




# Traditional Leaders On The Frontline

Addressing Harmful Cultural Practices to  
Reduce Gender-based Violence and HIV in southern Africa



## 2. **Traditional Leaders On the Frontline**

Addressing Harmful Cultural Practices to Reduce Gender-based Violence and HIV in southern Africa



# Traditional Leaders On the Frontline

## Addressing Harmful Cultural Practices to Reduce Gender-based Violence and HIV in southern Africa

# Table of contents

<b>About this book</b> .....	05
<b>Foreword</b> .....	07
<b>List of Acronyms</b> .....	09
<b>Chapter 1:</b> The context of HIV and interventions to tackle the epidemic in southern Africa.....	10
<b>Chapter 2:</b> Addressing cultural practices that predispose communities to HIV and gender-based violence.....	16
<b>Chapter 3:</b> The role of African culture in tackling HIV and AIDS .....	19
<b>Chapter 4:</b> Traditional Leaders as champions for prevention: The leadership “Rock” Programme.	25
<b>Chapter 5:</b> Indigenous leaders and the control of HIV and AIDS .....	31
<b>Chapter 6:</b> Traditional leaders’ efforts to address HIV and AIDS, gender and sexuality issues in their jurisdictions.....	36

## About this book


An increasing number of traditional leaders are taking a leading role in addressing gender-based violence (GBV), harmful cultural practices and HIV at community and national levels. It was against this background that Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) organised a regional traditional leaders' summit (Indaba) that brought together 65 participants to deliberate and dialogue on socio-cultural challenges related to HIV and seek culture-specific solutions. Traditional leaders from Malawi, Mozambique, Namibia, South Africa, Swaziland and Zimbabwe attended the forum that took place in Johannesburg, South Africa, in April 2011.

The purpose of the summit titled *Unleashing the power of traditional leadership in HIV prevention in Africa: Leaders committed to zero new infections, zero discrimination and zero AIDS-related deaths* was to provide a platform for traditional leaders in southern Africa, where SAfAIDS' Changing the River's Flow (CTRF) project is being implemented, to come together and discuss how they can become engaged in fighting GBV and harmful cultural practices that perpetuate HIV infection. The forum also provided traditional leaders with an opportunity to interact with HIV, gender and human rights organisations and activists with the aim of finding possible ways to complement each other's efforts. The summit was also attended by SAfAIDS partners implementing "Changing the River's Flow" programme.

The objectives of the *Indaba* included:

- reaffirming and strengthening the role of traditional leadership in fighting HIV and GBV;
- consolidating partnership between traditional leadership and AIDS service organisations (ASO) to complement each other's efforts in the fight against GBV and HIV;
- equipping traditional leaders with knowledge and skills on how to reduce personal risk as well as motivate others and
- providing an experience sharing platform for traditional leaders to learn how they can be involved in programmes dealing with GBV, HIV and AIDS in southern Africa.

The *Indaba* was a platform for sharing information, experiences, lessons learnt, good practices, challenges and practical solutions on how traditional leaders can be engaged in HIV and gender issues; creating a regional community of practice to respond to health and legal needs of people affected by HIV and GBV and supporting traditional leaders and partners to roll out the good practices against HIV and GBV.



The aim of publishing this book is to share widely deliberations at the Indaba. This book targets traditional leaders in southern Africa and other regions of Africa, SAfAIDS partners implementing the “Changing the River’s Flow” programme, policy makers in the field of HIV and AIDS, sexual and reproductive health and GBV, academics and researchers studying ways of combating HIV, AIDS and GBV.

The objective of the book is to empower these target readers with deeper insights which could help enhance their various efforts in addressing HIV, AIDS and GBV.

Eliezer F. Wangulu  
Editor  
SAfAIDS  
Pretoria, South Africa



## Foreword

HIV and AIDS is one of the most devastating challenges to development efforts in southern Africa. Three decades after the discovery of HIV and AIDS, the epidemic continues to affect many communities, despite concerted efforts aimed at stemming infections and also providing quality treatment and care for those infected by HIV.

In line with international declarations and commitments, regional political leaders, together with civil society organisations, are channelling their efforts on universal access to HIV prevention and treatment, pledging to reduce the number of new HIV infections by 50% and advocating for the elimination of mother-to-child transmission of HIV by 2015.

To date sub-Saharan Africa remains the epicentre of the HIV epidemic. An estimated 22.5 million people are living with HIV in the region, which is about two thirds of the global total. This implies that for every three people who are living with HIV in the whole world, two reside in the sub-Saharan region.

The link between traditional leadership in Africa and culture is a strong one. Traditional leaders are some of the custodians of culture. On the other hand, HIV infections occur and interventions to stem them are implemented in cultural arenas. As aptly put by Professor Claude Maririke, during a presentation at the *Indaba* summit, culture and a people's value systems should be part of the solution to the prevention and control of HIV and AIDS. According to the professor, people must rally around traditional leaders and support them in their efforts to keep their communities healthy and safe. It is therefore gratifying to note that SAfAIDS is making efforts to place traditional leadership at the centre of interventions to address the 30-year-old epidemic. Traditional leaders have been the missing link in interventions and they can make a difference in communities in the response to the HIV epidemic and other socio-cultural challenges that are fueling the epidemic.

Traditional leaders are highly respected and influential in their communities. People turn to them for guidance and solutions to different challenges they might face. Even with HIV, people have been looking upon us (traditional leaders) and half the time, our interventions were uninformed. It is my wish that through reading this book, we will become motivated and encouraged to start assisting our community members to effectively tackle HIV and AIDS in their communities.

