

**A CULTURAL APPROACH TO  
HIV/AIDS PREVENTION AND CARE**

UNESCO/UNAIDS RESEARCH PROJECT

**ZIMBAWE'S EXPERIENCE**

**COUNTRY REPORT**

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## **Special Series on HIV/AIDS Prevention and Care: A Cultural Approach**

Since the mid-eighties, the fight against HIV/AIDS has gradually mobilized governments, international agencies and non-governmental organizations. However, it became evident that despite massive action to inform the public about the risks, behavioural changes were not occurring as expected. The infection continued to expand rapidly and serious questions began to emerge as to the efficiency of the efforts undertaken in combating the illness. Experience has demonstrated that the HIV/AIDS epidemic is a complex, multifaceted issue that requires close cooperation and therefore multidimensional strategies.

The establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1994 initiated a new approach to the prevention and care of this disease. The first requirement stressed was the need for increased coordination between institutions. An emphasis was also made on the need to work on both prevention and treatment while considering the significant social factors involved. As a result UNAIDS was involved in several studies focusing on developing new methodological strategies with which to tackle the issue.

Following a proposal made by UNESCO's Culture Sector to the UNAIDS Programme, on taking a cultural approach to HIV/AIDS prevention and treatment for sustainable development, a joint project "A Cultural Approach to HIV/AIDS: Prevention and Care" was launched in May 1998. The goals were to stimulate thinking and discussion and reconsider existing tools with a cultural approach.

Taking a cultural approach means considering a population's characteristics - including lifestyles and beliefs - as essential references to the creation of action plans. This is indispensable if behaviour patterns are to be changed on a long-term basis, a vital condition for slowing down or for stopping the expansion of the epidemic.

In the first phase, of the project (1998-1999) nine country assessments were carried out in three regions: Sub-Saharan Africa (Angola, Malawi, South Africa, Uganda, Zimbabwe), Asia and the Pacific (Thailand and bordering countries) and the Caribbean (Cuba, Dominican Republic, Jamaica). The findings of these studies were discussed in three subregional workshops held in Cuba, Zimbabwe and Thailand, between April and June 1999. All country assessments as well as the proceedings of the workshops are published within the present Special Series of Studies and Reports of the Cultural Policies for Development Unit.

The opinions expressed in this document  
are the responsibility of the authors and  
do not necessarily reflect the  
official position of UNESCO

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## **LIST OF ABBREVIATIONS**

1. UNESCO : United Nations Educational, Scientific and Cultural Organization
2. UNAIDS : United Nations Programme on AIDS
3. AIDS : Acquired Immune Deficiency Syndrome
4. HIV : Human Immunodeficiency Virus
5. ZANU PF : Zimbabwe African National Union - Patriotic Front
6. FGD : Focus Group Discussion
7. BAC : Binga AIDS Committee
8. PWA : People Living with HIV/AIDS
9. ZINATHA : Zimbabwe National Traditional Healers Association

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## **EXECUTIVE SUMMARY**

### **Introduction**

As the HIV/AIDS pandemic continues to escalate especially in Sub-Saharan Africa, efforts to fight it are being intensified as well. While the real cause for the escalation remains unknown, organizations are beginning to evaluate their efforts in order to understand how they can make their programmes more effective. In some of the programmes, the issue of cultural factors keeps on surfacing as one possible cause for the escalation.

In an effort to understand the interaction between cultural/social factors and the current HIV/AIDS prevention efforts, UNESCO together with UNAIDS launched a project on “The cultural approach to HIV/AIDS prevention for sustainable development”. The project seeks to understand the interaction between cultures and the evolution of AIDS and development problems. Ultimately, the project seeks to assist in the formulation of a set of methodological proposals and guidelines for utilizing cultural approaches in designing, implementing and adapting AIDS prevention strategies and programmes.

To achieve this ultimate goal, UNESCO undertook a two pronged study. The first part of the study involved an institutional assessment of a sample of organizations both national and international, working in AIDS prevention and caring programmes in Zimbabwe. This part of the study has been completed and a report submitted. The second part of the study entailed an in-depth case investigation in an area where the AIDS situation is particularly critical and the interface between the local, social and cultural factors is especially significant. This report gives a detailed account of this case investigation. The report starts by outlining the objectives of the study followed by a brief background of the selected area for the case study. The methodology, findings and discussion of the findings then follows. The report then ends with recommendations, constraints and conclusion.

### **Objectives**

1. To understand the relationship between cultures, development issues and AIDS.
2. To identify cultural and social factors likely to increase/decrease risk of infection.
3. To assess the availability and coverage of HIV/AIDS programmes in the area.
4. To assess the knowledge, perceptions, attitudes and beliefs about HIV/AIDS.
5. To identify priority issues for future research and strategies.

## **Methodology**

### *Sampling*

Due to numerous constraints: communication, time, distance, financial and human resources, convenience sampling was used. This meant that whoever was available and willing to be interviewed was included in the sample provided they were in the target group (sexually active). The available financial resources permitted only three researchers to conduct the study over a period of only three days. Initially appointments had been made with three chiefs and these chiefs were to gather about fifty people each from their areas for interviews. However, due to cross communication problems, the research team found that on arrival in Binga, the three chiefs had been ready for the research the previous week. Hence they had not organized their people neither were they themselves available for interviews. The research team ended up seeking the District Administrator's assistance to get the required sample. The DA then referred the team to the ZANU PF Coordinator who helped the research team for the three days. Through her, the team was able to interview a total of forty people individually, and hold focus group discussions with another twenty people, ten men and ten women. The people interviewed were from three areas within a 40 km radius of Binga mainly Siachilaba, Manjolo and Sikalenge. In addition participants' observations were also used as well as secondary sources of information and key informants in the area.

### *Problems Encountered*

The major problem encountered was time. The financial resources available were barely enough for three days for three researchers. The situation was made worse by organizational and communication complications as well as the terrain and long distances the research team had to travel. Because of the long distances, it was difficult for the research team to go in different directions and collect data. Due to the presence of wild animals in the area, the research team could not work into the late hours of the evening as they had to travel back to their base before dusk.

Another problem encountered was language. While the research team had been made to understand that the majority of the people in the area understood Shona, a number of them required translations for some of the interview questions. This problem was overcome by the intervention of Ms Munkuli who was with the research team all the time.

Despite these problems, the interviews and FGD as well as observations made in the field, yielded enough information to draw some basic conclusions about the Tonga people living in the areas of study vis a vis HIV/AIDS. It is envisaged that this small study lays the framework for further comprehensive study if deemed necessary.

### *Data Analysis*

Data obtained was analyzed using SPSS statistical analysis package for Windows. Due to the small size of the sample, the analysis was limited to frequency distributions. Cross tabulations and tests that require much larger samples were not possible. The findings are presented under the following profiles: Demographic, Health Services, Knowledge, Attitudes and beliefs about HIV/AIDS; Practices; Migratory patterns and gender issues.

