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Healing Culture, Healing AIDS[1]: A Review of some African Cultural and Religious Beliefs and Practices in Contexts of HIV and AIDS

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Abstract

This essay sees culture as a two-edged sword in HIV and AIDS response. It argues that while scholarly attention has mainly been on how certain cultural practices facilitate the spread of HIV and stand in the way of prevention, treatment and care, there are some ethno-cultural and religious beliefs and practices that can be used for positive HIV and AIDS response. The essay thus identifies and discusses some ethno-cultural and religious factors that contribute to the spread of HIV with the aim of 'healing' those that fuel the spread of HIV and promoting those that can be used for positive response.
Key words: HIV and AIDS, ethno-cultural and religious beliefs, healing

Introduction

The HIV and AIDS pandemic breeds in certain socio-cultural and religious beliefs and practices throughout the world. In a study on the male psyche with respect to reproductive health, HIV, AIDS and genders issues in Zimbabwe, Chiroro, Mashu and Muhwava (2002) found out that the culture and legal system in Zimbabwe provide a fertile ground for the propagation and perpetuation of adversarial sexual beliefs, gender role stereotypes and high-risk sexual behavior among men and male youths. Culture, more often, prescribes specific behavior patterns for women and men that put them at risk of HIV and AIDS. The Centre for the Study of Violence and Reconciliation in South Africa (Berner-Rodoreda 2006), for example, has identified a township culture that prescribed many sexual partners as a mark of manhood. But socio-cultural and religious

[1] This title is influenced by Ezra Chitando's (2009) chapter 2 title, 'Healing Culture: Inculturation theology and HIV.'

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beliefs and practices do not only pose risk to the spread of HIV and AIDS, they can also be used to respond positively to the pandemic especially in prevention, care and solidarity with the infected and affected. For example, some cultures and religions emphasize sexual ethics that can be used to respond positively to HIV and AIDS. Weinreich and Benn (2004), note the Muslim, Jewish and Christian teachings on pre-marital abstinence and lifelong marriage faithfulness that can be used for HIV prevention. In cognizance of these two realities: that socio-cultural and religious beliefs and practices can fuel the spread of HIV and AIDS; and that these factors can also be used for positive HIV and AIDS response, in this essay I intend to identify and discuss some factors that contribute to the two scenarios with the aim of 'healing' those that fuel the spread of HIV and promoting those that can be used for positive HIV and AIDS response. As the world seeks healing of HIV and AIDS, traditional cultural and religious beliefs and practices need serious attention. This is because it is through them that people perceive the world and make sense of it.

I approach the discussion from my own social location. A social location is an individual's place or location in society (Dube 2003:101) from which s/he understands, makes judgments, values and thinks (Randolph Tate 2006:340) thus determining actions. One's social location is made up of many factors: family, work, church, neighbourhood, education level, gender, nationality and so on. In discussing one's social location Mary Tolbert (1995:305-317) identifies two categories of issues on social location: issues of bread (economic issues) and issues of blood (biological issues). I shall not give a comprehensive description of these two issues of my social location but simply to mention few issues that directly affect my discussion in this essay. My social location will therefore be limited to my gender, age, geographical location, profession and religious/church inclinations. After this brief description of my social location, I will outline and discuss factors that tend to fuel the spread of HIV and AIDS. In the third section I outline and discuss factors that can be used as anchors for positive HIV and AIDS response. Lastly, I will then reflect on how the Church[3] and all those who want to respond to HIV and AIDS can learn from these ethno, socio-cultural and religious factors in developing tools and programmes for positive HIV and AIDS response in the areas of prevention, care and support.

My Social Location

I am a man of forty years, married with two children, a boy and a girl. I am a Zimbabwean by nationality, living and working in Botswana. I am an academic, teaching and researching at the University of Botswana in the area of theology and religious studies. I am also an ordained minister of the Church of Christ. Apart from teaching theology and religious studies, I have conducted research in the area of HIV and AIDS. I have led several research projects on religion and HIV and AIDS and in one of these projects we developed a strategy for HIV and AIDS response by the faith sector in Botswana under the auspices of the Ministry of Health. I therefore address issues of ethno-cultural factors and HIV and AIDS from my social location perspective. Much of

[3] The Church in Africa is a significant player in HIV and AIDS response (see Dube 2008, Igo 2009, Parry 2013 on the Church and HIV and IDS response). I also focus on the Church here since I consider it better placed to deal with issues of cultural and religious beliefs that have an impact on HIV and AIDS response. During the missionary period, it is the Church that condemned African religious and cultural practices. The Church may consider reversing this attitude in this post-colonial and HIV and AIDS context where certain cultural practices can help in HIV response.

what I say in this essay is therefore based on my experiences as a man living in Zimbabwe and Botswana, privileged to impart wisdom to others (in church, at institutions of higher learning, to government policy makers etc). My social location also allows me to be able to compare and contrast what I have experienced, what I have learnt from my Shona[4] culture with what I know of other cultures through travel, research and reading.