Stigma and discrimination has been a major stumbling block to the efforts by implementers to mitigate the effects of HIV amongst communities. We have instances where people would not seek HIV services early for fear of being labelled, mocked, abused and ostracised Others on antiretroviral treatment would miss their treatment especially when they are at community gatherings like funerals, because they do not want the person next to them to know that they are on treatment. Traditional leaders should play a major role in the fight against stigma and discrimination and protect the rights of the infected and affected and other vulnerable population groups in their respective areas.

In this book you will find testimonies from leaders from a number of countries in southern Africa, leaders' profiles and Indaba summit presentation papers. It is our hope that these experiences will inform your approaches, as traditional leaders, as you guide your community members in stemming the tide of HIV and AIDS. Your involvement and that of your communities is critical for us to attain the broad goal of achieving Zero New Infections, Zero Discrimination, and Zero AIDS-related deaths.

Let your beloved ancestors give you wisdom and guidance in your endeavours to contribute towards the fight against the bane of HIV and AIDS.



Dr Masenjana Sibandze

Deputy Director General: Research, Policy and Legislation Development  
Department of Traditional Affairs, Pretoria, South Africa



# List of acronyms

AIDS .....	Acquired Immune Deficiency Syndrome
ART .....	Antiretroviral therapy
ARV .....	Antiretroviral
ASO ... ..	AIDS service organisation
CTRF .....	Changing the River's Flow
EU. ....	European Union
GBV .....	Gender-based violence
HBC .....	Home-based care
HIV .....	Human Immunodeficiency Virus
MCP .....	Multiple and concurrent sexual partnerships
MMC .....	Medical male circumcision
OI .....	Opportunistic infection
PLHIV .....	People living with HIV
PMTCT .....	Prevention of mother-to-child transmission of HIV
SADC .....	Southern African Development Community
SAFAIDS .....	Southern Africa HIV and AIDS Information Dissemination Service
SANAC.....	South African National AIDS Council
SASO .....	Swaziland AIDS Support Organisation
SWANEPHA.....	Swaziland National Network of People Living with HIV
UNAIDS.....	The Joint United Nations Programme on HIV/AIDS
VCT .....	Voluntary counselling and testing
WHO .....	World Health Organization

# The context of HIV and interventions to tackle the epidemic in southern Africa

**Mandi Chikombero, PhD**

Southern Africa remains the epicentre of the HIV epidemic. Although a number of countries (Botswana, South Africa, Zambia, and Zimbabwe) have shown declines or stabilisation in HIV prevalence, HIV statistics in the region remain unacceptably high. In 2009, 11.3 million people in the region were living with HIV (UNAIDS, 2010). Of all people living with HIV (PLHIV) globally, 34% reside in 10 southern African countries (UNAIDS, 2010). With 5.6 million, South Africa's epidemic is the largest in the world while at 25.9% Swaziland's adult prevalence is the highest.

The southern African epidemic has a number of key characteristics including the following:

- Prevalence and incidence rates are generally high;
- The epidemic is largely generalised although there are key populations at risk. In addition there is a high occurrence of discordant couples, in some places as high as 85%;
- HIV is transmitted primarily through heterosexual contact and through mother-to-child transmission;
- Women and young girls remain the most affected group. According to UNAIDS, about 40% of all adult women living with HIV are in southern Africa.

The reasons for these characteristics are varied and include: the fact that a more virulent HIV strain is common in the southern Africa region; women are biologically more susceptible to HIV infection through heterosexual contact; and the historical interconnected nature of the region which facilitates cross-border population movements that spread HIV. In addition to these explanations however, a number of underlying factors or 'key drivers' have been identified as fuelling the epidemic.

## Key drivers of HIV

The term 'key drivers' refers to factors that increase people's vulnerability to HIV infection. These underlying factors, as shown in diagram 1, can be socio-cultural, sexual, biological, and economic.

- Multiple and Concurrent Sexual Partnerships- A Southern African Development Community (SADC) Think Tank meeting in 2006 identified multiple and concurrent sexual partnerships (MCP) with low correct and consistent condom use in the context of low male circumcision as a key driver of HIV in the region. MCP takes many forms including polygamy and age-disparate sex. In any of its forms, MCP heightens risk of HIV infection. Negative socio-cultural norms fuel MCP.



Diagram 1: Underlying determinants of vulnerability to HIV infection

- Socio-cultural factors – Research (e.g. Price, 2009; Aihrihenbuwa & DeWitt Webster, 2004) has documented that all societies exist within cultural frames that contribute both positive and negative influences on all facets of human behaviour including sexual behaviour. The HIV epidemic in southern Africa exists in a cultural context that often facilitates the spread of HIV. This context includes unequal gender relations that limit communication about sexual matters between men and women. Women are often unable to negotiate for safer sex with their partners. Numerous cultural practices increase HIV risk for women. Dry sex (practiced in many parts of southern Africa) increases HIV risk for women due to lacerations resulting from drying agents used by women to minimise vaginal lubrication during intercourse. The practices of widow inheritance (where a widowed woman is inherited by a relative of the deceased husband and sexual cleansing (where a woman is required to engage in sexual intercourse with a relative of her deceased husband in order to be 'cleansed') may expose women (and their partners) to HIV. Practices such as spirit appeasement (where young women are given away to appease/ avenge the spirits of murdered people and become wives of the deceased's relatives) also heighten HIV risk.
- Other cultural elements that have an effect on HIV risk include male attitudes to sex and male sexual behaviour. Traditionally men initiate sex. This gives them a measure of control over their partners such that they decide if, when, and how sex occurs and whether or not condoms are used. In addition, cultural ideals of masculinity include sexual prowess. This can lead to married men having numerous sexual partners. In fact, in many southern African societies, male infidelity is culturally acceptable and condoned and women are expected to tolerate and accept it.
- Gender-based violence – The Global AIDS Alliance asserts that HIV is perpetuated by violence against women and girls (2010). Gender-based violence (including sexual violence) is sometimes ignored, if not sanctioned by culture, despite the fact that it is undeniably linked to HIV. For example, research in South Africa and Tanzania (UNAIDS, 2004, Dunkle, et al., 2004; Maman et al., 2002) has found that women who experience violence at the hands of intimate partners are more likely to become infected with HIV and that women who are HIV-positive experience more violence from their partners than other women. In addition, violence (or the fear of it) can affect women's willingness to disclose their HIV status to their partners putting their partners at risk of infection and putting themselves at risk of re-infection. Men who are physically and sexually violent are more likely to engage in risky sexual behaviours than other men (WHO, 2002). Finally, myths regarding sex with virgins place young girls and women at increased risk of sexual assault. Such sexual violence (including rape) increases the likelihood of HIV infection. In Swaziland a study found that 33% of women aged 13 -24 years had experienced some form of sexual violence (UNAIDS, 2010). According to the World Health Organization, gender-based violence is "often fuelled by longstanding social and cultural norms that reinforce its acceptability in society". Addressing it therefore requires approaches that address the cultural antecedents of violence.