## Summary of Findings

Several conclusions from this study can be summarised as follows:

- a) Binga district is a poorly developed semi-arid area with low and erratic rainfall, poor soils and an abundance of wild animals that destroy crops.
- b) The dominant ethnic group is Tonga who have lost both their hunting and fishing rights (their major source of food).
- c) The Tonga cultures of polygamy, marriages between young girls and elderly men as well as widow inheritance are still widely practised and the extended family is still very much intact.
- d) Women and girls are still very much marginalised hence early pregnancies and prostitution are quite prevalent.
- e) Young people are also marginalised as there are no employment opportunities for them nor are there any activities or facilities for them to develop their talents and equip themselves with life skills.
- f) The fishing industry in the area attracts many fish traders from outside the district resulting in increased prostitution in the area. Because of the extreme poverty in the area, many young girls who could be equipped with some basic skills for employment are the major candidates in this trade.
- g) The literacy level is still very low especially amongst women, as such malnutrition rates are high, birth rate is very high with no corresponding means of support for the many children born. It is children from such families who due to neglect grow up to be criminals or prostitutes, or are married off to older men in the area.
- h) The predominant religion in the area is Catholic. The Catholic Church is therefore an important resource in the area.
- I) One organisation in the area Save the Children Fund, runs AIDS programmes under the Binga AIDS committee. For an area extending almost 14 000 km with a population of over 96 000 people, one organisation cannot adequately cover everyone.
- j) Given the necessary support, chiefs still command respect from their people. Hence they can be an important resource in both development and AIDS programmes.
- k) The AIDS pandemic continues to escalate in the area despite the limited campaigns by the Save the Children Fund. As a result the number of orphans in the area is also rising. It is therefore important that more partners join in to strengthen the existing HIV/AIDS prevention programmes in more concrete and results oriented manner.

## **Recommendations**

1. Since poverty and lack of development are major drawbacks in the area, HIV/AIDS programmes should be incorporated into development projects if they are to have any impact. In fact programmes that focus on improving the general living conditions of people could do more to arrest the pandemic.
2. Since the predominant ethnic group is Tonga, HIV/AIDS education materials should be developed in Tonga and the messages should be as simple and direct as possible.
3. While the Tonga cultures of polygamy, widow inheritance are still rife, intensive education programmes for both men and women designed to highlight the possible risks associated with the practice and their corresponding impact on development in a non-threatening manner are required.
4. Since pre-marital sex and early pregnancies are prevalent in the area, intensive HIV/AIDS prevention and reproductive health education programmes should be targeted at both in school and out of school youth.
5. Peer education programmes should be enhanced by providing incentives for volunteers.
6. With no employment opportunities readily available for youth, multi-purpose centres should be established in each community to serve as the nerve for development, education and health related activities. It is easier to incorporate HIV/AIDS programmes in such a set up. Literacy programmes can also be run from these centres provided there are incentives for the educators. UNESCO is well poised for such educational and cultural programmes.
7. Since the predominant religion is Christian, religious leaders could be trained in HIV/AIDS reproductive health in order for them to educate their congregations on the impact of HIV/AIDS on their families and communities.
8. Religious institutions in these areas should be supported in initiating and implementing development and HIV/AIDS programmes.
9. Since chiefs have a good rapport with their people, they too can be agents of change by incorporating them into the planning and implementation of programmes. The chief and his people can be facilitated to analyse their situation and come up with appropriate programmes to address development and health issues.
10. Since women are very much marginalized, programmes should be heavily weighted on improving their condition through education, self-development and self-sustaining skills.
11. To avoid duplication of programmes, and minimise expenses UNESCO should partner with organisations already working in the area. It is up to UNESCO to identify programmes of interest and support these through the existing organisations rather than start up a whole new structure for UNESCO programmes.
12. If UNESCO is going to be carrying out more research of this nature in future the

following issues require serious consideration

- II) Adequate funding should be made available for the research team's needs viz.: accommodation, food, transport and daily subsistence.
- III) Adequate time especially in the field should be allowed to ensure collection of comprehensive data.
- IV) Adequate data analysis facilities - it is advisable to have these available on one of the computers at the main UNESCO office.

## **INTRODUCTION**

As the HIV/AIDS pandemic continues to escalate especially in Sub-Saharan Africa, efforts to fight it are being intensified as well. While the real cause for the escalation remains unknown, organizations are beginning to evaluate their efforts in order to understand how they can make their programmes more effective. In some of the programmes, the issue of cultural factors keeps on surfacing as one possible cause for the escalation.

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To achieve this ultimate goal, UNESCO undertook a two pronged study. The first part of the study involved an institutional assessment of a sample of organizations both national and international, working in AIDS prevention and caring programmes in Zimbabwe. This part of the study has been completed and a report submitted. The second part of the study entailed an in-depth case investigation in an area where the AIDS situation is particularly critical and the interface between the local, social and cultural factors is especially significant. This report gives a detailed account of this case investigation. The report starts by outlining the objectives of the study followed by a brief background of the selected area for the case study. The methodology, findings and discussion of the findings then follows. The report then ends with recommendations, constraints and conclusion.

## **OBJECTIVES**

1. To identify cultural and social factors likely to increase/decrease risk of infection.
2. To understand the relationship between cultures, development issues and AIDS.
3. To assess the availability and coverage of HIV/AIDS programmes in the area.
4. To assess the knowledge, perceptions, attitudes and beliefs about HIV/AIDS.
5. To identify priority issues for future research and strategies.

## **BACKGROUND TO AREA OF STUDY**

Binga District is a poorly developed, semi arid area with low and erratic rainfall and poor soils. The vast majority of Binga District's population comprises the Tonga people who were forced to move from their homes alongside the Zambezi river onto the scapement above upon completion of the Kariba Dam.

Relocation for most people was onto the poorest soils of the district and meant the loss of access to the alluvial soil of the river bank gardens on which the Tonga depended for food. The Tonga people before relocation relied on fishing, hunting and riverine gardening for food and livelihood. Through displaced the Tonga people have held onto some of their cultures and traditions. However, the currently increased movement amongst the Tonga and non-Tonga people especially in the fishing camps has resulted in the population facing an increased risk of HIV/AIDS infection. As noted by Save The Children who operate in the area, migrant labour has encouraged multi-partnering while the fish industry attracts many traders from outside the district resulting in a lively "sex" for fish"<sup>17</sup> trade in the fishing camps as well as in the beer halls at growth points. Based on this brief background and the findings of part one of the study, Binga district was selected for this in-depth case study.

## **METHODOLOGY**

### ***Sampling***

Due to numerous constraints: communication, time, distance, financial and human resources, convenience sampling was used. This meant that whoever was available and willing to be interviewed was included in the sample provided they were in the target group (sexually active). The available financial resources permitted only three researchers to conduct the study over a period of only three days. Initially appointments had been made with three chiefs and these chiefs were to gather about fifty people each from their areas for interviews. However, due to cross communication problems, the research team found that on arrival in Binga, the three chiefs had been ready for the research the previous week. Hence they had not organized their people neither were they themselves available for interviews. The research team ended up seeking the District Administrator's assistance to get the required sample. The DA then referred the team to the ZANU PF Coordinator who helped the research team for the three days. Through her, the team was able to interview a total of forty people individually, and hold focus group discussions with another twenty people, ten men and ten women. The people interviewed were from three areas within a 40 km radius of Binga mainly Siachilaba, Manjolo and Sikalenge. In addition participants' observations were also used as well as secondary sources of information and key informants in the area.