Socio-cultural and Religious Beliefs and Practices that fuel the spread of HIV and AIDS

A number of African traditional beliefs and practices have come under fire in this era of HIV and AIDS (PACANet 2011). It is therefore not possible for me to exhaust them in this section. I select a few for discussion, exposing why they could be risky beliefs and practices in the context of HIV and AIDS.

Stigmatisation

Despite many years of education, people infected or affected by HIV and AIDS remain stigmatized. A number of people, especially in churches, continue to associate the condition with immorality. The level of HIV and AIDS stigma is seen in that very few church leaders have publicly declared their HIV positive status. Very few churches also provide an environment that allows people living with HIV and AIDS (PLWHA) to come out in the public and declare their status. In the Church of Christ, I am not aware of anyone who has declared his/her positive status among laity and clergy despite the fact that in Zimbabwe the HIV rate stands at 15% and in Botswana it stands at 17.5%. Pastors also tend to avoid the topic as it is possible to go for a whole year without hearing a sermon addressing HIV and AIDS.[5] We all act as if the Church is full of people not infected or affected by HIV and AIDS.

Bride wealth

Most African societies practice the payment of bride wealth or *lobola*. Traditionally understood to be a sign of appreciation of the man to his wife's family, *lobola* seems to have lost its symbolic meaning in contemporary settings. In Zimbabwe there are many cases of parents who ask for luxurious items such as cars, expensive cell phones, large amounts of money, etc for *lobola*. In Botswana, some ethnic groups ask for as many as eight herds of cattle, three goats and a sheep over and above some other monetary charges. In cases where the woman has fallen pregnant before marriage, 'damages' are charged resulting in the *lobola* prices doubling in some instances. This has made marriage very expensive resulting in many young people settling for cohabitation rather than marriage. The ability of marriage to stop the spread of HIV and AIDS has been questioned (Parikh 2007; Chirau 2006; Bruce and Clark 2004), however it remains the second most efficient method of HIV prevention after abstinence especially when the married are not infected and remain faithful to each other.

The problem with cohabitation is that it is not socially binding as the two just stay together without informing their relatives. As a result the cohabiting partners often break up and get new partners exposing themselves and their new partners to the risk of contracting HIV. Apart from making marriage expensive and promoting the risky

[4] The Shona make up the largest ethnic group in Zimbabwe.

[5] I have experienced this in the church I attend in Gaborone.

practice of cohabitation, *lobola* brings about gender imbalance in a marriage relationship. S. LaFont (2007:1-19) is right when she argues that today *lobola* is more often seen as payment for a bride, meaning that the husband and his family have purchased the woman, including her future domestic production and children. This practice therefore, right from the beginning of the marriage, appears to relegate the woman to an inferior position. It tends to put her in a powerless position that may promote sexual and physical abuse and also limits her ability to negotiate safe sex even when she knows her husband's unfaithfulness. In their study, Chiroro, Mashu and Muhwava (2002:16) found out that over 80% of Zimbabwean men believe that payment of *lobola* means that a woman becomes a man's property, "just like his bed, goats, cows, chickens, and so." They report that in one of their focus group discussions, one man challenged them, "Would you allow your goat to challenge you and decide what it wants? If women want equal rights, they should also pay *lobola*" (2002:16). I have heard similar views even among Christians. Some men strongly feel that payment of *lobola* declares them masters over their wives and therefore women cannot make decisions for them.

In Zimbabwe, the payment of *lobola* leads to many other cultural practices that have been condemned for the spread of HIV and AIDS. *Chiramu, kuzvarira, kugadza mapfiwa* and *kugara nhaka*[6] all are connected in some way to payment of *lobola*. *Lobola* entitles a man to *chiramu,* a practice whereby brothers-in-law are allowed to sexually play and touch young sisters-in-law in the confidence that they too are wives. Often it ends up in sex and in some families I have been informed that when the son-in-law visits the in-laws without his wife, he is given a sister-in-law to 'entertain' him over the night. This is a risky practice in the era of HIV and AIDS. Related to it is *kuzvarira*, which is a practice where a poor family marries a daughter, often an underage one, to a rich man in exchange for goods. More often than not, such a man would already be married to one or more wives. The practice leads to abuse of young girls and to their exposure to HIV and AIDS. The practice has the same effect as *kugadza mapfiwa,* which is a practice of marrying a young girl to a son-in-law in the event of the death of his wife. I discuss *kugara nha*ka separately below.