- Stigma, discrimination and violence relating to HIV increases risk of HIV infection in a number of ways. People may avoid HIV testing or seeking treatment for fear of stigma thereby putting themselves and their partners at risk.

Gould and Miskelly (2010) note that culture plays a role in “establishing the practices, values and attitudes which create stigma and discrimination, gender and other inequalities” (p. 2). There is therefore a need to engage and interrogate these negative cultural norms and practices through appropriate cultural approaches. In this regard, traditional leaders, as custodians of culture in many African communities, have an important role to play in addressing the negative socio-cultural practices which contribute to the further spread of HIV and AIDS in sub-Saharan Africa.

### **Interventions to date**

Although HIV prevalence remains unacceptably high in most countries in the region, the AIDS response in southern Africa has yielded a number of positive results to date. These include decreasing levels of new infections, increased condom use, and success in Prevention of mother-to-child transmission of HIV (PMTCT) programmes. For example in Namibia and Zambia, overall HIV incidence decreased by more than 25% between 2001 and 2009 (UNAIDS, 2010). Similar trends have been observed in Zimbabwe. The practice of having multiple sexual partners has declined in most southern African countries. In Botswana and South Africa condom use at last sex was higher than 75%. Antiretroviral therapy (ART) coverage has increased in the region with Botswana and Namibia achieving ART coverage of 83% and 76% respectively among adults living with HIV (UNAIDS, 2010). Botswana had 90% coverage for children in 2010.

However, knowledge of HIV and how to prevent it is still lacking, particularly among young people in a number of countries including Botswana, Malawi, South Africa and Zambia. Enrolment and access to ART remains low in some countries. Mozambique, South Africa and Zimbabwe have ART coverage of less than 40% among adults. In addition, interventions have failed to address the key drivers of HIV in the region. They have remained focused on individual determinants of risk and behaviour. Despite their best intentions such interventions, as Leclerc-Madlala (2009) notes, “will likely have as limited success as past prevention efforts if the cultural milieu in which sexual partnering practices are located and reproduced remains poorly understood, unaccounted for, and unaddressed in prevention programming” (p. 103).

Research however, shows that individual behaviours operate within and are influenced by shared/cultural factors (Airhihenbuwa & DeWitt Webster, 2004). Individuals are unable to make health decisions such as using condoms if such practices are not socially or culturally accepted or encouraged.

There has also been an over-reliance on mass-mediated communication approaches to behaviour change. Such approaches are limited because they do not reach most rural areas and they remain distant and removed from the intended beneficiaries. These gaps in interventions can be closed by partnering with traditional leaders who are ‘in touch’ with beneficiaries in their communities and can use traditional structures such as traditional courts to support interventions. An example of this would be traditional leaders exerting their authority to establish and enforce punitive measures to address perpetrators of gender-based violence.

Despite the fact that traditional leaders are the gateway to the communities that have been targeted in various interventions, their involvement has not always been central to these interventions. Studies have found that in some cases, “traditional leaders felt marginalised and circumvented ... yet almost all were eager to become more involved in the development and health improvements in their areas.” (Palitza, 2010). Traditional leaders must be involved in the conceptualisation, planning and implementation of these interventions.

There is evidence showing the effectiveness of meaningful involvement of traditional leaders in community interventions. In the response to HIV in southern Africa, it is time to tap into the influence of traditional leaders in order to achieve sustainable outcomes. Although it is widely acknowledged that culture can present obstacles in HIV prevention, working with traditional leaders emphasises that culture can also be a positive ally in protecting vulnerable groups. Culturally-positive and appropriate responses are available through the traditional leadership system. As custodians of culture, traditional leaders are intimately in touch with the norms and values of people in their communities. They can advise on how to approach and uphold long-held customs in a way that minimises HIV risk for communities across southern Africa in a sustainable and culturally-sensitive manner.

## References

1. Airhihenbuwa, C. O. & DeWitt Webster, J. (2004). *Culture and African Contexts of HIV/AIDS Prevention, care, and Support*. *Journal of Social Aspects of HIV/AIDS*, 1(1), 5-13.
2. Dunkle, K. L. et al. (2004). *Gender Based Violence, Relationship Power and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa*. *The Lancet*, 363(9419), 1415.
3. Evans, J., Delva, W., Pretorius, C. (2010). *Condom Use Among Young Swazi in Mixed-Age Relationships*. *Exchange on HIV and AIDS, Sexuality and Gender*, 4, 7-8.
4. Gould, H. & Miskelly, C. (2010). *Cultural Approaches to Addressing the Social Drivers of HIV/AIDS*. *Creative Exchange*.
5. Kernohan, V. (2010). *Interrogating Culture in Addressing HIV, Gender and Sexuality*. *Exchange on HIV and AIDS, Sexuality and Gender*, 2, 8-10.
6. Leclerc-Madlala, S. (2009). *Cultural Scripts for Multiple and Concurrent Partnerships in Southern Africa: Why HIV Prevention Needs Anthropology*. *Sexual Health*, 6, 103-110.
7. Maman, S. et al. (2002). *HIV-Positive Women Report More Lifetime Partner Violence: Findings From a Voluntary Counselling and Testing Clinic in Dar es Salaam, Tanzania*. *American journal of Public Health*, 92(8), 1331-1337.
8. Palitza, K. (2010). *Traditional Leaders Wield the Power, and They Are Almost All Men: The Importance of Involving Traditional Leaders in gender Transformation*. *Sonke Gender Justice Network*.