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### ***Data analysis***

Data obtained was analyzed using SPSS statistical analysis package for Windows. Due to the small size of the sample, analysis was limited to frequency distributions. Cross tabulations and significance tests which require much larger samples were not possible. The findings are presented under the following profiles: Demographic, Health Services, Knowledge, Attitudes and beliefs about HIV/AIDS; Practices; Migratory patterns and gender issues.



## RESEARCH FINDINGS

### *Demographics*

**Table 1: Respondents' Age**

Age	Count	%
16-20	4	10
21-30	6	15
26-40	30	75

The population interviewed fall within the sexually active group 15 and above with 10% in the 16-20 age group, 15% in the 21-30 year group and 75% in the 26-40 year group.

**Table 2: Respondents' Sex**

Sex	Count	%
Male	25	62.5
Female	15	37.5

The sample consisted of 62.5% males and 37.5% female.

**Table 3: Ethnicity of Respondents**

Ethnic Group	Count	%
Tonga	39	97.5
Other	1	2.5

There is little variability in ethnicity of people. The dominant ethnic group is Tonga 97.5%.

**Table 4: Education Level of Respondents**

Education Level	Count	%
Primary & below	37	92.5
J.C.	2	5
O-Level	1	2.5

The majority of respondents (92.5%) have been to school only up to primary or lower. This low level of education has serious implications for any type of programmes to be introduced.

**Table 5: Respondents' Religion**

Religion	Count	%
Christian	39	97.5
None	1	2.5

The majority of respondents (97.5%) are Christians.

**Table 6: Respondents' Occupation**

Occupation	Count	%
Student	4	10
Employed	2	5
Unemployed	34	85

Most of the respondents (85%) are unemployed, students (10%) and only 5% employed.

### *Health Services*

**Table 7: Health Service providers in the Community**

Provide	Count	%
Govt./Clinic/Hospital	34	50.0
Traditional healer	15	22.1
Faith healer	17.6	30.0
NGO	5	7.4
Village worker	2	2.9

As the table shows the largest provider of health service to the community are the conventional facilities such as hospitals and clinics (50%) followed by faith and traditional healers 30% and 22.1% respectively.

**Table 8: Accessibility of Health Centres**

	Count	%
Accessible	16	40%
Not Accessible	24	60%

For the majority of the respondents (60%) the health facilities are not easily accessible.

**Table 9: Satisfaction with Health Service**

	Count	%
Satisfied	6	15
Not Satisfied	34	85

Shows 85% of respondents are not satisfied with the health service.

## *Knowledge, Attitudes and Beliefs about HIV/AIDS*

**Table 10: Knowledge about AIDS**

	Count	%
Yes	39	97.5
No	1	2.5

The majority of respondents (97.5%) knew or had, heard something about HIV/AIDS.

**Table 11: Belief about AIDS**

Belief	Count	%
Yes	39	97.5
No	1	2.5

The majority of respondents (97.5%) believe in the existence of AIDS.

**Table 12: Perception of Risk of HIV Infection**

	Count	%
Yes	21	52.5%
No	19	47.5%

Of the total respondents, 52.5% perceived themselves to be at risk of infection while 47.5% did not perceive themselves to be at risk. However, as table 13 shows, prostitutes followed by married people and youth are perceived to be at a higher risk of infection.

**Table 13: Risk Groups**

Group	Count	%
Prostitutes	19	25.3
Married	15	20.0
Youth	17	22.7
Everyone	13	17.3
Alcohol abusers	9	12.0
Bus/Truck Drivers	2	2.7

**Table 14: Acceptability of Condom Use**

	Count	%
Yes	21	87.5
No	3	12.5

Condom use is tolerated or accepted by 87.5% and not tolerated by 12.5% of the respondents.

**Table 15: Availability of Condoms**

	Count	%
Clinic	34	85
Health Educator	2	5
Community Health Worker	4	10

Condoms are available from clinics (85%), health educator (5%) and community health worker (10%).

**Table 16: Fear of AIDS**

	Count	%
Yes	38	95
No	2	5

The fear of AIDS was high amongst the respondents (95%).

**Table 17: Barriers to participation in HIV/AIDS Programmes**

Barrier	Count	%
Time	10	17.5
Transport	10	17.5
No incentives	7	12.3
Illiteracy	3	5.3
Resistance by elders	1	1.8
None	26	45.6

Time, lack of transport and no incentives (17.5%) and (12.5%) respectively are the main barriers to respondents participation in HIV/AIDS programmes.

### *Practices and Family Systems*

**Table 18: Circumcision**

	Count	%
Yes	0	0
No	40	100

All respondents 100% reported no practice of circumcision.

**Table 19: Checking Pre-marital Sex Offenders**

	Count	%
Yes	2	5
No	38	95

Of the total respondents 95% reported no knowledge or awareness of a system of checking girls for engaging in pre-marital sex.

**Table 20: Prevalence of Pre-marital Sex**

	Count	
Prevalent	38	95
No prevalent	2	5

Pre-marital sex was reported to be prevalent in the community (95%).

**Table 21: Prevalent Family System**

	Count	%
Nuclear	13	32.5
Extended	27	67.5

67.5% of respondents reported the prevalence of the extended family over the nuclear family.

**Table 22: Prevalent Family Type**

	Count	%
Monogamy	4	10
Polygamy	36	90

The majority of respondents (90%) reported polygamy as the more prevalent family type in the community.

**Table 23: Prevalence of Extra-marital Affairs**

	Count	%
Prevalent	27	67.5
No Prevalent	13	32.5

Extra marital affairs were reported to be prevalent ( 67.5%) of the respondents.

**Table 24: Prevalence of Rape Cases**

	Count	%
Prevalent	30	75
No Prevalent	10	25

Rape cases were reported to be quite common (75%) of the respondents.

### *Migratory Patterns*

**Table 25: Age Groups Most Involved in Migration**

	Count	%
Youth	37	92.5
Old	1	7.5

Age group that is prone to migrate to other areas is mostly youth as reported by 92.5% of the respondents. Reasons for migration will be discussed later.

**Table 26: Presence of Military Camps or Construction Work**

	Count	
Yes	35	87.5
No	5	12.5

87.5% of respondents reported presence of military camps and/or construction work in their areas.

**Table 27: Migrant Husbands Taking Wives with Them**

	Count	%
Yes	8	20
No	32	80

For those husbands who migrate to other places, 80% of respondents reported that they leave their wives behind, sometimes for as long as two years without ever coming back.

**Table 28: Common Forms of Migration**

Form Of Migration	Count	%
Look for work	39	97.5
Resettlement	1	1

The most common form or reason for migration is work given by (97.5%) of respondents is looking for work.

**Table 29: Potential Destinations for Migrants**

	Count	%
Towns	33	87.5
Mines	5	12.5

The popular places for migrants to look for work are towns (87.5%) and mines (12.5%).

**Table 30: Common Sources of Employment**

	Count	%
Fishing	16	29.1
Farming	10	18.2
Income generating projects	21	38.2
Regular employment	8	14.5

The common sources of income are income generating projects (38.2%), fishing (29.1%) and farming (18.2%). Formal employment is the least source of income (14.5%).