Kugara nhaka (Levirate / Widow inheritance)

Levirate practices (*kugara nhaka* in Shona) are strongly connected to the payment of *lobola* as I argued above. The Zimbabwean (or generally African) understanding of marriage is that a woman marries the family not only her husband. As a result, traditionally all family members made contributions for the *lobola* in one way or the other. Although this has slightly changed for working class men who can raise the money to pay *lobola* for their wives, unemployed men and those in rural areas still depend on their parents or on bride price paid for their sisters to raise *lobola*. The woman is therefore not only married to her husband but to the whole family. This explains why when the husband dies, the woman is expected or even forced to marry someone in the family. Among the Shona people, this is either a brother or a nephew. This practice poses high risks of HIV infection both to the widow being inherited and to the one inheriting her.

Dangerous Masculinities

By dangerous masculinities here is meant ideas/conceptions of manhood that expose man to HIV and AIDS. Virility is a common expression of masculinity as Chiroro, Mashu and Muhwava (2002) studying Zimbabwean male psyche found. Their study

[6] These Shona terms cannot be directly translated into English. I therefore explain them below.

established that generally Zimbabwean men think of sex as an activity that should result in optimal satisfaction for the man. The language that some men use in describing sex shows its close association with violence. I remember our adolescent sexual discussions describing sex by a language of violence. To have sex was referred to as *kutema* (to cut), *kubvarura* (to rip), *kurova* (to beat) and such other terms of violence. As a result manhood is characterized by having multiple partners. Even being infected with a sexually transmitted infection (STI) is given a masculine commendation: *nzombe inorwa inoonekwa nemivare* (a fighting bull bears scratch marks). This mentality results in no use of condoms, sexual coercion for women and even rape. This kind of masculinity finds it normal for men to have multiple partners as well, thus exposing themselves and their sexual partners to the risk of contracting HIV.

Anti-condom

The anti-condom attitude is taken both from religious and even non religious points of view. From a religious perspective, condomisation is seen as promoting unfaithfulness. In a study of faith based organizations (FBOs), Togarasei, et al (2008) found out that nearly all faith organizations in Botswana were against the use of condoms, especially outside marriage. Respondents found it incompatible for a Christian to carry a Bible and a condom at the same time. In the early 2000s, Pastor Noah Pashapa of the Baptist Church in Harare, raised a controversy when he suggested distributing condoms in the church and went on to keep some in his office at the University of Zimbabwe where he was a part time lecturer. The general public perception was that the pastor was promoting fornication and adultery. I remember a certain lady raising the topic of the use of condoms by married couples at the Church of Christ annual conference in Harare in 2009 in a couples' meeting. She raised the question as a complaint and a report to church pastors that there were some young women who were asking their husbands to use condoms when they come back from migrant employment.[7] It soon emerged that the issue had earlier been discussed in the women's fellowship groups and an agreement was reached by senior women that such women were not being 'submissive' to their husbands. Condoms are so shunned that there is a strong belief that they should not be used even in marriage. This is also coupled with the fact that there are many Christian organizations that are against the use of contraceptives.

From a non-religious perspective, condoms are shunned on the basis of people's understanding of sex. For those against condoms, sex with a condom is like 'having a shower with a raincoat' or 'eating a sweet in its wrapper'. In their study, Chiroro, Mashu and Muhwava (2002:25-29) found out that many Zimbabwean men (over 90% of their respondents), had a negative attitude towards condoms describing them as causing HIV, itchiness, many other diseases especially with prolonged use, as denying sexual pleasure, as providing false sense of security and as showing mistrust especially for those with a long term relationship. From our study in Botswana (Togarasei et al 2008), the attitude towards condom use from a non-religious point of view seems to have improved especially for casual sex with first time partners. The problem arises when relationships are long term and people get to 'know' and 'trust' each other.

[7] Since 2000 Zimbabwe has seen many young men leaving the country to seek employment in neighbouring countries like South Africa and Botswana. Many of these young men leave wives behind and some of them come back ill, often, with HIV and AIDS. It is these wives who, on noticing that the husband might be infected, ask for use of condoms.

Sex should be practiced but not publicly discussed

Concerning the secrecy that shrouds sex among most African people, Chitando and Togarasei remarked, "Were it not for the children born, couples would never disclose that they have sex" (2008:4-15) Yes, African traditions shroud sex such that we grew up being told that children are bought from the hospital. A number of people, both in and outside the church, are uncomfortable talking publicly about sex. I remember the last time we would publicly talk about it was when we were adolescents. Thus, although people practice sex almost 'daily' they rarely talk about it publicly. This is true even between parents and children. This is because the subject of sexuality is often associated with shame and guilt. Many of us have learnt about sex from peers. Never would parents directly address the subject except to tell you of the dangers of contracting HIV and AIDS. Even parents find it difficult to address the topic. When should I start introducing the topic? Should I open up and talk about use of condoms? Is it not that when I introduce the topic I am telling him/her of the existence of the practice? Should I continue assuming that she/he is not aware of it? These are some of the many questions parents encounter in trying to talk about sex to their children. Failing to get answers, many parents often realize too late the need to have introduced the topics earlier.