9. Price, L. (2009). *Conserving (Not Preserving) Culture: Avoiding the Damage to Culture of Veiled Moralism in HIV Education*. *The Southern African Journal of HIV*, 12-15.
10. **SADC Region 8 Country Comparative Research Report (2009). Ubuntu Institute.**
11. Susser, I & Stein, Z. (2000). *Culture, Sexuality, and Women's Agency in the Prevention of HIV/AIDS in Southern Africa*. *Public Health Matters*, 90(7), 1042-1048.
12. *The Role of Traditional Leaders in Preventing and Addressing Sexual and Gender-Based Violence: Findings from KwaZulu-Natal, Northwest and Limpopo Provinces in South Africa (2010)*. Population Council.
13. *UNAIDS Report on the Global AIDS Epidemic 2010*. UNAIDS.
14. *Women and HIV/AIDS: Confronting the Crisis (2004)*. UNAIDS/UNFPA/UNIFEM.



# Addressing cultural practices that predispose communities to HIV and gender-based violence

**Gillian Makota, Lois Chingandu and Ngoni Chibukire**

Culture is central when addressing gender-based violence and HIV. Women and girls are the worst affected by both GBV and HIV. Socio-economically, culturally and politically, women are the most disempowered due to the gender inequalities that persist in many African societies.

Tracing the Link: Culture, GBV, HIV and women's rights

Current understanding of violence against women suggests that women's experiences of violence are associated with an array of complex individual, family and societal influences. The ecological model by World Health Organisation (2002) outlines the multi-faceted nature of gender-based violence and explores the relationship between individual and external influences. Cultural values and beliefs are identified as possible contributors to violence against women. Factors such as masculinity associated with dominance, male entitlement and 'ownership' of women and approval of chastisement of women are some of the practices putting women at risk to GBV and HIV. Basically, community acceptance of norms of masculinity and men's use of power over women promotes inequality between the genders, which can lead to violence and thus increase women's vulnerability to HIV infection.

## **Harmful cultural practices and beliefs fuelling GBV and HIV**

Several harmful cultural practices that make women and girls vulnerable to HIV and GBV have been discussed in the community dialogues held by SAfAIDS and its partners in different countries in southern Africa. Such practices include:

### **1. Widow cleansing**

This is a practice commonly performed in Malawi. Widow cleansing is where a 'hired cleanser' or relative of the deceased is engaged to cleanse the widow. This ritual is carried out so as to cleanse all the evil spirits that can be surrounding the widow before she can be re-married. It is said that widow cleansing involves having unprotected sexual intercourse for it to be culturally accepted. According to information gathered during dialogues in Malawi, this practice has greatly put women at risk of HIV infection.

## 2. Multiple concurrent partnerships

This is a culturally acceptable behaviour in which men are allowed to have relationships outside marriage to prove male prowess and masculinity whilst the female counterpart (wife) is expected not to question but accept that “that’s what men are” - (*ndozvinoita varume, mukadzi anoshingirira* - Shona). In Zimbabwe, this practice is commonly referred to as the “small house”.

According to research and discussions in community dialogues, this belief is one of the aspects fuelling HIV as well as exposing married women to GBV. The women are not allowed to negotiate for safer sex even if they know that their husbands have relationships outside marriage. Below is a quotation from one of the Swaziland dialogues where a woman raised much concern about this unfair treatment by men:

*“Ngihlala lapha ekhaya ngigadze likhaya lakhe ahambe ayo sebenta. Angabuyi namali, siswele kudla, bantfwana bashela imali yesikolwe. Aphindze abuye neligciwane le HIV, ale kusebentisa i condom.*

*“I am expected to stay at home to look after his home, he goes to work in town and brings no money and now I will not only be struggling for food and the education of my kids but I will be HIV positive too because he refuses to use a condom since I have no rights to my sexual reproductive health.”*

## 3. Polygamy

Polygamy is one of the cultural practices that predispose women to gender-based violence and HIV. Culturally, polygamy was encouraged and usually practised by wealthy men in order to provide for wives and children with wealth as well as to have labourers to work on the land.

It has been reported that women in polygamous marriages experience some form of violation. More often than not, most of the women involved are at a high risk of being infected with HIV as safe sex is usually not practised.

## 4. Property inheritance

In the African context, males or the male children are regarded as the sole heirs to their parents’ property. It is assumed that women benefit from the wealth of their husbands. Also, widows do not benefit from the estate of their late husbands; only male relatives of the deceased have the right to inherit them. In some cases, women who try to inherit their husbands’ property become victims of violence.

## **5. Girl pledging – Ngozi**

This practice is popular in Zimbabwe, where a young girl, usually a virgin is pledged to appease the spirit of the deceased's family. This is done when a member of a family has committed murder and a girl is pledged to be a wife to the wronged family. Pledging of a young virgin is a sign of acknowledging that one has done wrong and needs to make peace with the wronged family. This practice exposes the young girl to abuse.

