reason. Most participants acknowledged that many villagers conduct sessions with witchdoctors when they are sick to find the cause of the illness, and most of the time the witchdoctors will confirm that they have been bewitched for a number of reasons, such as jealousy on the part of the person who bewitched them. One participant reported "*many people who are sick do not accept that they have AIDS but they say someone has bewitched them*". This situation is not unique to Malawi. For instance, Peltzer et al. (2006) found that around 40% of rural South Africans consult traditional healers. Traditional healers often give advice, medicine, provide support, and in most cases give information on the cause of the disease, which is often an identifiable individual.

The researcher was able to identity throughout the interviews that one of the reasons that have contributed to high HIV prevalence in Malawi is the lack of understanding among some people about how HIV is transmitted. This was evident during the current study by the manner in which some participants themselves responded to the questions. One participant reported "*witch doctors will tell you if you have a girlfriend or if your wife is sick, not to eat a four-legged animal and then you forget and eat, and then you can become infected. Sometimes you are given* mankhwala a u temwa *(traditional medicine for love) and if you forget taking them and you meet a woman, you will get infected and you will not be protected from AIDS"*.

4.3.2.10 Programmes that link to culture

Most of the participants mentioned that there are a number of programmes on HIV and AIDS which are broadcast in all languages in Malawi on radio and television. In addition, the participants mentioned that there are programmes which are targeted at villages. Such programmes focus on HIV and AIDS and advising people on how to prevent contracting the virus. The participants (4 of 6) reported that other programmes exist that focus on cultural practices. Most of these programmes campaign against practices such as polygamy, wife inheritance, and encourage people to go for HIV testing in hospitals or clinics. One participant mentioned "these *programmes are not successful because people are scared of it being known to others that they are positive. HIV carries a lot of stigma in Malawi"*. According to the participant, this is what contributes to people not wanting to test, for fear of being found positive, because once it is known in the community, they can be stigmatised. One participant mentioned "*A lot of people who work in the clinics are part of the small village community and if they know one's status, there is a high chance that they can reveal it to others and this is what people fear the most. As a result, they do not go to be tested and they can infect others innocently*".

In addition, four of six participants mentioned that the government is involved in a lot of HIV and AIDS campaigns and education. One of the participants stated *"Any meeting, whether presidential or anything, does not start before people talk about AIDS, condoms or how to prevent it. However most of the talks about AIDS are general and they do not link to cultural practices alone"*. The participants explained that these campaigns encourage people to stop risky behaviour. Furthermore, one participant reported *"programmes fail because of lack of man-*

power on the part of government, lack of resources to put out a full campaign and the people themselves are not willing to be part of the campaigns'.

One participant was concerned with the lack of leadership among the people involved in HIV awareness campaigns. He *explained "people understand what they are supposed to do in order to prevent HIV infection,, however, the people that are part of these educational campaigns do not lead by example and this is what contributes to the failure of such programmes*".In addition, he reported "*my aunt who teaches about HIV and AIDS is well known in the village, they know how she moves, they know her full story, if you are a leader and tell people don't do this and they can see you are doing it they say 'what he is telling us'? So this does not work because people live in the same area and they know each other. It would be better for someone from another area to come and teach because then people can understand and listen.*

Other participants assigned the failure of programmes to the lack of sponsorship to conduct them. Most participants gave examples of some programmes that exist which are aimed at the youth to prevent them from indulging in risky behaviour, such as sporting activities. The participants expressed concern that there is usually poor attendance when it comes to these programmes because of lack of funding. One participant stated "*the children feel that they would rather stay at home since they do not get anything in terms of money, food or clothing"*. It was identified by the participants that it becomes a challenge to motivate such children to attend without any sponsorship. One participant reported *"because of lack of sponsorship, people do not attend such programmes because they feel there is no benefit and others do not see why they should attend any HIV and AIDS programmes. They say 'why should I go, AIDS is just like any other disease, it is not only me, why should I prevent it, we are all dying anyway'. Other people say 'if I am found with HIV I will accept it, I will not find any problem, and I will die just like anyone else'. As a result, people do not see the need to attend HIV and AIDS programmes"*.

Another participant discussed civic education as one of the HIV and AIDS educational programmes that exists in his village. He reported "*a lot of people go to rural areas to give civic education for the youth and elders. They make groups, have dances and youth clubs however, most of these programmes are not successful because husbands command their wives to stay home. They say 'do not go there' and the wives will stay home, so if you talk about ten people, and seven husbands say 'don't go' then only three women will show up and as a result, such*

programmes collapse. Loosli (2004) explains that it is important to gather both men and women to discuss HIV and AIDS issues and to encourage them to test together in order to adopt best sexual practice. In most cases in Africa, it is the men who usually bring the virus home and they are the ones who often refuse to use condoms in their relationships, as the women are often powerless to speak up on such matters. Hence their involvement in HIV and AIDS campaigns is crucial (Nyerges, 2006).

Most of the participants mentioned that lack of education among the rural people in Malawi also contributes to the failure of programmes. One participant mentioned *"people do not understand the extent to which their cultural beliefs are contributing to HIV infection, regardless of educational programmes, because they did not go to school. When the educators speak against some cultural practice that put people at risk for HIV infections, they tend to feel offended that the people are disrespecting their culture"*. Another respondent reported "*people feel that they are saying bad things about their culture because they are poor, as a result they get angry and stop going to attend the meetings. They are resistant to any message that speaks against their culture"*.

4.3.2.11 How Cultural Practice can be used as a way of reducing HIV infection

Most respondents (5 of 6) acknowledged that it is impossible to abolish cultural practice as it plays a significant part in the lives of the Tumbuka. The respondents reported that instead of abolishing cultural practice, alternative ways should be found to ensure that such practice is conducted in a way that does not pose a risk of HIV infection on the part of the people involved. One respondent suggested "people *should be encouraged to test for HIV before they get married, whether it is within a polygamist union, an ordinary marriage or wife inheritance"*.

Furthermore, the respondents argued that the communities should utilise influential people (especially those who are well educated on HIV and AIDS and culture) from outside their community to conduct educational campaigns around the topic. The participants mentioned that this would have more impact, especially where attendance is concerned, as people would listen to them. In addition, one participant argued *"in many cultures in Malawi, village elders are respected because they have lived for a long time; therefore they are viewed as wise and well-educated on cultural practice, beliefs and customs"*. The participant suggested that elders can be

used to speak to the young people about HIV because they will listen to them. This is confirmed by Scott (2009) that preventative programmes should try to make sexual behaviour safer in ways that are culturally appropriate to people. It is important to understand the cultural context and situational context before a programme can be planned and implemented because the cultural influence on behaviour and its influence on barriers to prevention must be understood in order for the intervention to be successful.

One participant, an elderly man himself, reported that *"elderly people must do what our ancestors did on virginity testing. In my tribal custom every young woman had to be examined the day before marriage to check if she was still a virgin, and especially the parents of the husband-to-be had to know that their son was marrying a virgin. This encouraged abstinence. Elderly people should therefore force people to abstain. They must insist that young women should go for virginity testing so that they should wait until they are married before they can be involved sexually. Young people should also be taught Christian values"*. The researcher is of the opinion that this statement is problematic since only girls are encouraged to abstain while the boys are not. Therefore, it will still pose a challenge to limit the infection. It would be beneficial to encourage both girls and boys to abstain in order to curb HIV infection.

4.3.2.12 Interventions that can be introduced to curb the HIV transmission

Most participants (4 of 6) acknowledged that a number of intervention programmes still need to be conducted, especially for the youth, in order to reduce HIV infection. One participant reported *"I have already started getting the young people in my village busy by introducing them to the church activities such as singing in the church choir. I feel that keeping them busy in the church will distract them from being committed to behaviour that puts them at risk"*. The participant reported that he bought musical instruments to ensure that the youth continues being interested in the choir. He stated that *"it is good to teach them about how it is important to have God and to behave as Christians and not to misbehave with their bodies. It is also important to distract them from early marriages because the youth marry at these ages because they have nothing to do"*. Two participants recommended that young people should be assisted to start small income generating activities such as gardening projects where they can sell their produce, as a way of assisting them to become self-reliant and to prevent them from being involved in risky behaviour.

In addition, three respondents suggested that the government should be involved in introducing more interesting programmes such as plays and drama, where they talk about the link between cultural practice and HIV and AIDS, as this would encourage people to attend in high numbers. This is confirmed by the study done by Gauseet (2001) which revealed that there was an increase in the use of condoms in the areas which had been toured by drama groups, yet this change did not occur in the two areas where only the normal state intervention of training community health workers had taken place. Many did not change their behaviour or increase condom usage. It is argued that drama groups provided information that was culturally acceptable to the audience; they used the vernacular speech, a popular and more interactive form of education, and involved the audiences in discussion at the end.

Furthermore, other participants suggested "parents *and elders should be part of the educational effort so that they are empowered to educate the children about behaviour that puts them at risk, since most of the time the parents do not talk about sex with their children"*. In addition, four participants recommended that civic education should be encouraged as opposed to the distribution of magazines and pamphlets, as these do not work in communities where a large percentage of the population is illiterate. In most cases the magazines or pamphlets are often thrown away. The participants identified the significance of talking to people as the effective way of getting the message heard.

One participant concluded that the government should be encouraged to set up centers in every village with people knowledgeable about AIDS, to teach villagers about it. He stated that "*people must fully understand. At present, not all understand. The people must be made to understand the importance of the campaign, elderly people must also be involved in order to assist, as people tend to listen to them in villages and they must work hand in hand with government"*.

4.3.2.13 Summary

The participants identified a number of cultural practices in the Tumbuka tribe that may put people at risk of infection. These included the practice of wife inheritance, polygamy, bride price, traditional marriages and initiation ceremonies. They mentioned that often people follow such practices without testing for HIV, which puts them at risk of infection. A number of factors were identified as accelerating the spread of HIV in Malawi which included lack of condom use,

cultural practice, lack of education and lack of values among the youth that is promoting risky behaviour and limiting behavioural change. Participants recommended that government should be involved with village elders in teaching people about the link between cultural practice and HIV transmission and to create programmes that are more interesting and culture-specific, such as drama, to encourage attendance and to ensure that people are able to receive information that leads to behavioural change

4.4. FINDINGS FROM THE YAO GROUP

4.4.1 The Yao group in Context

The group comprised six participants, five male and one female, who originate from the southern region of Malawi. Five of the participants come from the Mangochi district, one participant from the Machinga district. Most of the participants (4 of 6) were between the ages of 30-35. Two participants were between the ages of 36-40. When it comes to the level of education, one of the participants has a Master degree (MBA) and five of the participants hold a Malawi school certificate of education (known as M.S.C.E) which is the equivalent of grade 12 in South Africa. All the participants lived in their villages for a period of more than two years. When discussing the meaning of culture, all the participants (6 of 6) acknowledged the significant meaning that culture has in their lives. Most of the participants reported that culture is very important to them because it teaches them how to live with others, how to have respect for other people and it teaches them values which assist them in their day-to-day living. One of the participants stated "*Culture is significant in my life because everything that I do revolves around culture, from a personal perspective, social perspective and my everyday livelihood"*.

4.4.2 Significant cultural practices that contribute to HIV and AIDS infection

All participants identified the significant Yao culture practices that might contribute to HIV and AIDS infections among the Yao. The participants mentioned the practices that are significant in the Yao culture. These include the practice of initiation which is conducted when girls and boys reach puberty, the practices that are conducted when a mother gives birth, known as *chisamba*, and the practices that are conducted when one is getting married, and at death. The participants reported that these practices are still being practised today among the Yao in Malawi.

4.4.2.1 Initiation ceremonies

"Puberty is the great transition between childhood and physical maturity and is therefore an occasion for considerable ritual. The essential principle throughout is to make the child into an adult, a full person, and to introduce him or her to sex life" (Parriander 1981; cited in Jere, 2009 p. 78). At this stage the individuals in most African cultures are given instruction that emphasises the person's responsibility to preserve and enhance his or her life and that of the entire clan. The participants identified this stage of puberty with the initiation ceremonies that occur between young girls and boys in the Yao culture. All participants mentioned that boys go to male initiation (known as *jando*) at a young age of nine to ten years old. The participants mentioned that girls go to female initiation (known as *msondo*) as young as seven to thirteen years old. One of the participants stated that "*The Yao go to the mountains for initiation. The boy's initiation, known as* jando, *starts at around ten years old. Boys go to the mountains for one month where they are taught to respect elders, parents and old people, and they are encouraged to go to church (mosque) since 98% of us are Muslims. Women go to* msondo *where they are taught how to respect elders, they are taught not to go to their parents' bedrooms, how to respect and to treat their husbands and how to practise sex. When you come back you've learnt something. You learn how to relate to the world and to people*".

In addition, all participants mentioned that after the *jando* (circumcision) the boys are considered grownup and they can no longer play with boys of their age if they have not also been to initiation. Similarly, the women are considered grownup once they have been to *msondo* and "*they can equally be wives and be married at this age",* as explained by one participant. Such sentiments are shared with other African countries. For instance, two major tribes of Zambia (the Kaonde and Namwanga) who perform circumcision, feel that during initiation one dies as a child and is reborn as an adult. For them, circumcision symbolises a clear separation from childhood to adulthood, where the initiated is given lessons on sex and the responsibilities of an adult man. The boys at this stage are instructed in the new ways of having sex with girls (Jere, 2009).