**Table 31: Reasons for Commercial Sex Work**

	Count	%
Lack of employment	21	52.5
Poverty	18	45.0
Divorce	1	2.5

Reasons given for commercial sex in the area range from lack of employment (52.5%), poverty (45.0% to Divorce only (2.5%).

### *Gender Issues*

**Table 32: Education Favors**

Sex	Count	%
Boy	24	60
Girl	1	2.5
Both	15	37.5

Although education favors both girls and boys (37.5%), 60% of respondents confirmed that boys are favoured more than girls (1%).

**Table 33: Women's Capacity to compel Condom use**

Capacity	Count	%
Yes	10	25
No	30	75

The table clearly shows that 75% of respondents feel that women have no capacity to compel condom use, only a few 25% feel that women can compel condom use.

**Table 34: Can Women say No to unwanted Sex in a Relationship**

Can	Count	%
Yes	15	37.5
No	25	62.5

Respondents (62.5%) generally felt that women could not say “no” to sex in a relationship.

**Table 35: Who decides on children's education?**

Who	Count	%
Father	14	35
Mother	3	7.5
Both	21	52.5
Child	2	5.0

While both parents are viewed as jointly deciding on their child's education (52.5%), the father (35%) rather than the mother (7.5%) is viewed as being the decision maker on children's education.

**Table 36: Do Women have Right to Demand Fidelity from Husbands?**

Right	Count	%
Yes	19	47.5
No	21	52.5

More respondents (52.5%) feel that women have no right to demand fidelity from their husbands.

**Table 37: Family Income Contributors**

Contributor	Count	%
Father	24	60
Mother	1	2.5
Both	13	32.5
Child/other	2	5

In the majority of cases the main contributor to family income is the father (60%) while in some its both parents (32.5%). In a few cases (5%) a child or someone else other than parents is the main contributor. In a minority of cases (2.5%) the mother is the main contributor.

**Table 38: Sex favoured by Extra-marital Affairs**

Sex	Count	%
Men	11	27.5
Women	8	20
Both	21	52.5

While both men and women (52.5%) engage in extra-marital affairs, the practice favours men (27.5%) more than women (20%).

**Table 39: Expected Returns from Children's Education**

Expected Return	Count	%
Support in old age	28	70
Child's independence	7	17.5
To educate other siblings	3	7.5
None	1	2.5
New ideas for Community Development	1	2.5
Women		
Both		

The major reason given for educating children is support in old age (70%) followed by children's independence (17.5%).



## DISCUSSION

### *Demographics*

#### *Age*

The findings show that the majority of the respondents were in the 26-40 age group. As indicated earlier, the sample was purposely selected from the sexually active group. In addition since convenience sampling was used, it implies that this age group was more readily available for interviews than other groups.

#### *Sex*

The sample turned out to have more men than women. As FGD discussions revealed, women were not as open as men, even though they were in their own group. One participant in the group commented that women who talk a lot in groups are not viewed positively by men. The low percentage of women participants in the study could be attributed to this negative view.

#### *Ethnicity*

The findings show that the dominant ethnic group living in the areas under study is Tonga. Even though, the sample was small, focus group discussions revealed that there are no other groups that have settled in these areas. The few that are there have come by reason of marriage or work in the Binga town. Thus in a way, the Tonga culture is relatively intact compared to other cultures.

#### *Education Level*

The education level of respondents was very low, primary and below (92.5)%. This indicates that many people have no opportunities to go to school. The main reasons cited in FGD included unavailability of resources (poverty) and the inaccessibility of educational institutions.

#### *Religion*

The majority of respondents (97.5%) are Christians. Discussions in FGD showed that most of the respondents are Catholics. In fact the Catholic Church is one of the two organizations running health and education programmes in the Binga District. This may explain why the majority of participants are catholic.

#### *Occupation*

Many of the respondents (85%) are unemployed. The major reason given for the high unemployment is lack of employment opportunities. Information from BAC members revealed that other than the hospital, the District Council and the Binga District Council, there are no other available sources of formal employment. With the low level of education among the local population, the majority of openings in the above institutions are filled in by people from outside the area who are better educated and qualified. Those of the locals who want to generate employment through self help projects such as gardening, fishing and hunting can no longer freely do so due to the poor soils and rainfall as well as the stringent licensing requirements.

## **Health Services**

### ***Provision and Accessibility***

The main providers of health care in the area are Government hospitals and clinics. The main hospital is the Binga District hospital plus nine health centres in the area. BAC Secretary Pat Griffin confirms assertions made during FGD that the centres are not easily accessible. According to her estimate, the nearest health centre for most people is about 20-30 km away. This is a long distance for someone who is not well to walk and get help timely. Traditional healers are an alternate health service, however, participants preferred the conventional modern facility mainly for their perceived safe and expert help. The major concern about the health facilities is the unavailability of medications and sometimes rough handling by some health personnel.

Regarding the HIV/AIDS programmes BAC funded by Save the Children is the main organisation that provides AIDS education. The programmes include peer education, community home based care and PWAs support groups. However, to improve the effectiveness of these programmes peer educators need incentives to sustain their interest and commitment, transport is required in order to cover all areas, some people are sparsely scattered throughout the district. More educators also need to be trained in order to cover everybody in the district.

As the AIDS situation continues to worsen in Binga more and more children are being orphaned. Save the Children Fund hopes to develop HIV/AIDS interventions focused on children while orphans with their extended families. This is a kind of a foster care system whereby foster families are identified and trained to develop the necessary skills to provide psychosocial support to the children. Such a programme requires increased awareness of the needs of children living in difficult circumstances, support for care givers and trained local staff to sustain the programme. Above all, the programme requires money. This is an area of possible involvement by UNESCO. The sound extended family structure provides the base for such a foster care programme.

### **Knowledge, Attitudes and Beliefs**

Knowledge of and belief about HIV/AIDS is quite high amongst the sample population (97.5%). Participants knew of the principle ways by which HIV can be contracted and they knew most of the symptoms of AIDS. Similarly the common STDs syphilis and gonorrhoea were consistently mentioned in interviews. This high level of awareness could be attributed to Binga AIDS committee which is funded by Save the Children Fund UK (one of the organisations in the area) that runs HIV/AIDS programmes. These programmes include workshops to train peer educators who in turn educate communities through drama and music. IEC, orphan care, training of volunteers in counselling and working with support groups. Most of the peer educators are out of school youths and commercial sex workers. They are volunteers without any meaningful form of remuneration. FGD revealed that most of them volunteer because they have nothing else to do. Involvement in AIDS awareness programmes is viewed as a way of whiling up time and a prospective source of employment. As table 12 shows, those who do not participate in AIDS programmes cite time, transport and lack of incentives as barriers to participation. It was evident as the research team looked for study subjects, that the main attraction to participate was the food made available to those who volunteered, highlighting the level of poverty in those areas. As soon as people sensed that there was food, the numbers of volunteers increased. Poverty and lack of employment ranked

high (table 26) on the list of reasons for commercial sex work.

One member of the commercial sex workers commented “ with no work, what do you expect me to survive on, I have children to feed”. Thus even though the study sample showed a high level of knowledge about HIV/AIDS, the contextual factors - poverty and lack of employment make it almost impossible to eradicate risky behaviours despite the availability and easy accessibility of condoms in the community. Culturally as discussed earlier, Tonga women have no capacity to either compel condom use nor to initiate sex. Tables 40 and 41 below further confirm this assertion.