## **6. Wife inheritance**

This is a common tradition in most southern African countries and was mentioned as one of the negative cultural practices during the community dialogues. In most cases, a widow is married to the late husband's brother; this is not a marriage of choice but is forced on the widow. The purpose of this kind of marriage was to ensure that the widow remained under the care of a close relative and not an outsider after the death of her husband. This was also done in order for the widow to remain in the family as well as enable the male family members to inherit the property of her late husband. In the case where the widow refuses to be inherited normally the family would normally not offer assistance to her or she would be sent away from her home. This practice exposes women to HIV infection. Through cultural dialogues and other initiatives Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) is working with traditional leaders in southern Africa to address these harmful cultural practices that predispose girls and young girls to HIV and gender-based violence.

# The role of African culture in tackling HIV and AIDS

**Risimati Samuel Khandhela**

South Africa is a largely rural country. A sizeable number of the population (about 21 million people) lives in the rural areas. The country's rural areas are mostly inhabited by people under the jurisdiction of traditional leadership. Traditional leaders (kings, amakhosi/ tihosi/ dikgosi and headmen) yield great influence as many rural people look upon them for guidance on matters of culture and tradition.

The South African government is fully aware of the importance of traditional leaders. This realisation has resulted in the government officially recognising traditional leadership at national, provincial and local levels, through the establishment of the National, Provincial and Local Houses of traditional leaders. The government also works closely with traditional leaders and their structures on matters of development. This paper seeks to examine the key role that can be played by traditional leaders and culture in the fight against HIV and AIDS, with specific focus on identified cultural practices that if practised as per original cultural dictates can help combat HIV and AIDS. This, however, should take into account the changing dynamics of societal life, and the inevitable need for culture to adapt to changing circumstances. There is much truth in the popular and widely held belief that culture that kills is not culture and culture that does not adapt dies.

In its fight against HIV and AIDS, the South African National AIDS Council (SANAC) has mobilised different sectors to form a united front. The traditional leadership is among the more than 20 sectors collaborating with SANAC. SANAC is guided by its National Strategic Plan (2007-2011), which emphasises key priority areas, namely; prevention, treatment, care and support, research, monitoring and surveillance and human rights and access to justice.

Traditional leaders should place more emphasis on prevention, prevention and more prevention. From a traditional perspective, culture can play an important role in the fight against HIV and AIDS. Traditional leaders are recognised first and foremost as custodians of culture and tradition. A case can be made that traditional leaders can champion the fight against HIV and AIDS through the promotion of certain cultural practices on the one hand, and, on the other hand, conscientise their communities about harmful cultural practices that either need to be discarded or adapted to the current environment.

The cultural practices that have been identified in the context of fighting the HIV and AIDS pandemic are ukusoma, ukuhlolwa kwentombi, polygamy, male initiation and other cultural practices associated with rites of passage that mark the transition of African boys and girls from boyhood and girlhood to manhood and womanhood, respectively. In the light of the devastating nature of AIDS, traditional leaders and traditionalists must advocate “going back to our roots” as an attempt to use widely practised cultural practices as weapons against the pandemic. On the other hand, no blind eye must be turned against any cultural practice that may be considered harmful and that may contribute to the spread of HIV. Such practices must be identified and open and frank debates be encouraged, with a view to either modifying them or eradicating them altogether.

### **Cultural practices associated with abstinence and virginity**

Ukusoma is a practice that in its original form, was meant to encourage boys or young men to refrain from having penetrative sexual intercourse with their girlfriends or partners in favour of non-penetrative sex. This was meant to avert teenage pregnancy and any other pregnancy before marriage, which was shameful to the teenager or unmarried girl and her family. Of course, there were rewards that were associated with virginity. For example, a virgin girl’s mother, among the Zulu, was often given a special cow (nqutu beast) as a token of appreciation for having brought up her daughter very well and ensured that she preserved her virginity until she got married. You may ask: Is ukusoma still practised today? It is doubtful if it is still practised. However, it can be argued that it is still helpful to inform young people about this practice and possibly other similar practices that were used by communities to combat certain social ills, and this can serve as a valuable lesson and encouragement in maintaining what is morally good.

What is still being practised today, particularly in some areas in the Eastern Cape and KwaZulu-Natal, South Africa, is ukuhlolwa kwentombi (virginity inspection), which involves determining the virginity or otherwise of young girls by elderly women in the community. Girls who are found to have preserved their virginity are acknowledged and singled out for praise by their respective communities. There is no doubt that the cultural practice of ukuhlolwa kwentombi does assist in the fight against early sexual activity, teenage pregnancy and the spread of HIV and AIDS. One needs to ask critical questions regarding virginity inspection, such as: why is virginity inspection done only on girls and not boys? How does one deal with the fact that virginity inspection is widely practised in provinces like KwaZulu-Natal (and even sanctioned by Zulu King Goodwill Zwelithini), a practice that nevertheless is considered to be in conflict with certain legislation (e.g. Child Act)?

Polygamy is another contentious practice widely practised among a number of African ethnic groups in South Africa. A claim that women in polygamous marriages stand a greater risk of contracting HIV cannot simply be dismissed as invalid; it can also be argued that polygamy in its original form can play an important role in preventing the spread of HIV. Debates about polygamy tend to be confused with infidelity and promiscuity, something that genuine polygamists aim to avoid by getting married to more than one woman. A true polygamist marries many wives in order to avoid having girlfriends, concubines and secret lovers. If he is faithful to his wives and all his wives are faithful to him, there exists virtually no chance of him or any of his wives contracting HIV.