All participants (6 of 6) identified the intrinsic value of initiation ceremonies. The participants mentioned that initiation ceremonies are significant because they teach young children how to respect elders, how to raise a family, how to look after a husband or a wife, and teaches them about sex. The respondents mentioned that this is what makes the young children become

responsible adults. For instance, at the girls initiation they are taught what to do when they get pregnant, the symptoms of how to know they are pregnant, how to treat their husband, as well as about sex. One of the male participants stated "*There is an intrinsic value in it, obviously if someone comes from initiation there is that feeling, that special feel that I am this special person, I am an adult, I can get the value and recognition from society that I am now an adult*". This statement is in agreement with the definition of initiation given by Jere (2009, p.55), which explains initiation as "a process by which one is admitted to a new status. It is passing or transition from one state or situation to another".

Most participants (5 of 6) expressed concern about the implications that such initiation ceremonies have for HIV transmission in Malawi. In addition, one participant reported "*Young children are taught bad stuff which is not appropriate for their age and this is what encourages them to become sexually active at a young age, while they are not taught about HIV preventative measures"*. Most of the participants believe that this is what encourages promiscuity among the Yao youth, therefore leading to high risk behaviour that promotes HIV infection.

Furthermore, one of the participants reported *"children are taught how to practise sex and this is what brings* chisokonezo *(disruptions) among the Yao people. It makes the Yao women be different from a young age to other girls that have not gone to* msondo*. This is what makes them be at a high risk of getting infected because they learn too early about sex and most of them are not taught about AIDS"*. This is in agreement with Mwale (2008) who argues that the practice of *msondo* for girls and *jando* for boys encourages unsafe sexual practice amongst the youth, which puts them at risk of infection.

Another participant mentioned *"I would not want my daughter to go to* msondo *because they are taught about sex at a young age. They teach them how to make sex and when children come back they still have this on their mind and they go and start being active at a young age. That is why in our culture you see that most women have children at a young age, at 13 they have a baby. They want to practise; only the people do not tell them when they are young about the dangers of getting pregnant and the dangers of HIV and AIDS"*. This is in agreement with what a female participant reported. She stated "*I got pregnant at 18 and got married. I did not even think about education. I think it is because I went to* msondo *and I was taught about sex. This made me want to have sex and I wanted to know how it felt when you slept with a man"*. Another participant

reported *"In terms of men, initiation encourages promiscuity as they are encouraged to go out and test their manhood and this is what encourages promiscuity; however, in terms of women there is a difference as most women look forward to getting married and to getting a partner.* This is no different to the statement by Nyerges (2006), who argue that it is possible that some salient cultural practices which are involved with the rites of passage in Africa provide fertile ground through which the HIV and AIDS virus is spreading.

Furthermore, 4 of 6 participants mentioned that these practices are still being carried out in Malawi today among the Yao, regardless of the implications that they have on HIV transmission. The participants reported that young people are still being taught about sex at *msondo* and the chance that such practice could stop is slim because it is part of the Yao culture. However, one of the female participants mentioned that a number of changes have been put into place because of HIV and AIDS implications and high teenage pregnancies. She stated that "70*% of initiation ceremonies that take place have been modified in that sex is no longer the main part of the teachings at* msondo, *but the remaining 30% of initiation ceremonies have not made any modifications and continue to teach young girls and boys about sex"*. Furthermore, she reported "*At* msondo, *girls were taught about sex and this used to make them want to go out and practice. This used to be very problematic because these girls would be very young and already they would be sexually active and most of them would get pregnant at a very young age"*. This corresponds with the findings by Nyerges (2006) in a study done in the copperbelt in Zambia that found that some of the initiation ceremonies had been modified and sex was no longer discussed. It was identified that lessons about sex only took place among children whose parents were illiterate. It is argued that the motive behind such lessons is to motivate the young girls to enter marriage soon after initiation. The educated parents and Christian parents ceased such teachings to their children in order for them to first focus on their education. Teaching about sex occurred at the time when the children were about to get married.

In addition, a female participant from the current study stated "*Whenever the child came out of initiation, she wanted to find a man, it was a must. Girls as young as ten, when their breasts have just started growing, you do find that they are already pregnant because they felt like they are older and want to experience what they have learnt about sex. If you are taught about how you feel when a man touches you or how a man is, you develop a desire, so you want to experience*

it". These sentiments are confirmed by Jere (2009) that during initiation the girl is confined in her grandmother's house after menstruation for a period of two weeks. She is given lessons on respecting elders, moral behaviour and cleanliness, and is taught sexual skills and to respect elders. Such sexual lessons taught to the girls at the tender age of thirteen or fourteen, have the capacity of bringing about confusion into their lives. It is argued that this is the reason that young girls behave in a manner that puts them at risk of HIV infection.

In contrast to the other respondents, one participant was in disagreement with these statements. He argued *"At this age children are too young to even develop sexual desires, so it is most unlikely that they practice sex, even though they can be taught about sex"*.

Although most of the participants (5 of 6) acknowledged the implications of the initiation ceremonies on HIV infection, they felt that it would be difficult to change such practices because they have a lot of value for the Yao's. Therefore, changing them would have a negative impact on the meaning of their culture as a whole. However, the participants confirmed that some alternatives have been found, especially in the case of male circumcision, which is known as *jando*. Most of the participants reported that the government encourages the use of new razor blades for each child during the process of circumcision and this has contributed to significant changes where new razor blades are used for each child. In some cases, boys who go for initiation are encouraged to take their own razor blades. The participants also reported that government campaigns have also encouraged families to get involved in ensuring that their children are provided with their own razor blade when going for initiation.

In addition, most participants acknowledged that alternative ways of circumcision have been introduced. It was reported that educated people have opted to take their children to hospital to be circumcised instead of taking them to the secluded initiation area where circumcision is conducted, because they feel that there's a slim chance of being infected by HIV during the process. The parents send the children to initiation ceremonies after the circumcision is done at the hospital, to be counseled and to receive advice only. As one participant explained *"Such practices have been modified, especially in the men's side, because of HIV. When you go to the mountains they cut the foreskin and most of the people are afraid because they use one knife. Nowadays people who are aware and educated take their children to hospitals since they are too scared of getting infected. After that they send their children to go to the mountains to learn, but*

the less educated ones still go to the mountains. This is in agreement with Auvert, Buve and Lagarde (2001) who argue that there is a high possibility that male circumcision facilitates the transmission of HIV in cases where the equipment is not sterile and leaves a wound on the initiates, as this provides risk of infection until healing has occurred. Nyerges (2006) argues that in some African countries, such as Zambia, it used to be considered shameful for one to be circumcised at the hospital or clinic, partly because this was not ceremonial and it was not accompanied by song and other rituals. In addition, it was not common because such medical facilities were usually frequented by women. However, due to the implication that such a practice has on HIV infection, it has become readily acceptable for people to be circumcised at hospitals. However, two participants felt that these changes have not taken place in all areas, as some people in rural areas continue to re-use one razor blade for all the boys at the initiation. The participants felt that the practice of *jando* (circumcision) continues to put people at risk of HIV infection, regardless of government initiatives, especially in rural areas.

4.4.2.2 Beliefs about significant cultural practices that may contribute to the high prevalence rate in Malawi

All participants were concerned with the high rate of HIV infection in Malawi. Most participants mentioned that it is not cultural practice alone that causes the increase of HIV and AIDS in Malawi. Rather, it is personal choice in behaviour and the failure to use condoms when involved in sexual intercourse that has put them at risk of HIV infection. Most participants (5 of 6) reported that among the Yao, there is a lot of belief that is associated with condom usage. The participants mentioned that most people believe that condoms can hurt them. One participant mentioned *"the Yao believe so many things about condoms;, that it will burn you, it gives you lacerations, so many beliefs, especially for those who did not go to school, who just have sex without protecting themselves and this is what makes them get infected".*. Another participant stated *that "young women do not have the power to ask their partner to test, especially if they are poor; as a result, they marry someone who is already infected. I can say ignorance and poverty are what killing people is".* In addition, another participant stated *"no one cares if you are infected or not. Everyone is positive anyway and people just don't want to use condoms because they say condoms have disease*". This is confirmed by Loosli (2004) that a number of people in some parts of Africa and Asia still believe that condoms have pores and that condoms

reduce the enjoyment of sex. This is based on studies conducted in Uganda. It is argued that some people believe that sexually transmitted diseases can be prevented by taking antibiotics before or after sex and that someone's HIV status can be determined by their physical appearance. If they seem outwardly healthy, then condom use is not a necessity. This demonstrates how people's beliefs about condoms make them vulnerable to contracting HIV.

The responses by participants in the current study lend powerful support to the study conducted by Gauseet (2001) in Zambia that a number of beliefs about condoms that exist among the Tonga of Zambia prevent condom use, hence promoting HIV transmission. Some of the beliefs that the Tonga's hold that prevent them from using condoms are the belief that semen is good for a foetus as it gives it strength, and that a woman can only reach orgasm when she receives semen from the man into her womb. The Tongas, like some members of the tribes in the current study, also associate metaphors such as 'it's like eating a sweet with the paper', with condom use. Some of them also believe that condoms remain in the vagina after sexual intercourse, making women sterile, or that using condoms makes men sterile. It is argued that it is such beliefs about condom use that prevents behaviour change, hence putting people at risk of HIV infection.

Most participants mentioned that unfaithfulness and the lack of trust in relationships contribute to HIV transmission in Malawi. One participant reported "*because of education and independence that women are acquiring these days, they are challenging their partners, especially if they suspect that he is cheating, they go ahead and cheat without the use of condoms and this is what is contributing to HIV and not cultural practice alone"*. Other participants mentioned that Christianity and churches are also discouraging the use of condoms as making people become promiscuous, and this is contributing to HIV transmission.

Most of the participants (5 of 6) attributed the increase of HIV to poverty. This corresponds with the discussion from Nyerges (2006) on the relationship between HIV and poverty. It is argued that poverty, with its accompanying side effects such as prostitution, poor living conditions, poor education and poor health care conditions, are major contributing factors to the current spread of HIV. In addition, poverty limits the ability of individuals to make appropriate decisions about safe practice that would protect them from HIV.

In agreement with this statement, one female respondent explained that HIV is still increasing despite the knowledge and awareness, because of poverty. She mentioned that most women in her village are sleeping with men for basic things such as sugar, salt and food, even though some of these women are married. She reported *"these women are not aware of the implications, they are not aware of what they are getting themselves into, which is getting infected by HIV"*. Four participants were disturbed at the rate of early marriages among young people due to poverty, which is viewed as contributing to the high HIV infection rate. One participant mentioned *"young people are getting married at a young age because of poverty; as a result, they get into marriages where both parties have not tested for HIV and this puts them at risk"*. It becomes a challenge for such young women who marry men to escape poverty to initiate condom usage in marriages, for fear of being divorced and sent back to their homes, as explained by one participant. This is congruent to the findings of the study done in Zambia by Gauseet, 2001, that condom use is associated with casual sex and therefore with lack of trust or with suspicion between two partners. Therefore, when a woman in such a marriage proposes to use condoms, it can be taken that she does not trust the partner, or suspects that the partner is infected, or unfaithful. Scott (2009) argues that in most cases, the partner refuses to use condoms to prove his integrity.

Furthermore, a few respondents (3 of 6) expressed concern that some cultural practices that are still in existence in rural areas, such as the practice of *jando* (male circumcision) and the continuous use of one razor blade for all boys is contributing to high HIV infection rates. According to one participant, in some areas people are still using the same razor. He mentioned that "*People believe that the mountain where the initiation takes place is a protected place because of the traditional medicine that the elders conducting the ceremony use, and that they feel that the children are protected from witchcraft*". According to the respondents, this is what concerns them more than the use of one razor blade. Most of the participants stated that it would be such a challenge to modify such practices, especially to people who are illiterate and unwilling to change.

4.4.2.3 Awareness of the linkage between significant cultural practices and HIV and AIDS

All respondents acknowledged that there is a link between cultural practice and HIV infections. However, the respondents confirmed that the awareness does not equate to change because most

of the people in rural Malawi are illiterate. As one participant stated, *"It is the lack of understanding in terms of the measures, if you look at discussions that go around at the boys initiation for instance, they say 'you don't eat a sweet in a packet' implying that you cannot enjoy sex with a condom. So you cannot attribute that to cultural practice, but basically to the level of understanding of people in terms of prevention"*. Another participant reported *"ignorance is the main problem because three quarters of the Yao people do not go to school.* One of the female participants stated "*as women we look forward to getting married, that is it, and not going to school. Similarly, the men just go to the lake and fish to get money to help themselves and do not go to school"*. One can argue that it is not strange in the African context for women to want to get married at a young age. As confirmed by Nyerges (2006), the pressure to get married increases when someone comes of age in many African cultures. This pressure begins to increase both from the person himself/herself and those around them. The reason behind this is that in some African countries it is considered a shame for someone to be of a certain age and not yet married; as a result people pursue marriage in an effort to rid themselves of the shame. In most instances, marriage is often not made out of love (Geubbles & Bowie, 2006). One participant explained clearly that such marriages put the young women at risk of HIV infection since they rush to get married without both parties being tested for HIV.