In Church the subject of sexuality is even more difficult to discuss publicly. Amanze (2007:36) sees this as a result of the negative theology of sex and human sexuality that has been the hallmark of Christian ethics from the apostolic age to the present day. The Church limits sex only to those who are married. This is despite the glaring truth that very few in Church live by this moral standard. This is evident from the fact there are many unmarried people who get pregnant or make others pregnant in the churches. Many youths have premarital children. Some of them end up getting married and rising to become church leaders. These are clear indications that many Christians are not able to abstain from sex.

Women cannot initiate sex, their No means Yes!

It is only recently in Zimbabwe that cases of women raping men have been reported (*The Herald*, 6 October 2010). In the majority of cases, women are the victims of rape by men. Cases of women rape are so high that in 2002 Caroline Dempster of the BBC reported that South African women have high chances of being raped than of learning how to read (http://news.bbc.co.uk/2/hi/1909220.stm). The high rape cases have a lot to do with cultural beliefs, for example, that women do not initiate sex.[8] I remember our older adolescent peers telling us that women will never tell you that they want sex. Even when they want they will pretend that they do not. The belief was that the mere fact that she has accepted your love proposal is enough to tell that she wants sex. Thus men 'force' women to have sex assuming that even when they say 'no' to sex they are just following the cultural expectation not to openly accept. Because of such beliefs there are some women who have their first sexual encounters through rape. The belief also makes women even in marriage relationships vulnerable. In their study, Chiroro, Mashu and Muhwava (2002:20) found out that Zimbabwean men believe that there is no rape between people who know each other, are married or are in love. As they write:

> They (men) argued that agreeing to a relationship means that the woman has given the man the right to do whatever he wants with her body, including sexual

[8] The high rates of rape in Africa referred to by Caroline Dempster are also a result of criminal rape cases. However, I am of the opinion that there are many other unreported cases of men forcing their girlfriends into sex.

> penetration… In their view, no married woman can be raped by her husband because marriage means the woman can comply when the man wants 'to have it'. One man retorted: "How can I be told that I stole that which I bought, its mine to use whenever and whatever way I want!"

The belief that women do not consent to sex leaves women not empowered to decide on safe sex. It also does not give the perpetrators the chance to put on condoms. This often happens in what Cowan (2000) calls 'date or partner rape.' The following is a description of what happens to most women for their first sexual intercourse, what Cowan calls date or partner rape,

> "Claire and Steve had been dating for a year and were planning to be engaged. Claire had told Steve that she did not believe in having sexual intercourse until after marriage, and Steve seemed to understand. One Friday while at their favorite lookout, Steve and Claire began kissing. Soon the kissing escalated and Steve threw her down on the seat and pinned her arms down with one hand while he ripped off her clothes with the other hand. Claire cried "No," but Steve overpowered her and had sexual intercourse with her" (Cowan 2000:812).

The description above suits what our older adolescent peers told us about having sex with your girlfriend. There was no belief that this could be called rape. "Women do not consent to sex, even when they want it they will appear to resist," were the words of our older peers. The belief was that only prostitutes can openly talk about and consent to sex.[9]

Polygamy and its modern forms

A number of both ethnic and Christian communities in southern Africa, e.g. in Zimbabwe and South Africa, practice polygamy. Apostolic churches lead the pack of Christian communities that practice it. The relationship between the practice of polygamy and HIV and AIDS is, however, contested (Saddiq, Tolhurst, Lalloo and Theobald 2010:146-151). Whereas some think polygamy exposes people to HIV and AIDS, others think it is a solution. Some members of the Johane Apostle Church of God in Botswana (otherwise known as Bazezuru) believe that it is not polygamy that poses a risk to HIV and AIDS but promiscuity by the monogamous. One member of the church, Nomsa Tatenda, said the following about polygamy, "I would say it's much safer to have two or more wives legally than to have several illegitimate partners." Be that as it may, polygamy raises the risk of HIV transmission since if one of the many partners is infected chances are high that it will be spread among the other partners. But Nomsa Tatenda's observation has been confirmed by a number of studies. For example, Saddiq et al (2010:150) concluded from their study in Nigeria that, "it is not polygamy/monogamy per se that shapes vulnerability to HIV and AIDS; but the ways in which women and men experience different types of marital union, which in turn is inextricably linked to religious discourses and gender roles and relations." It is mainly modern forms of polygamy in the form of multiple partners, so-called 'small houses,'[10] that pose high risks of HIV transmission. A number of men in southern Africa are in

[9] These are obviously the claims of men. Women's agency in sexual relations requires investigation.