A dangerous scenario that is not given enough attention is that of a monogamist who is legally married to one wife but has a string of girlfriends, concubines or secret lovers. If the monogamist is unfaithful to his wife or one of his lovers, there exists a high risk of him and all his lovers getting infected with HIV. It cannot be disputed that most HIV infections within marriages come as a result of one of the partners being unfaithful. Polygamy can be considered a way of ensuring that a man does not have multiple sexual partners, and in that way it can contribute to the fight against the spread of HIV, provided that all partners in such marriages are faithful. Polygamy should not be equated with infidelity or promiscuity. Ukungena (wife inheritance) is another controversial cultural practice. People who are against it argue that women, who are “inherited”, like those in polygamous marriages, also run a high risk of contracting HIV. The idea of ukungena, in the past traditional set-up was to ensure social security for the widow as she would marry one of the deceased’s brothers. It also ensured that the children had a common identity as they would share a common surname. It is common today for a woman to have, for example, three or four children from different fathers. Such children are referred to as “choice assorted” in township lingo, a reference derived from the famous Choice Assorted biscuits brand, whose packet contains different types of biscuits. What is often being questioned today is the coercive element of ukungena, whereby a woman is forced into a marriage with one of the deceased’s brothers in the family, and that the woman runs the risk of contracting HIV if the inheritor is HIV positive. Also, the inheritor risks contracting the disease, particularly if the deceased died of an AIDS-related illness.

From a traditional perspective, in the light of the challenges highlighted above, is it fair to say that ukungena should not involve any coercion, and in cases where there is mutual agreement between two adults about this practice, the necessary precautions must be taken to minimise the spread of the disease (e.g. through testing). Traditional leaders, as custodians of culture and tradition, and considering the fact that culture is dynamic, can take a lead in initiating debates that seek communities to dialogue on certain cultural practices that have a bearing on their lives, on the need to either adapt such practices or get rid of them altogether.

An initiation school for boys is one practice that can play an important role in the fight against HIV and AIDS. The initiation for boys, which is variously referred to as ngoma/ koma/ ulwaluko is practised by most ethnic groups in South Africa, namely the Ndebele, Pedi, Sotho, Tsonga, Xhosa and Venda. One may ask: “Given the risk associated with some initiation schools for boys (including penal amputations and deaths), why is hospital, medical circumcision not considered the way to go in the wake of HIV?” In addressing this question, it is important to mention that traditional initiation for boys is not synonymous with circumcision.

True, circumcision is part of the initiation, but circumcision is not initiation. Circumcision is limited to the surgical operation whereas in initiation the operation is just a small part of the whole process, which incorporates training and inculcation of values and norms. Initiation is often referred to as “a school of life”. In many communities boys take great pride in going to the mountain to undergo the initiation rite. There are cases of boys who, even after being circumcised in hospitals or by private surgeons, still run to the mountain or bush initiation schools. This is primarily due to the cultural pride associated with attending ngoma. In communities which practise ngoma, boys and men who did not attend the initiation school are often despised and looked down upon. Often labelled “boys” irrespective of their age, uninitiated men are often not allowed to take part in “male” activities, such as attending and expressing views in traditional gatherings. Girls are also discouraged to date and marry them.

Stigma associated with not having attended this “school of life” explains to a greater extent why, despite the deaths of initiates associated with this practice (particularly in the Pondoland region of the Eastern Cape Province), many young men still flock to these schools, with or without parental consent. In addition to the cultural pride associated with ngoma, research shows that there are advantages associated with being circumcised. This constitutes a very good case for the promotion of initiation schools for boys. According to research, male circumcision reduces the risk of contracting HIV by 60%, a direct benefit to circumcised males and an indirect benefit to their partners.

Furthermore, research has also shown that not only is the risk of contracting other sexually-transmitted infections (STIs) such as Hepatitis B drastically reduced when one is circumcised but the general health of the penis is improved, penile cancer is drastically reduced among males and cervical cancer is reduced among females.

The hypothesis put forward here is that traditional leaders, as custodians of culture or tradition, can play a pivotal role in the fight against HIV by promoting this cultural practice. Concerted efforts must be made to ensure that current challenges (e.g. deaths of initiates in some areas) are minimised.




Cultural initiation practices associated with girls include domba (among the Venda), ku khomba among the Tsonga, imemulo among the Zulu and intonjhani among the Xhosa. During these cultural practices, which constitute rites of passage from girlhood to womanhood, life lessons are imparted to the girls by elderly females. It is advisable to use these practices to create awareness and educate girls and young women about the dangers of the disease by introducing in the initiation curriculum lessons on handling puberty, sexuality, teenage pregnancy, STIs and HIV and AIDS.

Certain cultural practices have been identified to be useful in the fight against HIV and AIDS. These include ukusoma for boys, ukuhlolwa kwentombi (virginity inspection) for girls, polygamy and initiation schools (koma/ ngoma/ ulwaluko) for boys. Traditional leaders, as custodians of culture and tradition, must use aspects of identified cultural practices that many of their people believe in, to fight HIV and AIDS. To show their objectivity and commitment, traditional leaders must be courageous in confronting harmful cultural practices that hamper rather than support efforts to fight the pandemic. Traditional leaders, bearing in mind that culture is dynamic rather than static, and that culture that kills is not culture, should encourage their people to engage in debates about the need to modify these practices or adapt them to current circumstances, and where necessary eliminating cultural practices considered harmful altogether.

The concept of ubuntu or butho is an African concept. Ubuntu is humanity in the broadest sense. Its tenets encompass everything and anything that is positive and good: unconditional love for the next person, understanding and catering for the next person's needs, celebrating with the next person when he/she is happy and feeling his/her pain when they are hurt. The Xitsonga expression "Xa mina i xa wena, xa wena i xa mina" (yours is mine and mine is yours) succinctly sums up this concept. In a traditional African community set-up children were a responsibility of all adults, and any adult other than the biological ones could send any child on errands, reprimand and even punish the child concerned, and the child would not even report to his/her biological parents about having been, for example, punished by the next door neighbour, for fear of further punishment by his/her parents.