Most of the respondents (5 of 6) mentioned that although people are aware of the link between HIV and AIDS and cultural practice, their cultural beliefs are very strong and this is what poses a challenge to behavioural change. One respondent explained "*people are resistant to change because they are passionate about their beliefs and they would like to preserve their culture by transferring it to the new generation in the same way that it was transferred to them by their elders"*. In addition, another participant reported "*culture is inherited from elders so they would not want to change it or to find alternative ways as this would seem like changing what they value, therefore disrespecting the elders who taught them.* Furthermore, the participant mentioned "*some people in the villages are still using traditional midwives and do not go to the hospital to give birth, as a result, the HIV is transmitted to the baby because of lack of education and their cultural values"*.

One participant argued *"people believe that the cultural practices that have been taught to them by their grandparents are more helpful and significant in their lives today than anything else"*. He argued further "*if it helped my parents, my parents did not die, why then should they change the practices of msondo or jando?*" Another respondent reported *"people do not want to accept that things have changed, even the way of life, the way people used to live then is not the same as they do today. People are failing to understand that HIV was not there then, but is here today"*. This is also consistent with findings by Mwale (2008) in studies done in Zomba, Malawi among the Yao tribe, that one of the reasons for the mismatch between knowledge of HIV and AIDS transmission and prevention dynamics and subsequent risk reduction is cultural practice.

Some of the participants (4 of 6) acknowledged that knowledge of the link between some cultural practices such as *msondo* and *jando* as linking to HIV infection have contributed to behavioural change in modifying and finding some alternatives to some of the practices. However, the participants were concerned that the overall change in the some of the risky practices has not completely taken place as some people continue practising risky behaviour.

4.4.2.4 Preventative programmes that focus on the link between significant cultural practices and HIV and AIDS

All participants mentioned that there are a number of programmes about HIV and AIDS in Malawi that are broadcast on television and radio in all Malawian languages. One participant explained "*programmes are conducted village-to-village and they focus on HIV awareness campaigns*". Another participant mentioned "*programmes are often not successful because people are resistant to listening to any message that speaks against their cultural practice, and also fail because of lack of sponsorship and funding to sustain them.* In addition, all participants (6 of 6) acknowledged that there is lack of support and lack of attendance by the community members when there is HIV and AIDS programmes or awareness campaigns. The reason given was that the people want to be given something in return in terms of money for attending meetings. As one participant stated, "*people often want something if they are being called for talks. Without funding, it is difficult to convince people in villages to attend such meetings. It is also difficult to inconvenience the elders to find alternatives as they are often too much into tradition and they do not want to change and they feel like you are criticising their culture which is important to them"*.

In addition,6 of 6 participants suggested that elders should be involved in the planning and operation of the campaigns to ensure that the campaign is successful, as people tend to listen to village elders. One participant reported "elders *should be involved in what needs to be done and made to feel that they own the whole process of effecting change in behaviour"*.

4.4.2.5 How significant cultural practices can be used to reduce HIV infection

Most of the participants (5 of 6) mentioned that cultural practice can be used to prevent HIV infection. One participant mentioned *"cultural practice cannot be used in isolation to prevent HIV infection, only when there's government intervention and when government involves the elders in terms of assimilating its programmes into the culture and not imposing on, but rather involving the elders, then the programmes can be successful"*. Another participant reported "*it is important to educate elders/leaders and chiefs and traditional healers about HIV and AIDS so that they can use the platforms of* jando *and* msondo *to teach people about AIDS and teenage pregnancies instead of just focusing them on changing their culture*". He further argued that *"most of the people that implement these initiation programmes are older people who are always resistant to change and because of their resistance, they still want to implement the older ways of doing things and, in the process, they are not moving to ways that can prevent HIV"*.

In addition, other participants (3 of 6) mentioned the significance of encouraging people to find better ways to prevent the disease, such as using safe equipment such as one razor blade for each child during the practice of circumcision, instead of asking the people to stop sending their children to *jando*. Furthermore, one of the participants mentioned that cultural practices such as the practice of *jando* (circumcision) can be used to prevent HIV. He mentioned "*it is important to encourage people, especially Christians who do not follow* jando *like the Yaos and Muslims, that if what the technology is saying about circumcision lessening HIV and AIDS infection is true, then the chance of getting AIDS would be slim. It would be important to encourage cultures to go for circumcision because condoms are not helpful, a person can use a condom today, if they meet twice or thrice they stop using the condom. Circumcision can help out as it reduces the chances"*. This is confirmed by (Loosli, 2004) that it has been proven that male circumcision provides significant protection against HIV infection. Circumcised males are two to eight times less likely to become infected with HIV than the uncircumcised and circumcision also protects against other sexually transmitted diseases. It is in this light that many countries have taken steps

to encourage male circumcision for HIV prevention. In Botswana male circumcision has been integrated into the National Strategic Framework and Swaziland drafted a formal male circumcision policy due to the benefits of male circumcision for HIV prevention (UNAIDS Report, 2009).

Furthermore, 4 of 6 participants mentioned that it would benefit the community, especially the illiterate, if HIV messages were transmitted through songs and drama so that people can understand through entertainment, instead of transmitting the message through pamphlets in communities where most people are illiterate. One of the participants mentioned "*it would also be important to have sporting activities for the youth such as football clubs, buy them jerseys and to use such platforms to talk about HIV and AIDS prevention"*.

4.4.2.6 Summary

In conclusion, most of the participants identified significant cultural practice among the Yao such as initiation for women (*msondo*) and initiation for men (*jando*) as contributing to an increase in HIV infection through teaching the young people about sex, which can encourage promiscuous behaviour. The re-use of one razor blade during circumcision was also identified as contributing to HIV infection. Most of the participants acknowledged that some practices are being modified however, the challenge is that most of the people who live in rural Malawi are illiterate, have strong cultural values and are resistant to any change that goes against their values. All participants had the opinion that cultural practice could be used to prevent infection by involving the elders in programmes that can educate the people about the link between cultural practices and HIV and AIDS.

4.5. FINDINGS FROM THE CHEWA GROUP

4.5.1 The Chewa group in context

The group comprised five Chewa participants. These included four males and one female who originate from the central region of Malawi. Four participants originate from different areas in the Lilongwe district and one participant originates from the Salima district. The participants' ages were 30-35. One of the participants has a college diploma, three of the participants hold the Malawi school certificate of education (known as M.S.C.E) which is similar to grade 12 in South

Africa, and one participant completed primary school. Most of the participants had lived in the village for more than two years except one participant who had lived in the village for a period of 8 months. When pondering on the meaning of culture, most participants stated that culture plays a significant role in their lives. One participant mentioned that "*the Chewa culture gives us the true meaning of who we are and the responsibility to preserve and to transfer our beliefs and traditional practices to the younger generation*". Another participant explained "*Culture teaches people how to respect elders and it is very significant in the Chewa people's lives".* In contrast to the statements by most participants, one participant had a different view of the meaning of culture. He stated *"Culture is no longer part of me since I moved out of the village to come to Johannesburg. I am educated; I live a different life so I don't have any value for my culture anymore*".

4.5.2 Significant cultural practices

All participants mentioned a number of practices that are significant in the Chewa culture. These include the practice of initiation for girls known as *chinamwali* and the initiation for boys known as *chinamwali cha a muna* or *M'meto,* the way of life of the Chewa, also known as their religion called *Gule,* the practice of *fisi,* or hyena, and the practice of *kulowa fumbi* (wiping dust) which goes hand in hand with the girls' initiation.

4.5.2.1 Initiation for women (*chinamwali*)

All the participants (5 of 5) explained the process of *chinamwali* as one of the significant cultural practices amongst the Chewa. The participants reported that this practice takes place when the young girls have reached puberty and have started menstruating. The girls are usually from the ages of 12-14. In addition, the participants reported that during this period the girls are taken to a secluded area where they do not see their relatives for a month. The village elders, mainly women known as *nankungwis,* advise the young women on everything including marriage, how to treat a husband and they teach the girls about sex. The significance of puberty is the initiation rite for the girls. The rite is associated with the beginning of menstruation, which is believed to be a sign of growing up or becoming an adult. According to Jere (2009,p.55), "the girl is taught a number of things such as how to keep herself clean during the menstrual period, how to conduct

herself as a mature woman and how to behave in relationships with others". This practice is not unique to Malawians, it is known as *cinamwali* in Zambia.

In relation to this information, the participants discussed that there is an inherent value in *chinamwali* in that it teaches the young girls many values, such as how to respect elders, the value of marriage and how to behave as good wives once married. Most participants (3 of 5) reported that initiation ceremonies are significant because they give young boys and girls an opportunity to learn to be independent and responsible. One participant stated *"boys and girls are taught how to take care of their families, their younger siblings, how to build homes and how to farm"*. Most African people like the Chewa of Malawi and the Ngoni tribe of the eastern province of Zambia, see initiation as the process that changes irresponsible minors, immature minors, into morally responsible adults with the aim of assisting the young people to lead a productive and fruitful life (Jere, 2009). Furthermore, the participants explained that the young people are taught how to behave as a Chewa man or a Chewa woman. This is confirmed by Mbiti (1988, p.116; cited in Jere, 2009)that "traditional initiation rites in most African societies are very important because they mark the milestones that a person has gone through throughout his/her journey in life and each stage is celebrated with special rituals". A number of participants identified the significant role that *chinamwali* (female initiation) plays in the lives of the Chewa women. The female participant *stated "the good side of* chinamwali *is that you are taught how to handle marriage, how to respect your husband, how to communicate with him and when you get married, you have an idea of the married life, however the downside of* chinamwali *is that once you come back home, they find you a man to sleep with so that you can prove that you have learnt what you were taught about sex, this practice is called* kulowa fumbi*"*. In addition, she reported *"you are taught to be submissive to your husband in such a way that you cannot have any say in anything. You have to say yes to everything and you are not supposed to ask your husband anything because he is the head of the family"*.

4.5.2.2 Initiation for men (*chinamwali chamuna/Gule*)

All participants (5 of 5) explained that initiation for men is mainly known as *chinamwali cha amuna*, and the place where it takes place is called *Ku m'meto*. In most instances, the participants used *M'meto*, *Gule* and *chinamwali cha amuna* (male initiation) interchangeably.

In addition, the participants reported that boys go to initiation (*M'meto*) when they are 10 to 15 years old. The participants explained that it is often up to the parents to decide on the right age to send their children. The participants further explained that during initiation the boys spend seven days at a hidden place with the elders where they are taught about the values of the Chewa tribe. The participants also reported that boys who are at initiation are not supposed to meet relatives or friends, especially those who have never been to initiation (*osavinidwa*). One participant stated that *"at this stage of initiation, the boys move from childhood to manhood (rite of passage) and they are refrained from doing other things, such as not going into their parent's bedrooms. Children as young as ten go to* Kum'meto. *Parents are mostly the ones who decide that their child is now ready to go for initiation. Once you come out you no longer behave as a child because when you are there they teach you how to behave as an adult".*

All participants acknowledged the substantial value that the practice of initiation contributes to the boys' lives. The participants explained that the boys are taught about respect, important Chewa values and most of them are encouraged to continue their way of living and their religion, known as *Gule* or *Nyau*. The participants identified *Gule* or *Nyau* as one of the most significant cultural practices of the Chewa. The participants mentioned that you cannot talk about the Chewa culture without talking about *Gule*. They stated that *Gule* is the main part of the male initiation.

In addition, 3 of 5 participants) described *Gule* as a religion and not a way of life. The remaining participants described *Gule* as a way of life of the Chewa people. One participant stated that *Gule* is rooted in you as a Chewa. "*You are the real* gule wankulu *(big dance) as a person. It is a belief that Chewa people practice.* Gule *is the same as* Nyau, *and it can be demonstrated o*r *cerebrated through* Nyau *(a form of a unique dance). This is the Chewa pride, the belief in them that they are Malawians born in this country and they have to preserve their cultural values".*

All participants (5 of 5) acknowledged that although there is a significant value in sending children for initiation, there is also a downside to the practice, where the likelihood of promoting risky behaviour that may lead to HIV and AIDS infections among the youth is high. One of the participants stated that *"at* chinamwali *there is a practice called* thimbwiza*. They take women to* chinamwali, *although they say they teach them about marriage, they are generally taught about sex and how to please a man in bed. When these women come out, they change completely. They*

feel that they are mature, they change their way of life completely. They start wanting to be with men and this is what contributes to HIV infection, and it can destroy the way of life of the young children today". This is confirmed by Jere (2009) in a study done in Zambia. It is argued that girls are taught romantic practices once they reach the age of puberty. As a result, the girls feel that they are old enough and may try this on a man, especially when she is not married yet. This can result in the girl contracting HIV infection at the tender age of 12-14 years old.

Most participants (4 of 5) reported that the teaching about sex does not only take place at the female initiation, but also at the male initiation. One participant stated *"after* chinamwali *and* M'meto*, the girls from* chinamwali *(known as* thimbwiza *in other areas) the men known as (*m'*meto) or Gulewankulu, meet after their ceremonies and they start what they have been taught. They are not taught about condoms because this is a tradition that started a long time ago so it is just a continuation"*. Furthermore, one participant explained, *"This practice puts people at risk for HIV infection because at night, the young boys just walk around and often get to sleep with women. The odds of the young men using condoms are very slim"*.