**Table 40 : Women’s’ capacity to compel condom use.**

Can complex condom use	Count	%
Yes	10	25
No	30	75

**Table 41: Who initiates sex in a relationship?**

	Count	%
Men	39	97.5
Women	1	2.5

Even if condoms are readily available and accessible, Tonga women are at the mercy of men. On one hand they desperately need the money, on the other they cannot enforce condom use, thus placing themselves at risk of infection. It was evident in FGD that women were very shy to talk about their relationships. The researcher had to probe a lot more to get information from them whereas men were very outspoken.

### Practices

Though displaced from their original homes along the Zambezi in order to make way for the construction of the Kariba dam, the Tonga people have held onto some of their cultures and traditions. Table 22 clearly shows that polygamy is widely practiced among the Tonga people. Focus group discussions also revealed that marriages between elderly men and young girls and the practice of widow inheritance are still common. However, other cultures of circumcision, checking of pre-marital sex offenders and initiation into adulthood are not practiced at all by Tonga people. Thus risk of HIV infection associated with these practices is not an issue of concern among the Tonga people. However, polygamy, widow inheritance and elderly men marrying young girls all carry a high risk of infection. In the absence of significance tests, it is difficult to conclusively correlate cultural and development factors with prevalence of HIV infection in the area. However, the quantitative data from the small sample as well as FGD seem to suggest some correlation that needs further investigation.

Pat Griffin, the Secretary of BAC acknowledges that the extent of the AIDS pandemic in Binga may be much higher than in the rest of the country due to the high birth rate, poverty - which leads in part to prostitution- polygamous relationships and the culture of inheritance plus the

lack of education available for women. From her observations as a clinical nurse at Binga hospital she has witnessed several cases of a whole family husband and wives plus brothers who inherited the widows all being wiped out by AIDS. Reuben Mackenzie BAC AIDS project co-ordinator attests to the same observation. BAC as an organisation has witnessed several such cases. FGD confirmed these observations. One male participant remarked:

*“Nyaya yakupindira iyi, tiri kufa, tapera”*

(Translation: “This inheritance issue is killing us, we are finished”)

While these cultural factors might play a role in the spread of HIV the real underlying factors may be summed up as poverty and superimposition of very advanced western culture on a people barely equipped with skills and level of development to cope with basic survival issues. The high prevalence of pre-marital sex (95%) even though it is not condoned by the community as well as the high prevalence of extra-marital affairs are testimony of this poverty and superimposition of foreign cultures.

The introduction of western luxury items such as exotic foods, cosmetics, lavish life styles all entice people in the remotest parts of the country who have no basic education, nor basic survival facilities -such as accommodation, safe and clean water, toilets and employment- to consume these things without having the means to do so. Hence the increase in general violence, crime, rape and prostitution. Interventions will thus have to address basic issues of development while incorporating HIV/AIDS and reproductive education. The existence of the extended family structure (67.5%) can be incorporated as a positive aspect into HIV/AIDS programmes especially regarding orphan care and home based care.

### **Migratory Patterns**

The relocation from the water and fish of the lack resulted in the Tonga losing most of their traditional sources of food - riverine gardens with a potential for all year cropping and from the surrounding area which held abundant wild life and fish from the river. To make matters worse, fishing and hunting are severely restricted by licensing requirements which are strictly enforced. These factors have left the Tonga people so impoverished that most of the young men opt to migrate to towns and mines in search of work (table 25). Men leave wives behind (table 27) in search of work. Most of these men may come back home once or twice a year. The long separation from their wives exposes them to the risk of HIV infection as they try to fulfill their sexual needs elsewhere. Similarly, the wives left behind, in an attempt not only to satisfy their sexual needs but also to support their families, also expose themselves to HIV infection. As shown in table 23, extra-marital affairs are reported to be rife in the area. Some of the major reasons cited during FGD included lack of sexual fulfillment and need for money. It is a well established fact that multi-partner sexual relations have a higher risk of HIV infection. From the scenario described above, polygamous relationships, where one man with two or more wives leaves them behind for three to six months, places everyone in the relationship at even higher risk of infection.

The presence of military camps and construction work in the area (table 26) provides a ready source of partners to fulfill the sexual needs of the wives whose husbands are away for a long time. FGD revealed that some of the husbands not only go away for a long time but don't even send back money to support their families. This situation leaves the wives almost destitute thus forcing them into extra marital sexual favours in return for money or fish. A sex for fish trade has been reported by Save the Children in the fishing camps as well as in the beer halls at the main growth points. Poverty and lack of employment seem to be the main causes of migration

(table 28). Interventions to alleviate the impact of these factors could very well reduce incidence of HIV infection and curb its spread.

## **Gender Issues**

The results of the study indicated a dominance of the male species among the Tonga people. For instance decisions in the home especially on the education of children are made by the father (35%) instead of the mother (7.5%). In addition the education of children favours boys (60%) over girls (2.5%). This set up implies that girls are likely to be marginalized in terms of their advancement. Without education they are at risk of early marriages and pregnancies. Both these factors place young girls at a higher risk of HIV infection compared to the boys who stay in school and complete their education to career level.

**Tables 40 and 41** clearly show that women have no capacity to compel condom use neither can they say no to unwanted sex in a relationship. Part of this incapacity could very well be rooted in the dominant position of males in the Tonga community, but it could also be exacerbated by lack of education on the part of women. Lack of education makes women wholly dependent on men, hence the fear to say no even to behaviours that place them at risk of infection such as unprotected sex and infidelity on the part of their husbands. The role of the father as the major contributor of income (table 37) for the family, further limits the woman's capacity to stand her ground on matters concerning not only her health but life in general.

The implication of all these factors is that efforts should be concentrated on programmes that aim to empower women in all area of development particularly self consciousness, self confidence, assertiveness and communication. These elements of development can be incorporated into developmental programmes using the available and appropriate channels of communication. The most accessible channel of communication to rural communities is the radio. Newspapers and other print media in very simple form and translated into Tonga also provide a relatively effective means of communication.

## SUMMARY OF FINDINGS

Several conclusions from this study can be summarised as follows:

- a) Binga district is a poorly developed semi-arid area with low and erratic rainfall, poor soils and an abundance of wild animals that destroy crops.
- b) The dominant ethnic group is the Tonga people, they have lost both their hunting and fishing rights (their major source of food).
- c) The Tonga cultures of polygamy, marriages between young girls and elderly men as well as widow inheritance are still widely practised while the extended family is still very much intact.
- d) Women and girls are still very much marginalised hence early pregnancies and prostitution are quite prevalent.
- e) Young people are also marginalised as there are no employment opportunities for them nor are there any activities or facilities for them to develop their talents and equip themselves with life skills.
- f) The fishing industry in the area attracts many fish traders from outside the district resulting in increased prostitution in the area. Because of the extreme poverty in the area, many young girls who could be equipped with some basic skills for employment are the major candidates in this trade.
- g) The literacy level is still very low especially amongst women, as such malnutrition rates are high, birth rate is very high with no corresponding means of support for the many children born. It is children from such families who due to neglect grow up to be criminals or prostitutes, or are married off to older men.
- h) The predominant religion in the area is Catholic. The Catholic Church is therefore an important resource in the area.
- II) One organisation in the area Save the Children Fund, runs AIDS programmes under the Binga AIDS committee. For an area extending almost 14 000 km with a population of over 96 000 people, one organisation cannot adequately cover everyone.
- j) Given the necessary support, chiefs still command respect from their people. Hence they can be an important resource in both development and AIDS programmes.
- k) The AIDS pandemic continues to escalate in the area despite the limited campaigns by Save the Children Fund UK. As a result the number of orphans in the area is also rising. It is therefore important that more partners join in to strengthen the existing HIV/AIDS prevention programmes in more concrete and results oriented manner.