Western influence (with its aggressive urbanisation drive, technological innovation and emphasis on individual rather than community rights) and the resultant disintegration of African family values and norms constitute an assault on the family structure, the disintegration of which has manifested itself in a variety of ways, including increased poverty, indiscipline and general moral decay in the African society. Traditional leaders and African elders must preach the gospel of "going back to our roots" and promote past cultural practices that made us a better society.



Traditional leaders can spearhead campaigns to de-stigmatise HIV and AIDS, which will undoubtedly yield positive results, as many people will come out from their cocoons and declare their positive status without fear of being negatively labelled, while others will be encouraged to test for HIV or declare their HIV positive status.

In this paper, it has been argued that traditional leaders do have an important role to play with regard to combating the HIV and AIDS pandemic. They can do so by primarily advocating for people to “go back to their roots” through promotion of cultural practices that can help in the fight against the pandemic, notwithstanding the need to adapt some of these to current circumstances. In dealing with the stigma associated with HIV and AIDS, the African concept of ubuntu will go a long way in ensuring that infected and affected people are not discriminated against, but rather cared for.

# Traditional Leaders as champions for prevention: The leadership “Rock” Programme

**Maserame Mojapele, Lois Chingandu and Ngoni Chibukire**

In 2006, SAfAIDS piloted the Changing the River’s Flow (CTRF) programme in Seke, a Zimbabwean peri-urban community, 50km southeast of Harare. SAfAIDS has since scaled up this programme to nine countries (Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe). The CTRF programme was born out of the understanding that if African communities are going to effectively and sustainably fight HIV, there is a need to start thinking outside the box by addressing the epidemic through an African lens.

The cornerstone of this programme is the communities themselves, who are capacitated to identify their own problems and develop appropriate solutions to such problems. The communities have the willpower to address the cultural practices that fuel HIV and gender-based violence (GBV).

Under this programme SAfAIDS tailored the interventions to local circumstances in line with the “know your epidemic, know your response” strategy. SAfAIDS examined the HIV epidemic from an African perspective, and unpacked the key drivers which are different from those driving the epidemic in other parts of the world. What SAfAIDS found was that the African epidemic is different because of certain cultural practices, beliefs and value systems, that is, the way people live and interact as Africans. Although culture is not viewed as something bad, there are cultural practices such as wife inheritance that put women and girls at risk of HIV infection. Certain cultural norms have been found to dis-empower women in Africa, silencing their voices and contributing to the HIV crisis by hindering women from acting to protect themselves and their families. Therefore it was imperative for SAfAIDS to address some of the harmful cultural practices that increase communities’ vulnerability to contracting HIV.

Through this programme SAfAIDS influenced communities to change their behaviours and also to modify harmful cultural practices through the work of community-based volunteers. In this programme SAfAIDS reached 500 traditional leaders who are currently actively involved in the programme at the community level. Based on the work done, one of the things learnt in communities was the power of traditional leaders which was not understood until the discussions were held with them. The influential

power of traditional leaders can be employed to prevent HIV through working closely with them. It is against this background that the metaphor “Rock Programme” was born. SAfAIDS views traditional leaders as “Rocks”. This is because the rock is strong and immovable. People depend on the rock. When you leave the rock you will find it where you left it unlike trees that grow and wilt.

SAfAIDS is now working with traditional leaders to unleash their power in HIV prevention from a cultural perspective. They have the indigenous knowledge and this can be strengthened through capacity development initiatives and information provision, which is SAfAIDS’ comparative advantage. This combined expertise can make a difference. The Rock programme is an off-shoot of the CTRF programme where political and traditional leaderships are actively engaged in HIV prevention in order to attain the ‘three’ zeroes by 2015. The three zeroes are: zero new HIV infections, zero discrimination and zero HIV-related deaths. Working together with traditional leaders can bring about the desired change.



*Traditional leaders at the launch of the the Leadership “Rock” Programme for HIV Prevention*

### **The Leadership “Rock” Programme for HIV Prevention**

The Leadership Rock Programme for HIV Prevention is an innovative development initiative that is meant to unleash the power of traditional leaders in promoting and scaling up HIV prevention in their constituencies and communities in order to contribute to reducing by half all new HIV infections by 2015. The programme supports traditional leadership to champion HIV prevention at the community level by creating an enabling environment that promotes behaviour change towards risk reduction and address cultural norms that fuel HIV within communities.

The goal of the Leadership Rock Programme is to empower traditional leaders to champion HIV Prevention to:

- Reduce new HIV infections;
- Address gender and societal cultural norms;
- Stop violence against women and girls;
- Enhance social protection for people living with HIV (PLHIV);
- Prevent mothers and babies from dying of HIV.

## Traditional leadership

A traditional leader can either be a man or a woman who leads the community. Traditional leaders are recognised symbolic figureheads with power, charged with acting as arbitrators in local disputes. In some cases traditional leaders advise parliament on issues of customary law through formalised structures like House of traditional leaders. Traditional authority structures wield real power in the lives of rural residents. SAfAIDS views a traditional leader as a person who has power and authority to make decisions within the community, a person who always puts the interest of his/her community before his/her interest.

The history of traditional leadership is similar throughout the African continent, and the majority of SADC countries such as Botswana, Namibia, South Africa and Zimbabwe have dealt with the subject of traditional leadership in their post-independence governments. In these countries, the institution of traditional leadership had absolute authority over their communities prior to colonisation and to some extent even during colonialism (Keulder, 1998: 302).

There are different opinions regarding the origins of traditional leaders and the institution of traditional leadership. There are also strong beliefs in a link between traditional leaders and God – an opinion which traditional leaders appear to encourage and perpetuate. In this regard the South Africa Native Economic Commission (1930: 32) states that: The hereditary Chief is the link between the living and the dead. He is a high priest, and with certain tribes, he may become a ‘god’ during his lifetime. The reverence for the Chief and his family is, therefore, deeply ingrained among the Abantu.