In addition, other participants (3 of 5) explained that such practices not only encourage promiscuity among the youth, but also lead to some children misbehaving to their parents when they come back home, due to feelings that they are now responsible adults so they can do as they please. As one participant explained *"The downside of* M'meto *is that as parents you teach your children to behave in a certain way, however, at initiation they are taught something different, for instance as a parent you can be a Christian but you will find that when your child comes back, he is a completely different person. For instance, you believe that there's a God in heaven but when your child comes back he may stop believing in God or Jesus. He starts questioning a lot of things about Christianity because of* Gule *beliefs"*. Another participant reported *"at* M'meto *it is an environment that is infused with different people and you may be taught to insult or swear when you have not done that before, or you find that there are smokers, people who use dagga, people from different aspects of life, the moment you send your child you are putting him at risk. There can be 50 or less or more people at* M'meto *and it is not a controlled process, so others can be smoking or drinking when you are just there for advice."*

4.5.2.3 The practice of *Fisi* (Hyena)

All participants (5 of 5) explained that this is the practice that takes place on the last day of the female initiation. They explained that a male figure who is often an unknown male to the girls is brought to sleep with the women, often without the use of condoms. One participant reported "*after spending two weeks at the initiation, the women are forced to sleep with a man"*. In addition, two participants reported that the practice of *fisi* is still taking place among the Chewa in rural Malawi, although on a smaller scale. He explained that the practice is conducted in a few areas such as some parts of the Kasungu district, some areas of the district of Ntchisi and some parts of the Dowa district. In addition, the participant reported "*in other cultures, they choose a chief to sleep with the young ladies but in the Chewa culture they choose two guys and tell them that they will be needed on such a day and are asked to be ready for the ceremony. The girls are forced to sleep with the men to prove that they are now grown-ups"*. He further reported "*Women accept culture even if they can feel that what they are being forced to do is not right, they have no power to do anything about it. Most of the time these young girls are surrounded by ten ladies who are around 45-50 years old and you cannot disobey them It's the old ladies who tell you that they also went through the same thing, 'we have been doing these things and we were taught by our parents'. They tell you that you do not need to be discouraged, when you are married you should know how to please your husband. These people do not believe in education. When a lady has reached a certain age, 15-18 years, they expect the lady to be married. Going to initiation therefore proves that you have been prepared to be able to marry someone"*. Two of the respondents explained that the men known as *fisi* are not tested for HIV. Furthermore, another participant stated that "*the test for HIV is new it has just come into our country in recent years so it has not reached in deep rural villages and these men do not use protection. Regardless of the risk it has for HIV infections it is part of our culture, it is a way of preserving our culture"*. The practice of *fisi* in Malawi is also confirmed by Mwale (2008) who argues that the risk comes about when the girls are made to have sexual intercourse with a person whose HIV status is unknown, and often without the use of protection. It is important to note that the practice of hyena or *fisi* is not only practised in Malawi. Jere (2009) discusses that this practice is common among the Senga of Zambia. Among the Senga people a *fisi* is given to practically test the girl to see if she is sexually ready for marriage.

However, 3 of 5 participants argued that the practice of *fisi* has been discouraged because it contributes to HIV and AIDS transmission. They also acknowledged that it used to occur on a large scale during the olden days, however it has declined and in most areas it is not inexistence. Most of the participants linked this practice to another practice known as *kulowa fumbi* (wiping of dust) which is a practice where a man is chosen to sleep with the girls after they come from *chinamwali* (Mwale, 2008). Although 3 of 5 participants mentioned that this practice is not taking place anymore two participants expressed concern that this practice is still taking place in some areas in Malawi. Scott (2009) argues that the rate of decline of these risky cultural practices is not known.

4.5.2.4 The reasons for high HIV infection in Malawi

Most of the participants (3 of 5) reported that HIV infection is still increasing in Malawi because people are still following the cultural practices that put people at risk of HIV infection. The respondents ascribed this to the strong sentiments that people have for their culture, which makes them resistant to change. One participant explained that practices like *kulowa fumbi* (wiping of dust) where they find you a man to sleep with after the *chinamwali* (initiation for girls) ceremony put people at higher risk of infection. She stated that, "*most of the girls are put in a difficult position because they cannot refuse to sleep with a man after coming from* chinamwali*, they have to listen to the elders and they cannot say anything. There is no other way but to quit going to* chinamwali *like I did. I refused to go to* chinamwali *because I did not want this practice* of kulowafumbi *(sleeping with a man after* chinamwali*), I was scared of sleeping with someone I did not know, I don't know where that person is coming from and how many people he has slept with before me, I was scared of contracting AIDS*". This concern of contracting HIV through such practices in Malawi was also confirmed by Mwale (2008).

Furthermore, the participant mentioned "*elders in my village did not understand why I refused but my parents understood my decision, but many women in my village are not as lucky as I was. They are put under a lot of pressure to go to* chinamwali*. This is what puts them at risk for infection"*. This corresponds to the argument by Van Dyk (2008) that it is believed that the ancestors can punish their people by sending misfortune and illness if certain social norms are violated, or culturally prescribed rites and practices are neglected or incorrectly performed, or when people do not listen to the wise counsel.

In addition, participants (3 of 5) identified the cultural practices of female and male initiation as contributing to some extent to HIV transmission in Malawi. One participant reported "*at* M'meto *there is no age discretion. They just mix a ten year old with a fifteen year old and do not separate them, and when they talk about sex this pressurises the youth to go out and try it. It is significant to separate when giving advice. Without the separation, the youth are influenced to behave in a way that puts them at risk to contract AIDS because a ten year old will not understand what is being said when he has been taught about sex. In his mind he will just go for sex though he can be taught that after sex there are problems that you can encounter such as teenage pregnancies and HIV. A ten year old or an eleven year old cannot take in both sex and prevention at one time, he can feel that he needs first to go and test (have sex).The other reason is that no preventative strategies are discussed and for the elders, it becomes very difficult for them to understand the negative impact that such detailed advice on sex is making on the young boys lives because of the value they have for preserving their culture and because of lack of education. Things could turn around if the elders could be educated*".

Most participants (3 of 5) attributed the increase of HIV infection, regardless of people's knowledge on how one can be infected, to people's failure to use condoms. They argued that people in villages are not educated enough about condoms. This lack of knowledge about condoms is evident in the findings from a study conducted in Uganda where it was found that 75% of the youth use condoms, however, only 2% of that percentage knew how to use them correctly (Loosli, 2004).

In addition, all participants reported that a lot of people do not want to use condoms because they have certain beliefs about condoms such as they 'cannot eat a sweet in a paper'. Scott (2009) explains that condoms are not used in some cases because men dislike the idea of the rubber between themselves and their partner during intercourse, they prefer skin to skin. It is argued that some of the men dislike the use of condoms because it diminishes their sexual pleasure. This is one of the reasons that prompt some men to insist on 'flesh to flesh' as they believe that the exchange of body fluids ensures their health (Geubbles & Bowie, 2006).

Furthermore, all participants acknowledged that this careless behaviour of not using condoms is not only noticeable among the illiterate people in rural Malawi, but also among some of the educated Malawians who do not feel the need to use condoms. One participant stated "*many*

people do not like condoms, it does not matter who you are and if you tell your partner, she cannot say no. For instance you go home coming from Gauteng, you are able to provide the women with all that they need and then she will not have the power to ask you to use a condom and if she does and you say no, she cannot say anything else. You can just say I don't like condoms, and that's it". Likewise, participants recognised that most women, because of cultural norms and values, are socialised to be submissive and therefore they lack the courage to ask their partner to use a condom, regardless of knowing that the partner is unfaithful, and as a result it puts the women at risk of HIV infection. Correspondingly, Scott (2009) argues that most African women in patriarchal societies are socialised to be submissive in sexual matters, on the other hand, men are socialised to be daring. This becomes a challenge, especially when it comes to adopting safe sexual practice, like using condoms. It is argued that only when dominant patriarchal structures can be deconstructed in the light of HIV and AIDS can behavioural change then occur.

Additionally, two participants discussed that HIV is high especially among the youth because of peer pressure. This is consistent with Varga (2003; cited in Mwale2008, p. 296) that "indeed the boys are often most motivated by the desire to boast to their male peers about the number of their sexual partners". As one participant stated "*people like copying each other a lot in Malawi and if you see that your friend has a girl you also want to get a girl and because of certain beliefs about condoms such as 'you can't eat a sweet in a paper' you end up not using them*". Most participants (4 of 5) reported that people are not encouraged to be open about their status in Malawi. They explained that this is often the case because people who test positive are often stigmatised and isolated in their communities as being promiscuous, and this is what makes a lot of them scared to come out. As a result, most people who are positive do not want to reveal their status because of fear of being stigmatised and they continue to silently infect their partners.

4.5.2.5 Awareness about the link between HIV and AIDS and Cultural Practice

Most participants (4 of 5) acknowledged that most Chewa people are aware about the link between cultural practice and HIV and AIDS. However, the participants reported that the extent to which this awareness is leading to behavioural change is not known, as people continue practising risky behaviour. One participant stated "*These days people have the understanding about the link between cultural practices and HIV, for instance when you are forcing a child to*

sleep with a man that you don't even know, don't know the background, you are aware of the risk of HIV infection, even though there are a few that are still practising such practices such as in some parts of Kasungu, but a number of them have stopped and this demonstrates that there is knowledge, that people are aware that the practice of fisi *is not safe and it has to be stopped*".

All the participants attributed the lack of willingness to change the practices that are putting people at risk of infection to lack of education among people in the rural areas. One participant stated that "*illiteracy is what actively contributes to this lack of understanding*". Another participant stated that "*It remains the responsibility of the government and the local government to go and educate the communities, to talk to leaders and chiefs and get them to assemble people and tell them that these days you have to stop such cultural practices for the betterment of the community"*.

In addition, Loosli (2004) explains that many previous studies revealed that the knowledge about HIV risk does not automatically translate into modification of harmful behaviour. Condom use is still very low in many parts of Africa. It is argued that South Africa is one of the African countries with high condom usage; however, the rate is 10% to 20% of the population. In countries such as Cote d' Ivoire condom use is still low, despite the increasing prevalence of HIV and an extensive awareness of the transmission of the virus (Scott, 2009). Similarly, in Malawi as identified by Mwale (2008), the knowledge about HIV and AIDS transmission is very high; however, it does not translate to behavioural change. It is therefore argued that high prevalence and awareness are not a determinant of condom use or a modifier of risky behaviour. As confirmed by most participants, this reluctance to use condoms is mainly due to traditional values held by individuals from different cultures, and not the lack of knowledge about HIV transmission.

It is argued further that men often view themselves as having supernatural powers and having feelings of invincibility due to masculine issues that put them beyond any misfortune, especially in patriarchal structures(Loosli, 2004).It is often viewed as acceptable and the norm for men to have more sexual partners, unlike women (Mitsunaga, Powell, Nathan, Heard & Larsen, 2005). Condoms are viewed as un-masculine in some cultures. It is argued that Zambian men from rural areas of the country hold a belief that condoms affect male potency; therefore they are viewed as a sign of weakness (Nyerges, 2006).It is further argued that often such men do not feel concerned

by disease or illness, which is viewed as the business of women. For instance, in many cultures, men are often viewed as being invulnerable to illness or risk. This therefore contributes to the ineffectiveness of intervention programmes on awareness of transmission and preventative measures, which inhibits behavioural change. This statement is in agreement with the response from one participant who reported that, *"many men do not worry about contracting AIDS; they think they cannot get infected and that it cannot happen to them. It is mostly the women who worry about being infected by their partners"*.

4.5.2.6 Programmes that exists on HIV and AIDS and Cultural Practice

Most participants confirmed that there are a number of programmes that focus on HIV and AIDS; however, most of these programmes have not proven to be successful in reaching the targeted population. One participant reported "*although programmes are there, for instance programmes such as* Pa Kachere *where they show people how cultural practices are impacting on HIV infection, the extent to which such programmes are making a difference is not visible*". The participants reported that people just listen to the messages but they do not change their behaviour. Another participant stated "*A lot of programmes are there, especially through NGOs, but they are failing because people, especially the youth, are in a rush. They get involved too quickly before using condoms, or they feel that after two meetings they know the person and then stop using condoms"*. Most participants (4 of 6) attributed the failure of programmes to affect change in behaviour to the lack of attendance from community members who are the main target of the programmes. The participants expressed concern that most Malawians in rural areas are illiterate and the participants acknowledged that it is the lack of education among the population in rural areas that contributes to the failure of programmes, due to the lack of actual understanding on how some of their cultural practices are contributing to the high HIV transmission rate.

Most participants (4 of 5) also acknowledged the lack of youth involvement in some of the programmes, especially in HIV awareness campaigns. One participant recommended that it would be beneficial to extend programmes about HIV and condom use to Youth Centers, if programmes were to be successful. Another participant recommended government involvement in HIV and AIDS programmes in order to effect real change in risky behaviour among the population. He stated "*It is important for government to address such issues to chiefs because*

chiefs can reach villages. For someone to be taught that you have to change from point A to point B, it's a difficult thing, it's like rolling a stone from downhill upwards. You have to first go into villages, you have to change this from point A to B, culture has a meaning, you cannot just say 'do this and don't do this'".