## RECOMMENDATIONS

1. Since poverty and lack of development are major drawbacks in the Binga area, HIV/AIDS programmes should be incorporated into development projects if they are to have any impact. In fact programmes that focus on improving the general living conditions of people could do more to arrest the pandemic.
2. Since the predominant ethnic group is Tonga HIV/AIDS education materials should be developed in Tonga and the messages should be as simple and direct as possible.
3. While the Tonga cultures of polygamy, widow inheritance are still rife, intensive education programmes for both men and women designed to highlight in a non-threatening manner, the possible risks associated with the practice and their corresponding impact on development are required.
4. Since pre-marital sex and early pregnancies are prevalent in the area, intensive HIV/AIDS prevention and reproductive health education programmes should be targeted at both in school and out of school youth.
5. Providing incentives for volunteers could enhance peer education programmes.
6. With no employment opportunities readily available for youth, multi-purpose centres should be established in each community to serve as the nerve for development, education and health related activities. It is easier to incorporate HIV/AIDS programmes in such a set up. Literacy programmes can also be run from these centres provided that there are incentives for the educators. UNESCO is well poised for such educational and cultural programmes.
7. Since the predominant religion is Christian, religious leaders could be trained in HIV/AIDS reproductive health in order for them to educate their congregations on the impact of HIV/AIDS on their families and communities.
8. Religious institutions in these areas could be supported in initiating and implementing development and HIV/AIDS programmes.
9. Since chiefs have a good rapport with their people, they too can be agents of change by incorporating them into the planning and implementation of programmes. The chief and his people can be facilitated to analyse their situation and come up with appropriate programmes to address development and health issues.
10. Since women are very marginalized, programmes should weigh heavily on improving their condition through education, self-development and self-sustaining skills.
11. To avoid duplication of programmes, and minimise expenses UNESCO should partner with organisations already working in the area. It is up to UNESCO to identify programmes of interest and support these through the existing organisations rather than start up a whole new structure for UNESCO programmes.

12. If UNESCO is going to be carrying out more research of this nature in future the following issues require serious consideration:
- i) Adequate funding should be made available for the research team's needs viz.: accommodation, food, transport and daily subsistence.
  - III) Adequate time especially in the field, should be allowed to ensure collection of comprehensive data.
  - iii) Adequate data analysis facilities - it is advisable to have this available on one of the computers at the main UNESCO office.



## **CONSTRAINTS**

A study of this nature requires a lot of resources - time, funds and people to actually do the study. Due to the limited funds available from UNESCO, not enough researchers could be committed to the study and the field time had to be cut short. Research in rural setting is constrained by distances one has to travel, communication problems with semi-literate populations. These two factors require more researchers and more time in the field in order to collect comprehensive data. Due to the small sample involved in this study, qualitative analysis of data, which could have enhanced the interpretation of the data, was not possible. Future research of this nature should be adequately supported with both human and financial resources and provision of ample time in the field.

Another limitation of this study is that the results can only apply to the population under study, but cannot be generalised to the wider population. To be able to generalise the findings, a nation wide study would be ideal.

The unavailability of the SPSS software delayed the completion of the report. Since UNESCO didn't have the software, locating external organisations with the facility took forever. However, thanks to Centre for Population Studies and MOH for providing computer facilities for data analysis.

## CONCLUSION

It can be concluded from the findings of this study that: HIV/AIDS programmes are available in the area but with limited coverage in terms of the geographical areas; although knowledge of HIV/AIDS in those areas covered by BAC is quite high, risky behavior is still very prevalent; the practice of polygamy continues to place families at risk of HIV/AIDS infection; the areas of Siachilaba, Manjolo, Sikalenge of Binga are very much underdeveloped and poor, forcing many people men and women, young and old to engage in risky behaviours such as prostitution, sex for fish trade and illegal hunting. The view of the inhabitants of these areas is that the current HIV/AIDS pandemic is worsened by lack of development and lack of concern for people's basic needs of food, shelter and education. Programmes that focus on improving the general living conditions of people should be a priority with HIV/AIDS programmes incorporated into such general programmes. What is clear from this study is that given the opportunity, people in the Binga area value education for their children and would love to see them excel in all spheres of life, while adults are willing and ready to develop themselves. Priority issues for future research should focus on needs assessment in the area in order to design appropriate programmes. Participation by local people at all stages of planning is important for any programmes in the area to be successful.

UNESCO as an Education, Scientific and Cultural organisation is ideally suited to initiate programmes in all spheres of its operation. Putting Cohen and Trussel's assertion - which states that interventions that address contextual issues can arrest the escalation of HIV infection much more effectively and efficiently than interventions that target the individual perceptions and behaviours - to the test, is the challenge for UNESCO in order to arrest the escalation of HIV/AIDS among the rural populations.

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## **APPENDIX I**

### **List of Contacted and Interviewed Persons**

1. Griffin P. Secretary - Binga AIDS Committee.
2. Mackenzie R. - AIDS Project Co-ordinator - Binga AIDS Committee
3. Munkuli V. - Zanu PF Co-ordinator
4. D.A - Binga
5. DMO - Binga
6. Community members in Siachilaba, Manjolo, Sikalenge and Back Harbour
7. Students of Manjolo Secondary Schools
8. Headmaster - Manjolo Secondary School

## **APPENDIX II**

### **UNESCO “A CULTURAL APPROACH TO HIV/AIDS PREVENTION AND CARE”**

#### **INTERVIEW SCHEDULE: (General Community)**

##### **A. SOCIO-DEMOGRAPHIC VARIABLES**

- A.1 Name of the respondent (if s/he feels comfortable)
- A.2 Sex of the respondent (male/female)
- A.3 Age of the respondent (complete years)
- A.4 Marital Status of the respondent (married, single, widowed, divorced, separated)
- A.5 What religious group do you belong to?
- A.6 What ethnic group do you belong to?
- A.7 What is your highest level of education (JC, O-level, A-level, Certificate, Diploma, Degree)?
- A.8 What is your occupation? (employed, unemployed, housewife, student)?
- A.9 What is your place of birth?

##### **1. ETHNICITY AND LANGUAGE**

- 1.1 What values (worth) are attached to different ethnic groups and languages?
- 1.2 What practices/taboo are associated with each ethnic group and language?
- 1.3 Do ethnic groups and languages differ according to kind of issues being discussed (age, gender, level of discussion-family, meeting etc.)?
- 1.4 What is the effect of modernising influence on the significance of different ethnic groups and languages in your community?

##### **2. RELIGION**

- 2.1 What values (significance, worth) are attached to different religious groups?
- 2.2 What practices/taboo are associated with each religious group?