[10] 'Small house' is a term used in a number of southern African countries such as South Africa, Zimbabwe and Botswana to refer to the practice of having other sexual partners apart from one's wife or husband.

the habit of this practice, where they have one woman they are legally married to and several other women they have sexual relations and/or children with. Often those who practice it believe they have enough money to look after more than one wife as my story below testifies: Some years ago, I caught a lift from one gentleman from Masvingo to Harare. This is a 300km distance. On our way we started discussing various topics. I soon learnt from this man that he was coming from spending the weekend with a girlfriend. I enquired as to why he was doing this in this age of HIV and AIDS to which he responded by expressing his disbelief that I did not have a girlfriend. I explained to him that I am a God fearing man who loves his wife that I would not cheat on her. He had one last response, "Young man, you still do not have money. When you have it, you will get one and remember me!"

In Botswana, apart from polygamy, the practice of multiple partners is also sometimes promoted by cultural practices like concubinage. Nkomazana (2007:66) has it that traditionally women were not supposed to have sex when they were still breastfeeding. During this time (which could last up to two years) the man was free to seek a concubine if he was not a polygamist. There was also a belief that a man is shared like a calabash of water or an axe and as a result should not be asked where he has been or where he slept (Dube 2003:91).

Need for children especially, male children

Many Africans value children and see the birth of children as the primary purpose of marriage. In most of the southern African societies which are patriarchal, it is not only the need for children, but for male children. Problems arise when a couple fails to have children or when they fail to have male children. A childless marriage is therefore risky in terms of contracting HIV and AIDS. Often men (and in rare cases, women) will go out to 'test' themselves with other women. This exposes them and their wives to HIV and AIDS. The need for children also leads people to practice what is called *kupindira* in Shona. *Kupindira* is a practice in which a brother secretly has sex with his sibling's wife if it is believed that the said brother cannot make the wife pregnant. Often the husband of the wife will not be aware of the arrangement which is usually made by elder members of the family. Again this poses high risks for the spread of HIV.

Anti-gays, lesbians and bi-sexuals

Except for South Africa, all other African countries do not recognize same sex marriages or the free association and sexual expression of gays, lesbians and bisexuals.[11] In some countries like Botswana, the law even criminalizes such acts. Human rights activists, however, argue that this contributes to the spread of HIV and AIDS. Discussing in a programme called Law Matters on 28 October 2010 on GABZ FM (a Botswana radio station), the director of Botswana Gays, Lesbians and Bisexuals of Botswana, mentioned that a study they had conducted two years earlier among men who have sex with other men pointed out that of the 120 men who participated in the study, 17% were HIV positive. They attributed this to the society's non-acceptance of these people which results in them practicing unsafe sex. She pointed out that some of these men were married as a result of social pressure and thus were involved in multiple concurrent partnerships, heterosexual and homosexual.

[11] These are just official positions. There are many Africans who confess that they are gay, lesbian, bisexual or other sexual orientations. Thus in Zimbabwe, for example, the Gays and Lesbians Association is an active association advocating for the rights of sexual minorities. In Botswana Lesbians, Gays, Bisexuals of Botswana (LEGABIBO) is fighting for official recognition and registration as an association.

Other myths and misconceptions about HIV and AIDS

There are also many other ethno-cultural and religious beliefs that fuel the spread of HIV and AIDS. Such myths and misconceptions include the belief that God is in control of everything and therefore even cures HIV and AIDS. This myth has led some people to discontinue anti-retroviral treatment (ART) believing that they only need the power of God for healing. The danger here is that such people will get ill or pass on the virus to others thinking that they have been cured. Closely related to this misconception is what Togarasei (2009) calls blind faith. This is the belief by Christians that since God is in control of everything, then individuals cannot control their fate. No effort is then made to abstain, test or seek medical help believing that God is control. Musopole (2006:10) also noted this among Malawian young people some of whom even cited Ecclesiastes, "to everything there is a time" In defense of blind faith. Other misconceptions include the belief that sex with virgins cures HIV and AIDS. In Botswana, Nkomazana (2007:66) says the misconception stems from the traditional belief that sex with a young woman rejuvenates the blood of a man. As a result, it is then believed that sex with such a woman, especially a virgin, cleanses HIV from a man's blood.

Other myths include the rejection of Western medicine by some Christian groups. In Zimbabwe, the Johane Maranke[12] is one such church that is against Western medicine. This attitude means if their members are infected by HIV and AIDS, they do not enroll in ART. Kealotswe (forthcoming) also talks of many other misconceptions about HIV and AIDS in Botswana. He tells the practice among the Kalanga in northern Botswana where traditionally sexually mature girls were advised to have sex with sexually immature boys while sexually mature boys were advised to have sex with sexually immature girls to avoid pregnancies. Whereas such a practice was seen as a contraceptive traditionally, it presents high risks of HIV infection today.