4.5.2.7 How culture can be used as intervention to reduce HIV infection

All participants (5 of 5) recognised the significant influence that village elders have in their communities. The respondents recommended that elders can be involved by first educating them about the link between cultural practice and HIV and AIDS so that they can use their influence in order to curb the HIV infections in their communities. One participant mentioned that the elders should be encouraged to stop practices such as *kulowa fumbi* (wiping of dust) so that they can reduce HIV infection. Another participant stated *"it is important for government to talk to chiefs, by doing so people would respond. In Malawi people respect leaders, even if they say something that we believe is not good. People have this belief that leaders possess a certain supernatural power. There can be a change which would prevent things that are driving us to HIV and AIDS".* Ayikukwei, Ngare, Sidle, Ayuku, Baliddawa and Greene (2008) argue that traditional healers, chiefs, community leaders and political leaders, faith-based leaders, and elder men and women have a great role to play in HIV and AIDS prevention and care, because people trust them within their societies. This is due to the social power that they have which gives them the opportunity to promote behavioural change as well as HIV prevention strategies.

Other participants (3 of 5) suggested that the practice of *M'meto* (initiation ceremony) can be used as a platform to encourage people to be patient, to abstain and not to rush to sleep with girls/boys without protection. In addition, one of the participants recommended that *"People should be encouraged not to lose their cultural values and to continue behaving in a respectful way because many times once people have left the village, they think they are better than the villagers, they start behaving differently taking the western culture, getting involved with a lot of women, cohabitating or getting married at a later stage after being involved sexually with many people, which was not happening during the olden days when people got married and that was it".*

4.5.2.8 What can be done to reduce infection in Malawi?

Most participants (3 of 5) recognised the significance of including parents, together with leaders and elders, in HIV and AIDS campaigns. The participants reported that often parents in Malawi do not talk to their children about sex since is seen as a taboo in Malawian culture. It is undeniable that sex is often a matter that is not discussed openly in Africa among members of communities and between parents and their children. It is argued that to discuss sex is a taboo in Africa and is something that is not spoken about (Loosli, 2004).

It is well known that condom use is very low among adolescents in Malawi and an earlier sexual debut places adolescents at a higher risk of contracting HIV or any other STD (Mwale, 2008). Although the Malawian tradition encourages young girls to abstain from sexual activities, there is increasing evidence that an early sexual debut is the norm among adolescents. In a study conducted in Malawi by Geubbles and Bowie (2006) over 50% of adolescents reported having had sexual intercourse before the age of 15. This clearly demonstrates the significance of involving parents in HIV and AIDS intervention campaigns, as suggested by participants.

The participants recommended that parents should be involved because they have a lot of influence on their children, especially where initiation is concerned. Moreover, they are the ones who decide whether or not to send their children to initiation and at what age to send them. One participant stated that *"for instance a young boy can say 'I want to learn this' but the parents can say 'it's against our culture'. For instance, using condoms, which, in some cultures you cannot do, the child can feel that he wants to change this but cannot, because he may feel that he wants to respect the parents' wishes. The leaders should convince the parents and elders so that they move together to change the world. They can do this by first consulting with the chiefs to call people to talk about HIV. Parents could be encouraged to sit down with the youth* to *restore values and to teach them about HIV and AIDS since most parents in rural Malawi do not have sex education with their children"*.

4.5.2.9 Christianity and Culture

Two participants acknowledged that Christianity is often in conflict with cultural practice. One of the participants stated "the *Chewa people that believe in the cultural practice of* Gule Wankulu *are often not Christians, as this is part of their religion. Previously, in the 90s, people*

who were practising Gule *were not allowed to go into churches but now it is different, they are allowed. One can mix them because Christianity is about you and your God and* Gule *is about your cultural values. Others like me have combined both and take the* Gule *as traditional religion and then follow it with the Christian beliefs as well."* The participants acknowledged that those that strongly believe in *Gule* are not Christians and these are the ones that are resistant to change, especially when change means that they have to abolish their cultural practices. Gauseet (2001) argues that imported intervention programmes may be inappropriate, especially if they require people to change their culture, and hence may themselves be barriers to behavioural change in that by their very disregard for local concerns, they may promote negative reactions to intended prevention messages.

4.5.3 Summary

The cultural practices of initiation for boys and girls known as *chinamwali cha a muna* or *M'meto* and *chinamwali cha a kazi*, the practice of *fisi* (hyena) and the practice of *kulowa fumbi* (wiping of dust) were identified as the cultural practices that put people at risk of HIV infection. It was identified by the participants that young children are taught about sex at a young age when they go for initiation, which promotes the risky behaviour that may put them at risk of contracting HIV. It was further discussed that the practice of *fisi* and *kulowa fumbi* puts the young girls at risk of contracting HIV because they are encouraged to sleep with people whose HIV status is not known. Participants identified strong cultural beliefs, lack of education and the lack of desire to use condoms as some of the factors that are contributing to high HIV infection rates in Malawi. It was recommended that village elders should be involved in educating people about HIV and AIDS and more interesting programmes such as drama, could be introduced to teach people about HIV and AIDS.

CHAPTER 5: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents the main findings of the study as drawn from the results presented in the previous chapter. It will be presented in relation to the primary aim and secondary objectives of the study. Conclusions will be offered and recommendations in terms of practice, policy making and future research will be highlighted. The chapter will be concluded with final comments.

5.2 SUMMARY OF THE MAIN FINDINGS

The study hopes to contribute to the limited knowledge of social work and social development literature that addresses the role that cultural practice plays in promoting risky behaviour that leads to HIV transmission and that prevents behavioural change. Furthermore, it is hoped that the study will to contribute to the discovery and creation of new alternatives to cultural practices that might put people at risk of HIV infection and to the development of new intervention programmes that are culture-specific, in order to contribute to curbing HIV infection related to cultural practice in Malawi. This might also be useful and applicable to other African countries. The research study provided valuable information about the perceived link between cultural practice and HIV and AIDS and the extent to which such practice is occurring among the three tribes which were participating in the study. The study identified some of the reasons that could possibly contribute to new HIV infection in Malawi regardless of the awareness and knowledge that people have on HIV transmission, and the existence of HIV educational campaigns and intervention programmes that are aimed at reducing HIV transmission. In addition, participants

made recommendations on introducing culture-specific programmes that could better assist people to change the behaviour that puts them at risk of contracting HIV.

The main findings will be discussed in relation to the primary aim and secondary objectives of the study.

The primary aim of the study was to explore the understanding and perceptions of Malawians living in Gauteng, South Africa, about the role that cultural practices play in promoting the risky behaviour in indigenous Malawian tribes which could lead to HIV infection.

In the current study, it was clear that participants were able to perceive and understand the link between cultural practice and HIV transmission in Malawi. Participants were also able to identify significant cultural practice that puts people at risk of HIV infection. The practices identified were wife inheritance, polygamy, bride price, initiation ceremonies, belief in witchcraft and traditional marriages. The participants recognised the intrinsic value that cultural practice holds for the people in these particular tribes, especially those living in rural areas. These strong cultural values and beliefs accompanied by a lack of education among most people living in rural Malawi were identified as factors that are promoting the risky behaviour that leads to HIV transmission.

5.3 MAIN FINDINGS IN RELATION TO THE SECONDARY OBJECTIVES

(i) To establish the views of the Yao, Tumbuka and Chewa tribes on whether there is a link between cultural practice and the growing HIV and AIDS prevalence in Malawi.

Participants were able to identify the link between cultural practice and the growing HIV and AIDS prevalence in Malawi. Most of the participants mentioned that culture plays a significant role in people's lives. They reported that culture makes it possible for the tradition to be preserved, hence it allows for the beliefs, customs and practices to be transferred from the older generation to the younger ones. It was also identified that culture provides the basis for people's identity, dignity, and makes people feel proud of who they are. However, the participants reported that it is these sentiments that people hold about the value of their culture that makes them resistant to change when it comes to risky behaviour that promotes HIV infection. The participants were able to demonstrate an understanding of the cultural practice that plays a role in

promoting HIV and AIDS infection among the Chewa, Yao and Tumbuka tribes but at the same time limiting behavioural change. It was identified that practices such as wife inheritance, polygamy, initiation ceremonies that include the practice of *fisi* (hyena) *kulowa fumbi* (wiping away dust), the bride price and traditional marriage might contribute to HIV infection. For instance, the practice of wife inheritance was viewed as putting people at risk of infection in cases where the deceased had died of AIDS and chances that the widow was infected would be high. This therefore would put the brother of the deceased at risk of infection once he inherited the widow. The participants reported that people follow such practices because of the value that they hold for their culture and because of lack of education.

(ii) To explore how cultural practices among the Yao, Tumbuka and Chewa tribes might contribute to the risk of contracting and spreading of HIV and AIDS in Malawi.

The participants identified some of the cultural practice and the ways that such practice promotes risky behaviour leading to HIV infection. These were wife inheritance, initiation ceremonies, the practice of *fisi* (hyena) and *kulowa fumbi* (wiping of dust), polygamy, bride price, traditional marriage and belief in witchcraft. In the case of wife inheritance, participants reported that the practice is valued because it is viewed as helping the wife of the deceased brother and her children from becoming destitute. Such a marriage therefore provides protection to the family and ensures that the family does not suffer. However, the participants argued that the risk with wife inheritance comes when the husband of the widow dies of AIDS, since the chances of the widow infecting the brother of the husband are high. This is often the case, because the widow is seldom tested for HIV; similarly, the brother is also not tested for HIV. In addition, the risk with polygamy was identified in that if one party is infected, he or she infects everyone in the nuclear family. It was identified that often, people in such marriages do not go for HIV tests before becoming sexually involved. This is what puts them at risk of HIV infection (Mitsunaga, et al., 2005).

In the same way, initiation ceremonies were viewed as significant in that they teach the young people responsibility, respect, and how to behave as married women or husbands. However, initiation ceremonies were also viewed as promoting risky behaviour, where young people are taught how to practise sex at the vulnerable ages of 10-14. Furthermore, the boys are encouraged to test their manhood by sleeping with women, which puts them at risk of HIV infection and at

the same time promotes promiscuity among the youth. The participants identified that the strong cultural beliefs that people hold limit behaviour change because people are against listening to any message that they perceive as addressing their culture negatively.

The participants also identified other cultural practice as contributing to HIV infection such as the practice of bride price (*lobola*) that is encouraging young people to get married at a very young age in an attempt to address poverty. It was identified in the study, that often people get married without having had their partner tested for HIV. It was also reported that such a practice provides an environment in which the women feel powerless where the negotiation of safe sex is concerned, for the reason that the men feel that they own their wives since they paid for them and that the wives are now their property. This is confirmed by Struensee (2004), who argues that women are often trapped in loveless marriages because their families would have to pay back the *lobola*. In most cases, their families are poor. As a result, the women in such marriages stay in the marriage and are vulnerable to HIV infection.

Cultural practice was also identified as creating patriarchal structures where gender and culturally constructed roles prescribe women to be submissive to men while men are encouraged to be dominant and powerful. This was attributed to creating an environment where women feel inferior to men, who limit their ability to negotiate condom use. Participants were able to identify that in many cultures men do not want to use condoms because of many beliefs that they hold. For instance, some men do not want to use condoms because they argue that '*it is like eating a sweet in a paper'*, therefore they do not receive maximum pleasure. Others cultures believe that condoms cause disease and in most cases that using condoms in marriage demonstrates that one does not trust the partner. It is in this view that women continue to practise unsafe sex with their partners and/or husbands in marriages and in ordinary relationships, as they fear losing their partners even while they are at high risk of infection or re-infection by the virus. Although Scott (2009) argues that being in a formal marriage is thought to reduce the probability of HIV infection, in regions with high HIV prevalence, marriage may be a risk factor to HIV infection.

Participants also identified that cultural practices and beliefs encourage the young women and boys to get married at a young age. For instance in the Yao culture, most of the participants reported that girls are encouraged to get married and this is what makes them drop out of school

at a young age. This therefore, makes them become financially dependent on their partners and makes them vulnerable to HIV infection, as they have no education or any source of income.

In the current study, participants identified cultural practice and lack of education among other factors such as poverty and prostitution, as contributing to the high HIV prevalence in Malawi. The participants reported that people do not have a full understanding of HIV transmission and prevention measures. In addition, they explained that a number of people are not aware of the extent to which the continuing of such cultural practices is contributing to high HIV infection among people in their culture. For instance, it was demonstrated in the study that some of the participants themselves lacked understanding of the transmission of HIV. One participant explained that people often observe how the wife's husband passed away. They look at whether he suffered for a long time and how he looked during the period that he was ill. The decision to marry the wife is therefore based on this observation. This means that if they saw that the person looked healthy, or if the person did not suffer for a long time, then the marriage can take place. This clearly demonstrates that there are a lot of mixed messages when it comes to HIV, as people think that they have the knowledge but blindly continue with cultural practices that put them at risk of infection (Loosli, 2004).

Similarly, another participant demonstrated a lack of understanding on HIV and AIDS transmission. He mentioned that if a witchdoctor gives you some medicine that can protect you from getting infected and you forget to take it, you get infected. In addition, participants mentioned that most people in Malawi are illiterate and it is this, together with strong cultural beliefs that cause them to resist change. Participants reported that people do not have a full understanding in terms of how to promote the prevention of risky behaviour and they continue following practices that put them at risk of infection. Practices such as *fisi* (hyena), *kulowa fumbi* (wiping of dust) and circumcision with the use of one razor blade continue to promote HIV transmission on a large scale. The participants reported that people follow such practices because they are afraid of the consequences, such as being an outcast or being divorced. Ayikukwei et al., (2008) argue that culturally prescribed norms have certain consequences if one does not adhere to them. As superstition plays a role in many cultures, the fear of being isolated or of something bad happening to someone who does not adhere to the practice contributes to the continuous following of the practice, even though it puts people at risk of infection.