- 2.3 Do religious groups differ according to the kind of issues being discussed (age, gender, level of discussion-family, meeting etc.)?
- 2.4 What is the influence of modernising on the religions in your community?

**3. CHILD & ADULT EDUCATION**

- 3.0 How many schools or education centres are found in your community?
- 3.1 Who decides children's education (gender influence on level of education)?
- 3.2 What differences exist between the education of girls and boys in your community?
- 3.3 Which sex is favoured by the investment in education?
- 3.4 What can you say are the reasons for this imbalance/favouritism?
- 3.5 What efforts are being made or have been made to correct this imbalance?
- 3.6 What else needs to be done to ensure that investment in education does not favour one sex?
- 3.7 In your community, what returns are expected from the investment devoted to the education of children?
- 3.8 Do you think that the education of children and adults has positive contributions to the prevention of HIV/AIDS?
- 3.9 What reasons can you give for your answer?
- 3.10 Are there any adult education programmes going on in your community?
- 3.11 Who run these adult education programmes and who are the teachers?
- 3.12 What groups of adults (sex & age) are beneficiaries of these programmes?
- 3.13 What is taught (lessons learnt) in these programmes?
- 3.14 What health issues are covered by these adult education programmes?
- 3.15 What behaviour changes have you adopted in response to these programmes?
- 3.16 Are you satisfied with the effectiveness of these adult education programmes?
- 3.17 What needs to be done for these programmes to be more effective?
- 3.18 What is the effect of modernising influence on the significance of different traditional education systems in your community?

**4. FAMILY INCOME**

- 4.1 What are the different sources of income in your family/community?
- 4.2 Who are the people who contribute to this income (father, mother, son, daughter, relatives)?
- 4.3 How does each contribute to family income?
- 4.4 Do people at times engage in risky behaviours to earn income or a living?
- 4.5 What are these risky behaviours or practices people engage in to earn income?
- 4.6 Which persons are most vulnerable to these risky behaviours / practices?
- 4.7 What is the effect of modernising influence on the different ways through which families earn income in your community?

## **5. HEALTH SERVICE / FACILITY ASSESSMENT**

- 5.1 How many health facilities are found in your community?
- 5.2 Who are the different providers of health services and health education in your community (government, non-government, churches, faith healers, traditional healers etc.)?
- 5.3 How accessible or affordable are these health-related services?
- 5.4 What type of health-related services are provided to the community for children, women and men?
- 5.5 How satisfied are you with these health-related services?
- 5.6 What do you think determines which health provider to visit when you or someone gets ill?
- 5.7 Which health provider/s do you think is the best to visit when someone has HIV/AIDS?
- 5.8 Are there any customary laws/beliefs with regards to where one should seek treatment or health services?
- 5.9 What can you say are the main causes of illness in your community?

- 5.10 What can you say are the main causes of death in your community?
- 5.11 What are the traditional patterns of care for people with chronic illness?
- 5.12 Which health facilities do you prefer for child delivery? (childbearing women)
- 5.13 Why do you prefer some health facilities over others? (childbearing women)
- 5.14 How prevalent is home delivery for the local women?
- 5.15 What precautionary measures are taken on the materials (e.g. razor blade) used during home child deliveries to prevent the risk of infection with diseases?
- 5.16 Do you visit maternity clinics when you are pregnant? (childbearing women)
- 5.17 Are you tested for HIV/AIDS or sexually transmitted diseases during pregnancy? (childbearing women)
- 5.18 Are you willing to be tested and know your HIV/AIDS status? (childbearing women)
- 5.19 What is the effect of modernising influence on the significance of traditional health practices and services in your community?

**6. KNOWLEDGE, PERCEPTIONS, ATTITUDES & BELIEFS ABOUT HIV/AIDS**

- 6.1 Do you have any knowledge / what do you know about AIDS?
- 6.2 Do you believe in the existence of HIV/AIDS?
- 6.3 Do you have any fear of AIDS or those with AIDS?
- 6.4 If yes, what changes in behaviour have you considered? (using condoms, seeking counselling, testing for HIV/AIDS, celibacy, reducing number of sex partners or sticking to one partner)
- 6.5 What do you think are the causes or ways through which people can be infected with HIV/AIDS?
- 6.6 Do you perceive yourself to be at high risk of infection with HIV/AIDS?
- 6.7 Which individuals or groups of people do you perceive to be at high risk of infection with HIV/AIDS?
- 6.8 Have you ever seen or heard of people who suffered or died from AIDS?



- 6.9 If yes, give an estimate of their number?
- 6.10 Do you know or have you ever heard of the symptoms shown by someone suffering from AIDS?
- 6.11 If yes, what are those symptoms?
- 6.12 Do you know or have you ever heard of sexually transmitted diseases (STDs)?
- 6.13 If yes, which are those sexually transmitted diseases (STDs)?
- 6.14 Do you have any knowledge about where people with AIDS are being cared for? Which are those institutions/places? Who run those institutions/places?
- 6.15 What should people in your community do to prevent the spread of AIDS?
- 6.16 What is the effect of modernising influence on HIV/AIDS infection in your community?

**7. PRACTICES, RITUALS , TABOOS & HIV/AIDS**

- 7.1 What is done in your community to initiate a girl into adulthood?
- 7.2 What is done in your community to initiate a boy into adulthood?
- 7.3 If circumcision is practised in your community, on who is it practised?
- 7.4 What cultural values (significance) are attached to circumcision?
- 7.5 Is the practice customarily forced or is it a matter of choice?
- 7.6 If the practice was stopped, why was it stopped?
- 7.7 What objects/materials are/were used in the practice of circumcision?
- 7.8 Do you think circumcision exposes individuals to the risk of infection with HIV/AIDS?
- 7.9 What are those risks of infection with HIV/AIDS?
- 7.11 Which other practices and rituals are common in your society?
- 7.12 Of what value/significance are these to the people in your community?

- 7.13 Which are the common taboos in your society?
- 7.14 Of what value/significance is each taboo to the people in your community?
- 7.15 What is the effect of modernising influence on the significance of different cultural practices, rituals and taboos?

**8. *MARRIAGE / MARITAL RELATIONSHIPS & HIV/AIDS***

- 8.1 What does your society prescribe as the age of marriage for girls and boys?
- 8.2 Who decides when and to whom someone should marry?
- 8.3 What different forms of marriage exist in your community? (Kukumbira, kutizisa, musengabere, kuzvarira, chimutsamapfihwa, nhaka etc.)
- 8.4 Are there any cultural events that are linked to marriage practices (e.g. inheritance laws/nhaka, kuzvarira)?
- 8.5 What risks of infection do you perceive to be associated with such practices?
- 8.6 Are there any marriage practices that ceased to exist in your community?
- 8.7 Can you explain why those marriage practices stopped?
- 8.8 Which different family types are prevalent/popular in your community? monogamous or polygamous?
- 8.9 Which type of family do you associate with risk of HIV/AIDS infection and why?
- 8.10 Which different family patterns/structures are prevalent/popular in your community? Nuclear or extended?
- 8.11 What are the advantages/disadvantages of each?
- 8.12 How prevalent are extra-marital affairs in your community?
- 8.11 What can you say are the causes of extra-marital affairs in your community?
- 8.12 To what extent are extra-marital affairs tolerated/accepted in your community?
- 8.13 Do any customs favour a particular sex over extra-marital affairs?
- 8.14 What can you say are the reasons for that favouritism?