The association of HIV and witchcraft also stands in the way of turning the tide of HIV and AIDS. Associated with stigmatization which I discussed above, many families do not accept that their beloved ones are infected by HIV and so attribute the illness to witchcraft. This results in people not taking responsibility of their health and exposing themselves to HIV and AIDS. Related to associating HIV and AIDS with witchcraft is also the belief that HIV and AIDS is caused by the curse of angry ancestral spirits or a violation of sexual taboos. Such misconceptions lead to the stigmatization of the infected and people's lack of responsibility to protect their sexual partners.

Socio-cultural and religious beliefs and practices that can be used as anchors for positive HIV and AIDS response

The foregoing section has discussed ethno, socio-cultural and religious beliefs and practices that may spell doom for Africa. Some African traditions appear to be a source of death. This is not only true on issues of health but also on other developmental issues as has been discussed by other scholars. But this is not the full story of African socio-cultural and religious beliefs and practices. Eurocentrism is accused by some scholars of negatively contributing to the development of Africa. It is believed to be pushing aside African traditions leaving Africans with no identity. Chitando (2009:39-54), for example, reviews works by many African scholars who take this view. These scholars have noted that not all is evil and suicidal in African traditions and culture. Rather there are many

[12] This is a different church from the Johane Apostle Church of God in Botswana referred to above.

other ethno, socio-cultural and religious beliefs and practices that can be tapped for positive HIV response, from prevention to treatment and care. In this section I look at some of these.

Teaching against pre-marital and extra-marital sex

Sex is the most common way by which HIV is spread in Africa. It is therefore important to revisit the traditional and cultural teachings and beliefs on pre- and extra-marital practices. Both religion and traditional culture are well placed to address the pandemic. There is a strong belief especially among elders that HIV and AIDS is result of lax moral practices promoted by Westernization and urbanization. Like Christianity and Islam, African traditions also promoted abstinence and faithfulness in marriage. Virginity, for example, is highly valued in many traditions and religions in Africa. In traditional Zimbabwe, for example, on discovering that his wife was not a virgin, a man was allowed to return her to her parents and demand his bride wealth back. Not only was the virginity of girls checked, boys were also discouraged from pre-marital sex. There was proper sexual education through traditional family structures. In some communities in southern Africa, there were initiation schools for boys and girls. Christianity came and discouraged such schools and was not able to provide substitute institutions in its structures. In contexts of HIV and AIDS such cultural practices need to be revisited and strengthened.

Communitarianism

Despite the forces of urbanization and its promotion of individualism, most African societies, especially in the rural areas, still uphold the traditional African communitarian ethics and way of life. The communitarian concept sees an individual in the bigger picture of community. In the words of John Mbiti (1969:108) the concept can best be summarized and understood through the phrase, "I am because we are; and since we are therefore I am." Although some thinkers like Jonathan Gichaara (2008:188-199) see the concept as leaving most African women in a vulnerable position in the negotiation for safe sex, the concept promotes care of the infected and affected. Because people see themselves linked in relationships, they take it to be their responsibility to provide care to those of their own who are ill. Coupled with the Christian teaching of neighborliness, African communities are caring communities. No wonder many people will trace their steps back to the rural areas when they get ill from HIV. African communities also allow for the care of orphans left by those dying of HIV. The extended family structure allows for the care of one's relative's children. Such reception and care of the orphans is not seen as a choice but an obligation. The neglect of one's relatives is met with strong community criticism. Considering the number of people who have succumbed to HIV and AIDS, was it not for this communitarian concept that call people to take care of the children of their departed relatives, there would be uncountable orphans requiring state assistance in most African countries.

Religious compassion and concern for morality

Most religious organizations are known for their compassionate practices. In a rapid assessment study conducted in 2009 to develop a strategy for FBOs response to HIV and AIDS in Botswana (Togarasei, 2009), it was found out that most of the home based care programmes operating in different villages and towns were run by churches and religious NGOs. Generally, most religions and traditional cultures believe in the sanctity of life. They therefore attach high importance to the preservation of all life and they believe that serving God involves serving humanity through compassionate acts to all the suffering and the needy. Such beliefs and attitudes have led some of the religious groups

to be committed to the care and support of people infected and affected by HIV and AIDS through home-based care programmes, independent and organized home visits, hospital ministry, hospices, encouraging testing and enrolling in ART. In Botswana some churches are even involved in the provision of anti-retrovirals (ARVs) to migrant communities who do not benefit from the government programme.

Generally, most religions and traditional cultures teach love for the whole of humanity. This teaching should be adopted and emphasized to encourage care of the infected and affected. The same should also be done concerning religions and cultures' teaching of altruistic ethical systems. We have seen above that most of these ethical teachings, e.g. against pre-marital and extra-marital sex, contribute to reducing the spread of HIV. This is also true of religious and cultural teachings against alcohol and drug abuse, factors that are associated with the spread of HIV.