(iii) To explore ways in which way the cultural practices of the Yao, Tumbuka and Chewa tribes put people at risk of HIV infection.

Most participants were able to identify how certain cultural practices put people at risk of HIV infection. Among the Tumbukas, it was reported that the practice of wife inheritance, polygamy, bride price, traditional marriages and initiation ceremonies put people at risk of infection. The Chewa and Yao tribes mostly identified initiation ceremonies as contributing to HIV infection. When it came to wife inheritance, most participants were able to identify the risk it poses and that it is still taking place in some areas in Malawi. It can be confirmed by Scott (2009) that the chance of the widows being HIV positive is high, as many people die of AIDS according to the study conducted in Karonga, Malawi.

The participants argued that because of the need to protect the deceased's family it is most unlikely that such practices will stop and that they are often encouraged by the elders. Even though the brother may be unwilling he may be forced to comply by the elders, who are guided by cultural values and beliefs. Similarly, polygamy was identified as putting people at risk of infection. In most cases, when men remarry they do not test or have the new wife tested, and, as a result, all parties are at risk of infection (Mitsunaga, et al., 2005). Participants argued that this practice is also valued for many reasons, one being that if the first wife is barren, the husband can take another wife to bear him children. Although a few participants mentioned that the rate at which this practice is occurring has decreased, many of them argued that it is still taking place and it continues to put people at risk of HIV infection.

Participants also recognised the value of the bride price (*lobol*a). *Lobola* was identified as significant because it shows respect and dignifies the marriage, as it involves a number of people during the negotiations such as uncles from both families. Therefore, it is not easy for such marriages to just dissolve without the families intervening. As discussed previously, participants reported that it puts women at risk of infection because the men have the impression that they bought their wives, therefore they own them and can do as they please with them. The husband can therefore mistreat the wife, be unfaithful, and this can be condoned in some cases. The women can continue to stay in such marriages because it is tradition that if a woman wants to

leave the marriage, her family should pay back the *lobola*. This becomes a challenge especially in rural areas where people are too poor to pay back the money or the cows. As a result, the woman continues to stay in an unhappy marriage and can get infected by HIV (Struensee, 2004).

In relation to marriage, participants identified traditional and early marriages as putting women at risk of HIV infection. It was identified that in marriages people trust each other, therefore they do not use condoms. The culture prescribes gender roles that put women in a position where they are supposed to be passive, submissive and obedient to men, while men are encouraged to be dominant and powerful (Niehaus, 2007). The participants reported that men develop feelings of masculinity where they do not want to use condoms as they have a number of beliefs about them and often prefer what is known as 'flesh to flesh'. Scott (2009,p. 86)argues that "culture values the importance of 'flesh to flesh' contact in which condoms are perceived to prevent the intimacy". Some men refuse to wear condoms because they claim it is not in their culture to do so. Therefore in patriarchal societies, as reported by participants, women are not supposed to question their husbands, for instance in cases of infidelity, or to ask their partner to use condoms. The participants reported that this is what is putting many women in rural Malawi at risk of HIV infection because they are not allowed to ask their husbands/partners to use a condom as they fear the consequences of such an action. Scott (2009) argues that some cultural factors which impact on preventative strategies and decrease the use of condoms in developing countries include gender inequality in relationships, toleration of male promiscuity, the high value placed on fertility, and patterns of inheritance. This cultural belief therefore puts women at a particular disadvantage where safe sex is concerned.

All participants identified that initiation ceremonies put people at risk of infection. As discussed previously, participants expressed concern that young children from the ages of 10 are taught details of how to practise sex and are not taught how to prevent HIV transmission or about teenage pregnancy. The young children are also encouraged to practise sex once they are out of the initiation ceremonies. The boys are encouraged to prove their manhood and the women are encouraged to go and test what they have learnt so that they will be able to please their men in bed and keep their husbands from looking for other women once they are married. Among the Chewa, the practice of *fisi* (hyena) and *kulowa fumbi* (wiping of dust) was identified as putting them at risk of infection since the man that is chosen to sleep with the women is never tested for

HIV. It was reported that the young girls and boys feel as if they are mature once they come out from initiation and they can do as they please. Among the Yao, it was also identified that these feelings of maturity, accompanied by encouragement to have sex from elders or instructors known as *nankungwis*, promote high risk behaviour among the youth leading to HIV infection, STIs and teenage pregnancies, which were reported to be high among the Yao.

The practice of *jando* (circumcision) that takes place at the Yao initiation ceremonies was also identified as putting people at risk of infection. Although most of the participants reported that the government initiative to encourage people to use a new razor blade for each child when conducting circumcision, has been adopted by many people, alternatives such as taking a boy child to hospital for circumcision have become popular. A few participants argued that in remote rural areas, some people continue using only one razor blade for all the children, which is a high risk for infection, especially in cases where one child is HIV positive.

Most of the participants argued that because of strong cultural values, it is a challenge for the people who live in these cultures to be open to awareness campaigns and information sharing sessions that intend to facilitate behavioural change, because they feel and experience that people are against their culture. This, coupled with the lack of education was identified as one of the reasons contributing to the growing rate of HIV infection in Malawi.

(iv) To obtain views and suggestions of Malawians living in Gauteng about interventions to prevent the risk of HIV infection that might be caused by cultural practices of the Chewa, Tumbuka and Yao tribes in Malawi.

In the current study, it was identified by participants that most people in rural areas are illiterate; at the same time they value and hold strong cultural beliefs. Participants reported that a number of programmes in all official languages on radio, and some on television, are broadcast to educate people in towns and villages on how to prevent HIV transmission. However, it was identified that most programmes fail because of a lack of funding and sponsorship, poor attendance from community members who are the targeted audiences, lack of education and strong cultural beliefs which often lead to the disbelief of some of the factual messages. For instance, one participant reported that some people do not believe that AIDS exists and that some feel that it is just like any other disease and everyone will die anyway, so they do not see the

importance of changing their risky behaviour. Other participants identified the poor leadership on the part of people who lead HIV and AIDS educational campaigns within their areas.

Participants therefore recommended that intervention programmes should incorporate the cultural context and beliefs of the people, as this would have an impact on the success of the programme since community members would feel that they themselves own the process and are part of it. This corresponds with the views of Loosli (2004) that the significance of understanding the cultural context and situational context of communities before any programme can be planned and implemented and that the cultural influence on behaviour and its influence as a barrier to prevention cannot be underestimated.

In addition, participants suggested that government should therefore be involved in the creation of programmes with the help of community members. It was identified that village elders should be involved as they are the most respected by people in their communities; hence they are influential and can have an impact on such educational campaigns. Participants reported that it would be beneficial to educate the elders so that they can use the platform of initiation to teach the youth about HIV and AIDS transmission and prevention, in order to limit infection. In relation to this statement, the participants recommended that influential and educated members should be involved in educational campaigns since people tend to listen to those who are viewed as important. Other participants also suggested that the youth should be involved in activities like the church choir, drama and sport, to ensure that they are distracted and kept busy and to prevent them from being idle or involved in activities that cause them to be vulnerable to risky behaviour that promotes HIV transmission.

Participants recognised the significance of involving parents in sex education together with the elders and chiefs. The participants were concerned about the fact that children often receive information on sexuality from friends or the village elders (*nankungwis*) who may not have accurate information and do not talk about prevention and HIV transmission. This is in agreement with Geubbles and Bowie's (2006) views that in the Malawian culture, parents do not discuss such issue with their children. It is significant to note that in rural Malawi it is taboo to talk to children about sex; this is often left to the elders at initiation. Therefore, the involvement of parents is viewed as very important in ensuring that children are given full understanding at home, in an attempt to lower the risk of infection (Scott, 2009).

A few participants suggested that government should put more centres in rural areas, with educated members of the community who are knowledgeable, to coordinate awareness programmes about the link between culture and HIV and AIDS.

5.4 CONCLUSION

In conclusion, the aim of the study was to explore the understanding and perceptions of members of the Yao, Tumbuka and Chewa Malawian tribes living in Gauteng, about the role that cultural practice plays in promoting high risk behaviour in indigenous Malawian tribes. In particular, it looked at their views and perceptions on the link between cultural practice and HIV and AIDS, the cultural practice among the three tribes that put people at risk of HIV infection and suggestions about interventions to prevent the risk of HIV infection that might be caused by these cultural practices.

It appeared from the findings of the study that the participants understand and perceive the link between cultural practice and HIV and AIDS. The participants were able to identify the significant practices that put people at risk of infection such as wife inheritance, polygamy, bride price, initiation ceremonies and traditional marriages. For instance, the practice of initiation that takes place in all three tribes teaches young girls and boys about how to practise sex at the tender ages of 10 -14. The initiates are encouraged to go out and practice sex after initiation as a way of proving that they are able to practise what they have been taught. Practices such as *fisi* and *kulowa fumbi* that take place often among the Chewas were identified as putting people at risk of infection, especially in cases where the male is infected. Participants also identified the lack of condom use as one of the contributing factors to HIV infection, due to cultural beliefs about condoms and the gender-prescribed cultural roles that limit the ability of women to insist on condom use, both within marriage and in relationships. This coincides with other studies, for example, Tylor (1990; cited in Van Dyk, 2008) who found that people in Rwanda were well informed about AIDS; however, none of them were using condoms. Similarly, a study conducted in Uganda by Green (1995) found that only 3% of the population was using condoms, even though millions of condoms were distributed.

Given these circumstances, such practice puts people at risk of infection. The participants mentioned that it is difficult for members of such cultures to stop this practice as they have

strong sentiments for their culture. Most participants mentioned that such values preserve the culture that they have been taught by the elders, and allows this culture to be transmitted to the younger generation. Although a few participants acknowledged that some of the cultural practices such as *fisi* (hyena) occur on a very low scale, the extent to which these practices continue, or the extent to which they have stopped, is not known (Scott, 2009).

Participants also identified other factors apart from cultural practice, as contributing to HIV infection in Malawi. This was evident from the response that some participants gave in the study conducted, that most people in rural areas are illiterate so they lack full understanding of HIV transmission and prevention. In addition, it was discussed that factors such as poverty, peer pressure, unemployment, lack of Christian values and eroding cultural values contribute to high risk behaviours that lead to HIV transmission.

Despite the negative implications that were identified in the course of the study, participants were able to identify and associate with the importance, meaning and value of cultural values and practices to many tribes in Malawi. The participants mentioned that culture is important because it gives people feelings of belonging; it gives them their identity and dignity. Culture also teaches people how to conduct themselves respectfully. At the same time, it allows for customs and traditions to be transferred from generation to generation. Participants therefore identified that culture can be used to curb HIV and AIDS transmission. It was recommended that the practice of initiation could be used as a platform to teach the young people about HIV and AIDS. Some of the participants suggested that the practice of *jando* (circumcision) which is mostly practised by the Yao could be encouraged among other tribes in Malawi and be used as a preventative strategy to reduce HIV infection, as it is has been proven that this practice reduces HIV infection. Auvert, Buveand Lagarde (2001, p.104) explain the protective effect of male circumcision on the transmission of HIV in men as follows “it reduces the total number of HIV target cells (which are numerous in the foreskin) and the reduction in the viability of HIV on the penis after sexual contact, as the main direct factor accounting for protective effect”.

Furthermore, the village elders and chiefs could be taught about HIV and AIDS and they could be used in HIV and AIDS educational campaigns, since people listen to village elders. In addition, it was recommended that influential people who are educated members of the community could be involved in educational campaigns. Participants suggested that parents

could be involved in teaching the young about HIV and AIDS. On the other hand, the young could be kept busy with recreational activities such as church choirs and sports to ensure that they are occupied and not idle, which might prevent them from being involved in risky behaviour. The participants also suggested that cultural-specific programmes could be introduced, such as drama, to teach people about the link between HIV and AIDS in order to attempt to decrease the HIV infection rate in Malawi. As argued by Scott (2009) there is a need for HIV intervention and preventative programmes including condom usage and distribution to be designed around the intended population and on locally specific needs, in order for them to be successful.

5.5. RECOMMENDATIONS

The findings of the study will hopefully assist practitioners within the field of social work and social development to understand the role that the cultural practices of the Tumbuka, Yao and Chewa tribes play in exacerbating HIV infection and how such cultural practice can be modified to ensure that the risk of infection is reduced. Some recommendations will also address the type of programmes and interventions that can be introduced to ensure that HIV and AIDS transmission is reduced among the members of these tribes and other tribes in Africa.

5.5.1 RECOMMENDATIONS IN TERMS OF EDUCATION

Throughout the study, one of the factors identified as increasing HIV infection was the fact that many people in rural areas are illiterate therefore they lack full understanding of HIV transmission and preventative measures. Loosli (2004) argues that because of the lack of education and the strong cultural belief, people in villages are ignorant of the risk that some cultural practice poses for HIV infection. Therefore, education is significant in rural areas.