- 8.15 Do women have the right to require fidelity from their husbands? Give reasons for your answer?
- 8.16 What is the effect of modernising influence on the significance of different marriage and family practices/customs?

**9. FAMILY PLANNING PRACTICES & HIV/AIDS**

- 9.1 What are the common family planning methods (modern/traditional) available in your community?
- 9.2 What methods of family planning are prevalent in your community (usage levels)?
- 9.3 Is abortion permitted/prohibited in your community? Give reasons for your answer.
- 9.4 Knowing that a pregnant woman has HIV/AIDS, does your culture permit/prohibit abortion?
- 9.5 What is the average duration of breastfeeding in your community?
- 9.6 What substitutes for breastfeeding are used in your community?
- 9.7 How are these breastfeeding substitutes given to babies in your community?
- 9.8 How possible is it to sterilise feeding equipment in your community?
- 9.9 What is the effect of modernising influence on the significance of traditional family planning methods?

**10. MIGRATION & HIV/AIDS**

- 10.1 What forms of migration or movements are common in your community?
- 10.2 What are the sources of employment found in your community?
- 10.3 What kinds of work do these sources provide?
- 10.4 Which places do you know to be potential destinations of people from your community in search of work? (towns, mines, estates etc.)
- 10.5 Are there military camps or major construction works in the area?
- 10.6 How important is the tourist industry in your community?
- 10.7 Which age groups are mostly involved in migration to look for work?

- 10.8 What can you say are the reasons for this age selectivity?
- 10.9 Which sex is most involved in migration to look for work?
- 10.10 What can you say are the reasons for this sex selectivity?
- 10.11 In the case of married men, do they take with them wives and children to their work places?
- 10.12 For how long do those married men go away from their families / primary sexual relationship?
- 10.13 Is there any cultural obligation for the migrant husbands to visit their remaining wives and families?
- 10.14 How frequently do they visit?
- 10.15 Is there any cultural obligation for migrants to remit (in cash or kind) to their remaining families?
- 10.16 How frequently do they remit?
- 10.17 Do you perceive these migrant husbands to be at risk of infection with HIV/AIDS?
- 10.18 What reasons can you give for your perception - change in patterns of sexual behaviour?
- 10.19 Do you perceive the remaining wives of migrant husbands to be at risk of HIV/AIDS?
- 10.20 What reasons can you give for your perception - change in patterns of sexual behaviour?
- 10.21 What do you suggest should be done about marital separation to reduce the risk of contracting HIV/AIDS?
- 10.22 In what ways does migration increase the demand for commercial sex?
- 10.23 How is prostitution/commercial sex defined and organised in your community? (brothel-based, street work,nightclub-based etc.)
- 10.24 To what extent is prostitution/commercial sex tolerated in your community?
- 10.25 Is prostitution/commercial sex stigmatised in your community?

- 10.26 What can you say are the reasons for prostitution/ commercial sex in your community?
- 10.27 Is there any other form of sex for money or goods or favours in your community (not seen as commercial sex work but supplementary income)?
- 10.28 What are the sexual traditions and practices that may explain the origin of this type of sex work in your community?
- 10.29 In what circumstances / ways do you think migration can increase/reduce the risk of infection with HIV/AIDS in your community?
- 10.30 What is the effect of modernising influence on the different migration patterns and those involved?

## **11. *SEXUAL ISSUES / RELATIONSHIPS & HIV/AIDS***

- 11.1 Who initiate sex in a relationship in your community?
- 11.2 Can women say no to unwanted or unprotected sex in your community?
- 11.3 How common is forced sex (rape/incest) in your community?
- 11.4 What cultural treatment is given to perpetrators of rape or incest?
- 11.5 Are the condoms freely available in the community?
- 11.6 Where do people in your community get condoms from?
- 11.7 What are the barriers to women in your community in obtaining condoms?
- 11.8 Do women have the power to compel condom use? Give reasons for your answer?
- 11.9 Is condom use tolerated/accepted in your community? Give reasons for this?
- 11.10 How prevalent is pre-marital sex in your community?
- 11.11 What explanations can you give for your answer?
- 11.12 To what extent is pre-marital sex tolerated/accepted in your society? Is it permitted/prohibited?
- 11.10 When do young men and women start having sex in your community?
- 11.11 How much choice do young people have in determining their sexual behaviour?

- 11.12 Does this choice differ between men and women in your community?
- 11.13 If pre-marital sex is culturally forbidden, what correctional or disciplinary measures are taken for those caught engaging or known to have engaged in the act?
- 11.14 How does your community encourage young people to abstain from pre-marital sex?
- 11.15 Is there any customary requirement for checking for the offenders? How is it done in your society? Who does it? How is it done? On who is it done?
- 11.16 Do you think it is good to engage in that practice?
- 11.17 What are the predominant cultural patterns of sexual relationships (sex within/outside marriage, between men and men, between women and women, men and women, sharing of spouses)?
- 11.18 What are the socially acceptable and unacceptable forms of sexual relationships in your community?
- 11.19 What is the effect of modernising influence on the significance of sexual issues and relationships?

**12. HIV/AIDS PREVENTION AND CARE PROGRAMMES**

- 12.1 Are you aware of the existence of any HIV/AIDS prevention and care programmes in your community?
- 12.2 What are these HIV/AIDS prevention and care programmes found in your community?
- 12.3 To whom do these programmes belong?
- 12.4 What specific services/purposes do they provide/serve in your community?
- 12.5 What do you like about these programmes?
- 12.6 What do you dislike about these programmes?
- 12.7 What role/s do you play in any of these programmes?
- 12.8 Are there any barriers to your willingness to participate in HIV/AIDS programmes?

- 12.9 What do you suggest needs to be done if HIV/AIDS or other development programmes are to be very effective in achieving goals and targets in your community?
- 12.10 What materials and resources do you think are required in your community to combat the deadly HIV/AIDS epidemic?
- 12.11 How are the common symptoms of HIV infection being managed at home? (fever, skin problems, diarrhoea, anxiety, depression, mouth and throat problems, coughing, difficult breathing and pain)
- 12.12 Is there any support for those who look after people with HIV-related diseases at home? Who provide this support?
- 12.13 What is the effect of modernising on the significance of traditional ways of caring for chronic patients?

### ***13. HIV/AIDS INFORMATION & AWARENESS CAMPAIGNS***

- 13.1 What means of communication are available and accessible in your community? (radio, TV, books, news papers, magazines, pamphlets, mobile cinemas, performing arts/drama)
- 13.2 Are these means of communication equally available and acceptable to men and women?
- 13.3 Are these means of communication equally available and acceptable to different age groups?
- 13.4 Are these means of communication equally available and acceptable to different ethnic groups?
- 13.5 Are these means of communication equally available and acceptable to different religious groups?
- 13.6 How important or useful is each in disseminating information on HIV/AIDS?
- 13.7 What high-risk behaviours of HIV/AIDS infection have you changed in response to different messages from these means of communication?

*The End*