HIV as a violation of sexual taboos

The belief that HIV is a result of violation of sexual taboos can be utilized for HIV prevention. Most traditional African societies had a number of taboos that were meant to limit the practice of sex among the married. Some people in Botswana, for example, believe that HIV is a result of the accumulation of sperms in the womb of a woman who has had many sexual partners. This understanding discourages multiple sexual partnerships by women. There were also taboos that controlled promiscuity by men. Although there is need to correct the misconception of the causes of HIV, the teaching's discouragement of many sexual partners is a good starting point for teaching abstinence and faithfulness to one sexual partner. There is therefore a need to adapt this teaching in the era of HIV and AIDS.

Socio-cultural and religious beliefs and practices in times of HIV and AIDS: Reflections

In the foregoing section, I have looked at religious and traditional cultural beliefs and practices which are, from the outset, positive for HIV response. In this section I want to revisit some negative cultural and religious beliefs and practices and suggest ways by which they can be healed/adapted for them to 'heal' HIV and AIDS. It is my conviction that any attempt to contain the spread of HIV and AIDS and successfully mitigate the impact should take the people's culture and traditions seriously. Although African culture and traditions are changing with some waning with time, people still take pride in them. Culture is the sum total of people's life, from beliefs, food, the way they think/dress/behave etc. It cannot be completely abandoned. There is need to modify and adapt traditions and cultural practices for positive HIV and AIDS response. African church leaders who met in Nairobi in 2001 resulting in the formation of the Ecumenical HIV and AIDS Initiative in Africa (EHAIA) noted this need. However, as Chitando (2009:43) correctly notes, nothing much has been done. There is need to rethink such practices and beliefs and suggest ways of using them for positive response. The Church is a key player in this process as it was originally responsible for the denunciation of African culture (Amanze 1998). This is because so long as a people's culture is lambasted without an alternative being provided, such beliefs and practices do not die but simply go underground from which they even have more disastrous effects. Culture provides identity and should evolve naturally as the circumstances of the custodians of the culture changes. When it is forced to change, it often becomes stubborn and never changes. What I suggest below is what influenced the title of this essay, "healing culture, healing

AIDS". My reflections below are mainly focused on the Christian religion, being a Christian myself and living in predominantly Christian communities. Space does not allow me to discuss all possible ways of healing culture for healing HIV therefore I limit my reflections on polygamy, bride wealth, widow/widower inheritance, open discussion of human sexuality and the debate on the use of condoms.

Polygamy

There is a need to rethink polygamy in light of the reality that many men have more than one sexual partner in Zimbabwe. Of course this raises problems in view of the need for gender equality. Should women also be allowed to have many sexual partners? Many men who have many sexual partners argue that they do so because they are not sexually satisfied by one woman. In their study in Zimbabwe, Chiroro, Mashu and Muhwava (2002:24) say a common response by men was that, "because men need more sex than women, they have to sleep with other women to satisfy their sexual desires." Others, however, cite the fact that generally women are more than men. In most of the African countries, women form over 50% of the total population. In Botswana, for example, Kealotswe (forthcoming) estimates that in some communities, the ratio of men to women is sometimes 1:7. What should happen to the rest of the women if society insists on monogamy? What about the many young women widowed by HIV and AIDS? Traditionally in Botswana, these were catered for through polygamy or concubinage. I have also referred above, to a study from South Africa that showed that having many sexual partners is seen as a sign of true masculinity. A study in Namibia (cited by van der Brug 2007:41) also found out that, "For many men, a relationship with only one woman would have a negative connotation and would be associated with poverty, a low status and weak masculinity." Although there are also many cases of women who are having many sexual partners, more often the reasons given for such practices have to do with economic factors: money and gifts (van der Brug 2007:41, Weinreich and Benn 2004:28). Men also justify polygamy on religious grounds with Christians citing the many biblical cases of polygamy for the argument. Is it time the Church begins to rethink polygamy especially as studies in polygamous communities (Brempong 2007:82) and among Muslims who practice polygamy have shown lower HIV prevalence rates? There are some churches that accept polygamy but the majority of churches in Africa despise the practice.

Bride wealth

This is another cultural practice that requires healing. Elsewhere I suggest its total abandonment (Togarasei 2012). There are some churches (e.g. Jehovah's Witnesses) that are against practice of asking for bride wealth. But in view of the need to respect cultural practices for positive HIV programmes, it would not be wise to do so. Possibly, the best way is for Africans to go back to the traditional meaning of bride wealth. Traditionally it was supposed to be simply a sign of appreciation. Perhaps the Church and other traditional institutions like that of the chief, should advocate for lower bride wealth as a step towards total abandonment of the practice or the bride's family must also give some tokens of appreciation to the groom's family so that he does not feel superior to the bride.