(i) Education of village elders and chiefs

Loosli (2004) mentions that traditional healers, chiefs, community leaders and political leaders, faith-based leaders, elder men and women, have a great role to play in HIV and AIDS prevention and care because they are trusted within their societies. It is argued that their social power allows them to influence behaviour change, which might promote the prevention of HIV infection. It would be crucial to educate the elders on HIV and AIDS to ensure that they have full

understanding and knowledge on the issue so that they can be used to educate the people within their communities. As argued by Nyerges (2006,p. 49) "although a number of people can claim they know about AIDS, there seems a lack of accurate knowledge and understanding about how HIV infections occur, how treatment works and the detailed aspects of how the virus reacts in the body". This is what makes them believe that HIV is like any other disease. Therefore, involving and teaching elders and leaders in villages about the link would be very beneficial.

The elders should also be involved in programme development from planning until the end to ensure that they feel that they own the project, in order for the project to be successful. This is confirmed by Loosli (2004) who suggests that involvement of community leaders is crucial in the fight against HIV and AIDS, especially in villages where people listen to community leaders. Government should therefore be involved both in providing the education and in the educational campaigns as sponsors and as part of monitoring and evaluating the programmes to ensure that they are sustainable.

(ii) Influential /educated people within communities

Educated people who are successful members of the community could be used to educate people within villages with the guidance of government departments. Loosli (2004) argues that education is the key to ensuring that people receive the correct messages about HIV and AIDS. Therefore, educators responsible for HIV and AIDS educational campaigns in villages should be adequately informed on the link between HIV and AIDS and cultural practices within a particular community which might unknowingly be promoting HIV infection, and they should also understand the reasons that prevent people from practising safe sex within their area. This will make it possible for people to receive correct information which might cause them to reflect on and change the behaviour that puts them at risk of infection.

(iii) Education at initiation ceremonies

It would be worthwhile to do thorough training of the elders (known as *nakungwis*) who teach children at initiation ceremonies about HIV and AIDS transmission and preventative measures so that they can use the platform of initiation to teach the youth about the link between cultural practice and HIV infection and HIV and AIDS in general, STIs and teenage pregnancies. This is likely over time to contribute to the reduction of HIV infection. For instance, Nyerges (2006)

argues that in Zambia, traditional healers known as *fimbusa's* were taught about HIV and were in the forefront of encouraging the termination of sexual cleansing as an alternative practice. Similarly, the elders (*nakungwis*) could also be encouraged to find alternative ways of sex education, instead of teaching the children the graphic details of how to practise sex and how to please their husbands in bed. The elders could be encouraged to promote education and empowerment of the young women, instead of encouraging early marriages that often make the young women vulnerable to HIV infection.

5.5.2 RECOMMENDATIONS ON INTERVENTION PROGRAMMES

(i) Women and youth empowerment

Nyerges (2006) argues that traditional practice often reflects socially constructed defined gender and cultural roles that create an environment in which women are a challenged in initiating condom use in a relationship. This situation is common to many women from the tribes, as reported by participants. Such women are submissive and passive because of their culturally prescribed role; hence they do not attempt to negotiate condom use in fear of their dominant husbands or partners. As a result, they put themselves at risk of infection, especially in cases where their partner is infected. A study conducted by Geubbles and Bowie (2006) in Malawi confirms this statement. Only 6% of men and 3% of women reported use of condoms within marriage. It was identified that condoms were often used outside marriage.

It is argued that poverty contributes to prostitution and economic dependence, which makes it difficult for women to get out of abusive relationships and to negotiate safe sex (Scott, 2009). Poverty also contributes to women being financially dependent on their husbands. This is often the case in rural Malawi where most of the women are illiterate and depend on their husbands financially. In the same way, many members of the youth in rural Malawi are unemployed and live in poor conditions. As a result, they get involved in risky behaviour that promotes HIV infection. It is important for the government, together with non-profit organisations, to introduce programmes for instance for small business initiatives, micro loans, skills development and income generating projects such as vegetable garden projects and sewing projects, to empower both the youth and the women in rural areas so that they are able to become self-reliant.

(ii) Men's involvement in intervention programmes

It was argued by the participants that it is mostly the women who attend HIV educational campaigns and not the men. It was discussed that this is the case because men do not see the significance of attending such meetings as they often view illness as a subject for women and not themselves. It is significant to note that it is the men who often have the sexual power in relationships and who often insist on not using condoms. It would be significant to involve them in order for real change to take place where condom use is concerned. Nyerges (2006) argues that neglecting the males in interventions that are intended for both men and women results in failure of the programmes in meeting the needs of the people, as the ability to implement behaviour change is constrained by men.

(iii) Using entertainment to send messages

A number of programmes could be introduced, such as drama, which focuses on the link between cultural practice and HIV infection. These could be in the languages of the community members. Government should therefore be involved to ensure that there is adequate sponsorship of the programmes.

(iv) Accessibility of condoms

A study conducted in the rural Thyolo district in Malawi among VCT clients, found that 7% of participants used condoms always, 44% intermittently and 49% never used them at all (Geubbles and Bowie, 2006).Some of the reasons that were identified were that it was because they were having sex with a regular partner, that condoms were not available, the belief that condoms reduce pleasure and the partner's refusal to use condoms because of religious reasons. Geubbles and Bowie (2006) explain that the group with the highest rate of HIV in Malawi is the group of people between the ages of 15 to 19 years. In an extensive survey among secondary school students in Malawi by Population Services International (PSI) it was found that 34 % of sexually active girls and 55 % of sexually active boys had never used condoms (Geubbles and Bowie, 2006). The two main reasons for not using condoms were moral objections and that condoms were not available when needed. It is evident that condoms are not easily available and accessible in all areas in Malawi. It would be considerate of government to accept and implement

a policy where condoms are readily made available and accessible free of charge everywhere, but especially in the remote and rural areas of Malawi.

Loosli (2004) mentions that sex is often a taboo subject in Africa and it becomes embarrassing to buy or carry a condom because condoms are associated with promiscuity and prostitution. This is the case because it is believed that condoms were first used by prostitutes. Condom use is also faced with parental opposition which makes young people, especially young girls, feel embarrassed to carry them (Loosli, 2004). It is argued that parents, church leaders and community leaders think that talking about condoms and sexuality with teens could motivate them to start sexual activity. However, such people fail to acknowledge the fact that teenagers are becoming sexually active at a very young age, as compared to their era, regardless of whether or not they are taught about safe sex. It is undeniable that by ignoring this fact, more and more children will be infected.

(v) Education on Condom use and as a preventative measure

It is evident from the study that many people are ignorant about the importance of using condoms as a preventative measure. For instance, many people reported that condoms have pores, that 'it's like eating a sweet in a paper' and other beliefs discussed previously. This is confirmed by Loosli (2004) who states that most people in Africa are simply ignorant of condom use and have no basic sexual knowledge. It is important therefore to provide education on female preventative measures and on how to correctly use condoms and to emphasise the significance of their use.

5.5.3 RECOMMENDATIONS ON POLICY

(i) Policy for cultural practices

It was clear from the findings of the study that a number of cultural practices put people at risk of HIV infection. Instead of advocating such practices to be abolished, policy makers should encourage village elders and chiefs to find alternatives for such practices. Policy makers should therefore put laws in place that govern such practices, for instance every person who enters into polygamy and wife inheritance could be tested for HIV. In the same vein, in practices such as *fisi* (hyena) or *kulowa fumbi* (meaning wiping away of dust) the male partner should be tested for

HIV and be encouraged to use condoms. Jere (2009) explains that the possibility of contracting HIV is high, especially if the *fisi* is infected, then the girl can be infected and she can also infect the man she has to marry. The ritual therefore exposes the girl to the virus, as she does not know the status of the man she is going to have to sleep with.

(ii) Policy encouraging sex education among the youth

Although discussion with the youth about condom use and sex are often viewed as taboo among many adults in Malawi, it is however crucial to teach/inform young people about safe sex and to include this as part of policy. Studies have shown that sex education of young people does not encourage promiscuity, and when they are well informed about sexual issues studies have shown that young people are able to delay sexual activity (Nyerges, 2006).

5.5.4 RECOMMENDATIONS ON FUTURE STUDIES

(i) Studies on the extent to which cultural practice is still taking place

Contrary to the claims that practices such as wife inheritance, polygamy and the practice of *fisi* (hyena) have declined, many participants in the study stressed that these practices still occur today in Malawi, but on a low scale. Therefore, it would be valuable to conduct further studies to explore the extent to which practices such as *fisi* (hyena) or *kulowa fumbi* (wiping of dust) are taking place in rural and other remote areas of Malawi, in order to effect change. This is to ensure that intervention programmes are specific and up to date with what is occurring, instead of just assuming that such practices are no longer taking place. For instance in the study, a few participants mentioned that the practice of *fisi* (hyena) and *kulowa fumbi* (wiping of dust) is still taking place in the very rural areas of Malawi. Scott (2009) argues that it is important to conduct culturally relevant studies to inform prevention policies and programmes that can effectively reduce the spread of the disease.

(ii) Studies on the level of understanding of people about HIV and AIDS

Secondly, it would be worthwhile to conduct further studies on the level of understanding that people have on both the transmission of HIV and preventative measures and treatment in rural areas in Malawi, since a number of participants in the study did not have a complete understanding of the virus. The aim is to ensure that everyone is educated about the disease in

order to curb new infections. It would also be interesting to expand a similar study to other tribes in Malawi so that interventions can be introduced that will take into account the different cultural practices of the different tribes.

5.6 CONCLUDING COMMENT

From the study it was clear that traditional practices are fundamental to the Yao, Chewa and Tumbuka tribes in Malawi. At the same time, it has been identified that a number of cultural practices such as polygamy (*mitala*), wife inheritance (*kuhara*), the practice of *fisi* (hyena), *kulowa fumbi* (wiping of dust) and initiation ceremonies promote risky behaviour that put people at risk of HIV and AIDS infection. Although some literature has recommended that such practices be abolished or changed as they put people at risk, it is important to note that most of these practices are significant to the lives of African tribes such as the Malawian tribes that practice them, hence abolishing them would be problematic (Gauseet, 2001).

Many people in rural Africa do not view HIV as a result of cultural practice, belief and custom, but rather as a result of western practice and influences that have led to the erosion of many cultural beliefs, traditions and customs (Gauseet, 2001).The findings showed that it is not cultural practice alone that contributes to the high HIV infection in Malawi. Rather it is a combination of factors such as the lack of education, strong cultural beliefs, lack of condom use, peer pressure, poverty and gender inequality when it comes to condom use, that contribute to a lack of behavioural change among the members of the three tribes interviewed. It is therefore fundamental to understand that there are factors beyond cultural practice, which also put people at risk of infection. Parker (2001) confirms that factors influencing HIV infection are far more complex than cultural factors alone. It is clear that not just cultural, but structural, political and economic factors shape sexual experience and therefore prevent the possibility of sexual behavioural change. According to Spark-du Preez, Zaba, Nyamukapa, Mlilo and Gregson (2004) it is therefore critical to recognise cultural practice as one of, and not the only factor that puts people at risk of infection among the Yao, Chewa and Tumbuka tribes.

It would therefore be beneficial for interventions and programmes to be created in ways that recognise the cultural contexts of the tribes under study, in order for them to be successful. It has been argued that failure to recognise the context in which the cultural practices are embedded

when creating programmes has contributed to the failure of many of them in Africa(Pelto & Pelto, 2005).It is therefore beneficial to use culture as a resource in order to win the fight against HIV and AIDS (Gauseet, 2001).

REFERENCES

Abdool-Karim, S.S., & Abdool Karim, Q. (2005).*HIV/AIDS in South Africa*. New York: Cambridge University Press.

Ali, M., Cleland, J.G., & Carael, M. (2001).Sexual risk behavior in urban population of northeastern Africa. *Aids & Behaviour, 5, 4,* 343-352.

Auvert, B., Buve, A., & Lagarde, E., Kahindo, M., Chege, J., Rutenberg, N., et al. (2001). Male circumcision and HIV infection in four cities in Sub-Saharan Africa. *AIDS; 15, 4,* 31-40.

Ayikukwei, R., Ngare, D., Sidle, J.E., Ayuku, O., Baliddawa, J.,& Greene, J.(2008).HIV /AIDS and Cultural practices in Western Kenya: the impact of sexual cleansing rituals on sexual behavior. *Culture, Health & Sexuality: 10, 6,* 587-599.

Babbie, E., &Mouton, J. (2002).*The Practice of Social Research*. Cape Town: Oxford University Press.

Baylies, C., & Bujra, J. (2001).AIDS, sexuality and Gender in Africa. Collective Strategies and Struggles in Tanzania and Zambia: Social aspects of aids, institute of education. *Culture, Health and Sexuality, 4, 3*, 357-369.

Belgrave, F.Z., Marin, B.V.O., & Chambers, D. B. (2000). Cultural, Contextual and intrapersonal predictors of risky sexual attitudes among urban African American girls in early adolescence. Cultural Diversity and Ethnic Minority Psychology, 6, 309,322.

Bezuidenhout, F.J. (2008). *A reader on selected social issues.* (4th ed). Pretoria: Van Schaik.

Bless., Higson-Smith, C., & Kagee, A. (2006). *Fundamentals of Social Research Methods: An African Perspective.* (4th ed). Cape Town: Juta& Co Ltd.

Bryman, A., & Bell, E. (2007).*Business research methods*. (2nd ed). New York: Oxford University Press.

Caldwell, J.C., Caldwell, P.P., & Quiggin, P. (1989).The social context of AIDS in sub-Saharan Africa. *Population and Development Review, 15, 2*, 185-234.