Widow/Widower inheritance

This is another practice that needs healing. The general aim of the practice is commendable. A widow's children need a father figure while a widower's children also need a mother figure. The widow or widower, especially those who will still be young

also have sexual needs. Cultural practice meant to cater for these needs are positive. The only risky and negative factors are forcing the widow/widower into unconsented sexual relationships and engagement in sex without having tested for HIV and AIDS. The Church and other traditional institutions should therefore call for disassociation of inheritance and sex. Widow/widower inheritance should be limited to providing security, psychological and material support to the bereaved family. The widow/widower should also be allowed to make their choice as whether they want to marry or who they want to marry. The Church, which for a long time has been teaching against these cultural practices, should therefore not condemn them *in toto* but rather should adopt and adapt them.

Open discussion of human sexuality

The pushing of sexuality into a little corner in the public discourse of the Church and society needs to be healed in order to heal AIDS. Amanze (2007:28-47) has already called for the need by the Church to construct a positive theology of human sexuality. The Church together with other traditional institutions should help parents open up discussion on sex with their children. Traditional African cultures such as the Shona, often placed this responsibility in the hands of aunts and uncles. The disintegration of the traditional family due to urbanization means the aunts and ankles cannot continue playing this role. The Church is better placed to take over this role. As Amanze (2007:39) argues citing scripture and Christian theologians, "human beings are required to enjoy sex, celebrate and treat sex and human sexuality with the utmost responsibility." The subject of sexuality should be given urgent attention in the light of HIV and AIDS. It is through the public discussion of sex that dangerous masculinities discussed above can be tackled. It is also through public discussion of sex that women can be freed from the bondage of culture that silences them from initiating sex even with their partners and calling for safer methods of having sex. Treating sex as a taboo has really not been useful in our contexts of HIV and AIDS.

The Church has another compelling reason for it to quickly address the issue of sexuality. Traditionally, sexuality was also addressed through initiation ceremonies. The Church abandoned these and had nothing to replace them with. In a recent seminar, a respondent argued that the unprecedented problem of HIV in Africa is a result of Africans' identity crisis. He said the condemnation of African traditional beliefs and practices by Christianity and Western cultures has left Africans with no culture to hold on to. This is true with respect to initiation ceremonies. It is time Church and society should reconsider the reintroduction of such cultural practices. The health community's call for circumcision as an HIV preventive measure is a sign of the fact that not all cultural beliefs and practices pose danger to HIV and AIDS.

Condom debate

The condom debate continues unabated. Whether this is due to the Church's theological rigidity or timidity/mediocrity (Chitando 2007:16), is not clear. Studies show that generally churches are against the promotion of condom use. This is very unfortunate and is therefore a religious belief that needs healing. It is very clear that there are many people who fail to live up to the moral standards required by the Church. Considering that the Church allows repentance, surely those who sin should live to repent. Condoms have proven to have a high protection rate against HIV. The Church should therefore encourage its members who fail to abstain or being faithful to at least 'fail alive' and have a chance to repent. This should be based on the sanctity the Church attaches to life. The

Church should also think of many 'sinners' outside the Church there who are its potential members. It should encourage them to protect themselves against HIV and AIDS until they are converted and be able to live by the ethical teachings of the Church. Doing the two in no ways promotes promiscuity. After all, those who proceed to get HIV through sexual immorality while members of the Church, would have sinned anyway, whether protected or unprotected.

Conclusion

If there is anything that many African countries have succeeded in doing in this era of HIV and AIDS, it is to make people aware of this pandemic. Billboards, televisions, radios, newspapers, films, drama and all other forms of communication have been used to promote HIV awareness. Sex education has been gradually integrated into the formal school system with all ways of mainstreaming HIV in curricular and workplaces suggested. Most of these awareness programmes and activities have sought to undermine religious and cultural practices that seem to promote the spread of the pandemic. Surprisingly, equipped with all the knowledge, people's behaviours have not changed. Many people have decried the fact that knowledge has not translated into behavior change (Musopole 2006:12). What could be the causes of this reality? I have argued in this essay that one of the reasons could be the fact that HIV policy makers have paid too much attention to the negative impact of religious and cultural practices at the expense of those that can be used positively.

I have argued that religion and culture provide a grid of meaning and value systems for people and therefore should be taken seriously in HIV and AIDS response. Policymakers therefore need to design and implement policies that capitalize on the positive aspects of culture, while curbing the negative aspects. The essay has especially paid attention to those cultural practices which have for long been seen as promoting the spread of HIV, suggesting ways by which they can be 'healed' for positive HIV response. Instead of dumping all cultural practices into the rubbish bin, "Sensitivity to cultural attitudes is critical if there is going to be behavior change; otherwise people simply block the message, treat it as unacceptable and continue with their old ways of behaving." (Musopole 2006:16).

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