Campbell, T., & Kelly, M. (1995). Women and AIDS in Zambia: A review of the psycholosocialfactors implicated in the transmission of HIV. *AIDS Care, 7*, 3, 364-373.

Claton, G.J. (2000). *AIDS in Africa*: *A pandemic on the Move.* New York: Novinka Books.

De Vos, A.S, Strydom, H., Fouche, C.B., Poggenpoel, M., & Schurink, E.W., (1998).*Research at Grass Roots: A premier for the caring professions*. Pretoria: Van Schaik.

Feldman, D. A. (2008.)*AIDS, Culture and Africa*. Florida: University Press.

Garret, L. (1995).*The coming Plague*: *Newly emerging disease in world out of balance*. New York: Penguin.

Gauseet, Q. (2001). AIDS and Cultural practices in the case of the Tonga (Zambia) *Journal of Social Science & Medicine, 52,* 509-518.

Geubbles, E.,& Bowie, C. (2006). Epidemiology of HIV/AIDS in adults in Malawi Center for Reproductive Health, Department of Community Health, College of Medicine, Malawi.*Malawi Medical Journal, 18, 3,* 99-121.

Giddens, A. (2001).*Sociology* (4thed). Cambridge: Polity Press.

Green, E.C., Zokwe, B., & Dupree, J.D. (1995). The experience of an AIDS prevention Programme focused on South African traditional Healers. *Soc Sci Med, 40, 4, 503-15.*

Grinnell, R. M. (2005*).Social Work Research &Evaluation* (6thed) Itasca: Peacock.

Halperin, D. T., & Epstein, H. (2004).Concurrent sexual parterniship help to explain Africa's High HIVprevalence: Implications for Prevention. *Lancet, 3-9, 364*(9428), 4-6.

Hayase, Y., & Lee-Liaw, K. (1997).Factors on Polygamy in Sub-Saharan Africa: Findings based on the demographic & Health Surveys. *The Developing Economies, xxxxv-3,* 293-327.

Inungu, J., & Karl, S. (2006).Understanding the Scourge of HIV/AIDS in Sub-Saharan Africa. *MedGenMed, 9, 8, 4, 30.*

Jere, M.N. (2009). *The influence of cultural practices on the spread of HIV and AIDS on Zambian people.* Unpublished doctoral thesis. University of Pretoria, South Africa.

Kalipeni, E., & Ghosh, J. (2006).Concern and practice among men about HIV/AIDS in low socioeconomic income areas of Lilongwe, Malawi. *Social Science & Medicine, 64*, 1116-1127.

Kondowe, E.B.Z., & Mulera, D. (1999).*A cultural approach to HIV/AIDS prevention and care*: *Malawi's experience.* UNESCO/UNAIDS Research Project. Country Report. Studies and Reports, special series (of the cultural Policies for development unit), 5, 23. CLT.2000/WS/13. Retrieved from on 10th October 2010 from http://www.unesdoc.unesco.org.

Leedy, P.D., & Amrod, J.E. (2005) *Practical Research: Planning and Design*. New York: Allyn & Bacon

Leedy, P.D. (2005).*Practical Research: Planning &Design*. New York: Macmillan

Loosli, B.C. (2004). Traditional practices and HIV prevention in Sub-Saharan Africa. Geneva. Switzerland. Retrieved October 6, 2010 , from http://www.gtmer.ch/GFMER_members/pdf/Traditional_HIV_loosli.pdf

Lwanda, J. (2005). *Politics, Culture and Medicine in Malawi*: *Historical continuities and Ruptures with special reference to HIV/AIDS*. Zomba: Kachere.

Magezi, V., (2007).*HIV/AIDS Poverty & Pastoral care &Counseling: A home based and congregational systems ministerial approach in Africa*. South Africa: Sun Press.

Malawi Human Rights Commission. (2005).*Cultural policies for development unit. Cultural Practices and their impact on the enjoyment of Human Rights, Particularly in the Rights of Women and Children in Malawi.* Research report. Lilongwe: Malawi Human Right Commission.

Malawi Aids Policy. Retrieved 2nd March 2010 from http://www.Safaids.net/ files/Malawi_ nation/ 2003 Malawi AIDS Policy.

Maxwell, D.L., & Satake, E. (2006).*Research and statistical methods in communication sciences and disorders*. Boston: Thomson/Delmar learning.

McCrearly, L.L., Kaponda, C.P.N., Norr, K.F., Jere, D.L., Chipeta, C.H., Davis, K.K., et al. (2008). Rural Malawians' Perceptions of HIV risk behaviours & their social cultural context. *AIDS Care, 20,* 8, 946-957.

Mitsunaga, T.M., Powell, A. M., Heard, N. J., &Larsen, U.M. (2005). Extramarital sex among Nigerian Men: Polygyny and other risk factors*Acquir immune Defic Syndr, 39*, 4.

Mouton, J. (2001).*How to succeed in your Master's and Doctoral Studies.* Pretoria: Van Schaik Publishers.

Muganwa, D. (2005).*Project Performance for Sustainable Project Management*.University of the Witwatersrand, Johannesburg, South Africa.

Mwale, M. (2008).Behavioural Change vis-a vis HIV/Aids Knowledge Mismatch among Adolescents: The case of Some Selected Schools in Zomba. *Nordic Journal of African Studies, 17,* 4, 288-299.

Niehaus, I. (2007). Death before dying: understanding AIDS stigma in the South African lowveld.*Journal of Southern African studies, 33,* 4,845-860.

Nyazi, S., Emodu-Walakira, M., &Serwaniko, W. (2009). The Widow, the will and Widow-inheritance in Kampala. Revisiting Victimization arguments. *Canadian Journal of African Studies, 43,* 1, 73-89.

Parker, R. (2001).Sexuality, culture and power in HIV/AIDS Research. *Annual review of anthropology, 30,* 163-179.

Pelto, P.J., &Pelto. G. J. (2005). Culture and Behaviour in applied medical anthropology. *Medical anthropology quarterly, new series, 11,* 2, 147-163retrieved on the 10th October 2010 from www.jstor .org.

Peltzer, K., & Mngqundaniso, N., & Petros, F. (2006). HIV/AIDS/STI/TB/Knowledge, beliefs and practices of traditional healers in Kwazulu-Natal, South Africa. Human science research council of the University of Limpopo and Human science research council. Routledge Taylor and Francis group. *AIDS care August,* 18, 6, 608-613.

Poulin, M. (2005).*Giving and Getting: Rethinking Sex, Money, and Autonomy among Youth in Rural Malawi*. Paper presented at the Princeton Institute for International and Regional Studies Graduate Student Conference, April 8-9, 2005 retrieved on 19th March 2010 from http://www.princeton.edu/~gradconf/index_files/papers/Poulin.pdf]

Punch, K. F. (2005).*Introduction to Social Research:* Quantitative and Qualitative Approaches. Sage Publications: London.

Nyerges, R., J., A. (2006).*HIV/AIDS Prevention in Zambia: A preliminary study of obstacles to behavior change in the copperbelt.*Unpublished doctoral thesis. Naval postgraduate school: Montery, California.

Reniers, G., & Tfaily, R. (2008).*Polygny and the spread of HIV in sub-Saharan Africa*: A case of benign concurrency. California Centre for Population studies, University of California-Los Angeles, ccpr 043-09(Polygyn &HIV in Sub-Saharan Africa), 1-26

Report on the global Aids Epidemic. (2009). UNAIDS: Geneva.

Report on the global Aids Epidemic. (2004). UNAIDS: Geneva.

Schuklenk, U**.** (2004). *AIDS, Society Ethics, and law.* Burlington: Ashgate.

Scott, S. (2009). HIV/AIDS: understanding socio-cultural factors and their Influence on Sexual Behaviour and Decision Making in Africa. *Journal of the University of Manitoba Anthropology Students 'Association.Vol, 28*.

Seeley, J. A. Malamba, S.S., Nunn, A.J., Mulder,D.W.,Kengeya-Kayondo,J.F., & Barton, T.G. (1994).Socioeconomic Status, Gender, and Risk of HIV-1 infection in a Rural Community in South West Uganda. *Medical Anthropology Quarterly, 8, 1*, 78-89.

Shambley-Ebron, D.Z. (2009).My Sister, Myself: A culture-and Gender-Based Approach to HIV/AIDS prevention. *Journal of Transcultural Nursing, 20, 1*, 28-36.

Smyth, B. (2000). The commercial sexual exploitation of children in Southern Africa.*ECPAT International, 6-17*.Retrieved 19th March 2010from http://www.ecpat.net/eng.

Spark-du Preez, N., Zaba, B., Nyamukapa, C., Mlilo, M., & Gregson, S. (2004). Kusvika Taparadzaniswa Nerufu (until death do us part). *African Journal of AIDS Research* 3, 1, 81-91.

Struensee, V. (2004).The domestic relations Bill in Uganda: Potential for addressing polygamy, bride price, cohabitation, marital rape, widow inheritance, and female genital Mutilation. Retrieved on from 11October 2010fromhttp://www.preventgbvafrica.org/content/domestic relations-bill-Uganda-addressing-polygamy-bride price-cohabitation-marital rape, widow inheritance and female genital Mutilation.

Van Dyk, A.C. (2008). *HIVAIDS Care and Counseling: A multidisciplinary Approach.* (4th ed). South Africa: Pearson Education

Whiteside, A. (1998).Implications *of AIDS for demography and policy in Southern Africa.* Pine Town: University of Natal Press

Yin, R.K. (2003).*Applications of case study research* (2nd ed) London: Sage Publications.

Yoder, P.S., & Matinga, P. (2004).*Voluntary Counseling & testing (VCT) for HIV in Malawi: Public perspective & recent VCT experience*. Calverton, MD.

APPENDIX A

PARTICIPANT INFORMATION SHEET

Good day,

My name is Juliana Munlo and I am a qualified social worker and a Masters student at the University of the Witwatersrand. As part of the requirement of a Master in Arts degree in Social Development, I am conducting research on the role and implications of cultural practice in promoting HIV infection in indigenous Malawian tribes living in Gauteng, South Africa.

I therefore wish to invite you to participate in my study. Your participation is entirely voluntary and refusal to participate will not be held against you in any way. If you agree to take part, I shall arrange to interview you at a time and place that is suitable for you. The interview will last approximately one hour. You may withdraw from the study at any time and you may also refuse to answer any questions that you may feel uncomfortable answering.

With your permission, the interview will be tape-recorded. No one other than my supervisor will have access to the tapes, and on completion of the study, the tapes will be destroyed after a period of six years if no publications emerge from the study, or after two years if any publications arise from the study. Please be assured that your name and personal details will be kept confidential and no identity information will be included in the final research report.

Please feel free to ask any questions regarding the study. I shall answer them to the best of my ability. I may be contacted on 072 709 2676. Should you wish to receive a summary of the study; an abstract will be made available on request.

Thank you for taking time to consider participating in the study.

Yours faithfully

Juliana Munlo

APPENDIX B

CONSENT FORM FOR PARTICIPATION IN THE STUDY

I hereby consent to participate in the research project. The purpose and procedures of the study have been explained to me. I understand that my participation is voluntary and that I may refuse to answer any particular items or withdraw from the study at any time without negative consequences. I understand that my responses will be kept confidential.

Name of Participant: _____

Signature: _____

Date:_____

APPENDIX C

CONSENT FORM FOR AUDIO-TAPING OF THE INTERVIEW

I hereby consent to tape-recording of the interview. I understand that my confidentiality will be maintained at all times and that the tapes will be destroyed two years after any publication arises from the study or six years after completion of the study if there are no publications that arise.

Name of participant: _____

Signature: _____

Date: _____

APPENDIX D

SEMI-STRUCTURED INTERVIEW SHEDULE

DEMOGRAPHIC PROFILE OF PARTICIPANTS

GENDER

MALE	
FEMALE	

AGE

30-35	
36-40	
41-45	
46-50	
51-55	
56-60	
61-65	

ETHNIC TRIBE

CHEWA	
YAO	
TUMBUKA	

YEARS LIVED IN THE VILLAGE

4- 6 Months	
6-12 months	
1-2 years	
2 years and above	

EDUCATIONAL LEVEL

Below GR 8	
GR 10-12	
College Diploma	
University Degree	

1. **When you think about your culture how would you describe the meaning it has in your life?**

2. **Share your knowledge on the significant cultural practices in your tribe.**

3. **What do you think is the meaning attached to these cultural practices?**

4. **In your view are these cultural practices still common in Malawi?**

5. **Discuss the cultural practices that you still follow or adhere to.**

6. **Despite the fact that 90% of Malawians are aware of HIV and AIDS the prevalence is increasing, what is your opinion in this regard?**

7. **Which of the cultural practices in your tribe do you think might contribute to the risk of HIV infection?**

8. **Describe your view about the awareness, knowledge and understanding of Malawians in rural areas about the possible link between cultural practices and HIV and AIDS.**

9. **Discuss the intervention programmes on HIV and AIDS that were implemented in Malawi that you are aware of in relation to cultural practice and HIV and AIDS.**

10. **Why do you think those programmes were not successful?**

11. **How do you think cultural practices can be used as part of awareness and prevention campaigns in HIV and AIDS in Malawi?**

12. **If you were to develop and implement HIV and AIDS intervention in Malawi how would you do it?**

APPENDIX E

ETHICS CLEARANCE CERTIFICATE