According to d’Engelbronner-Kolff, Hintz and Sindano (1998: 4) “traditional leadership” refers to the authority that is based on the belief in “sacred traditions in force since time immemorial” and the legitimacy of those who are called to govern by the said traditions. Oomen (2005: 28-29) supports this assertion when arguing that “traditional authority like any other [legitimate] authority is coming from God and without it Africans would not have a community”. This authority is bestowed upon traditional leaders to shepherd traditional communities against unorthodox and orthodox sieges directed at destroying African nations. In this vein, traditional leaders are leaders in charge of the lives

of the people and the safety of the nation. They are leaders who rule and govern their societies on the basis of traditional practices and values of their respective societies (Ntsebeza, 2003: 31-32). The views presented above portray the extent to which traditional leaders held power over their subjects and the extent of their authority. The fact that a traditional leader was the central feature of a tribe also indicates the extent of power that such leaders had at the time.

### **What is the role and power base of traditional leaders?**

The majority of African countries are predominantly rural and the authority of urban governments often does not extend to these rural areas. As a result, traditional authorities can become critical in organising the people at local levels where the government does not reach. Traditional authorities have always been a feature of African societies and their involvement in governance issues has been recognised.

Traditional leaders claim legitimacy based on history and religion. Historically, traditional leaders claim political authority derived from the pre-colonial period. They are seen to represent 'indigenous, truly African values and authority'. Religiously, they claim links to the divine, whether a god, a spirit or the ancestors.

In most African countries, traditional kings and queens are the custodians of the customary laws and traditional norms that govern people at community level. Traditional leaders have powers in their own traditional jurisdiction, e.g., if one is summoned by the chief and he or she fails to appear before him, then the chief can withdraw the person's residential rights or force him or her to work in his maize fields for a certain period. Traditional leaders are community members who ought to protect the community, their families and tradition. He/she should be able to guide community members in all the matters pertaining to the well being of the community. Being a traditional leader means that one has the power to make decisions affecting the community.

According to Professor Claude Mararike of the University of Zimbabwe, traditional leaders should work with various institutions at the community level including families, schools, religious organisations, health delivery organisations and political parties and approach the issue of HIV as a window of opportunity to interrogate behaviours and value systems. But for their roles to be visible and effective, traditional leaders should express preparedness, readiness, awareness, willingness, ability and capacity to tackle social and economic challenges including HIV and GBV.

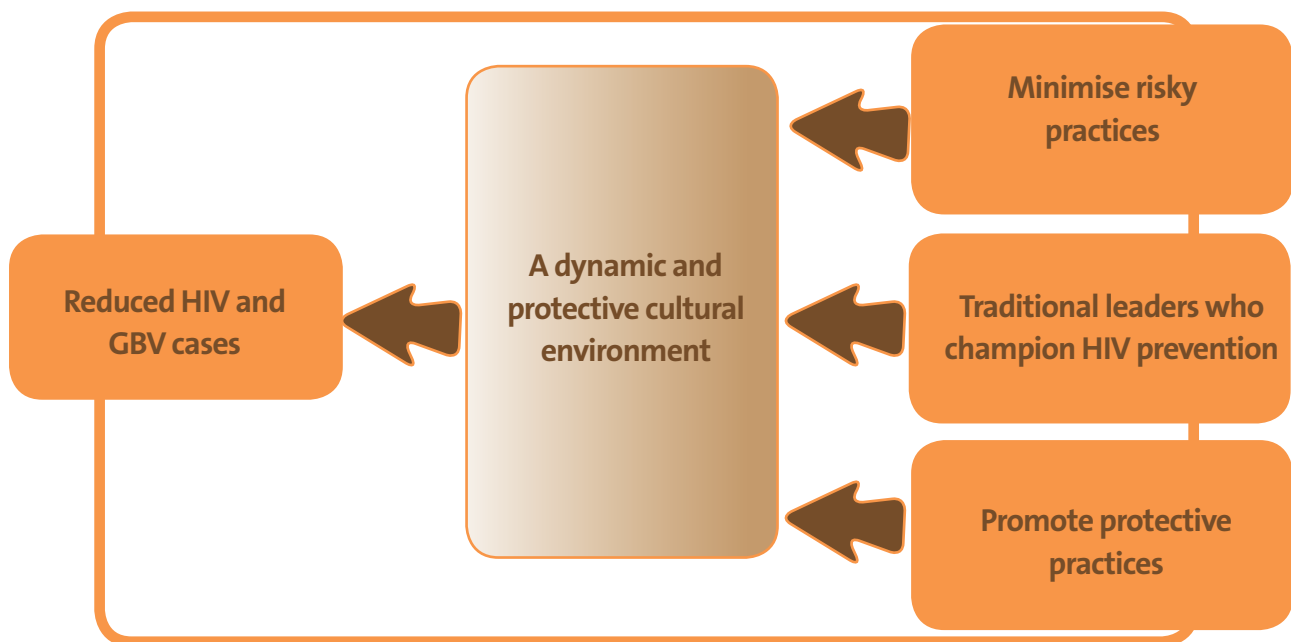
### **Why the traditional leader is a key player**

Traditional leaders and traditional structures of governance remain influential in both urban and rural areas of southern Africa. Commanding much respect and wielding immense influence in their communities, traditional leaders can facilitate positive change in local communities. Their influence



stems from the fact that they are formally linked to ruling governments and that they exercise legislative authority and preside over customary courts. Several countries in southern Africa recognise the role that traditional leaders can play in curbing HIV infection in their communities. For example, the National HIV Strategic Plans in Botswana, Lesotho, Malawi, South Africa, Swaziland, Zambia, and Zimbabwe highlight this key role.

As custodians of culture, traditional leaders are instrumental in the creation of protective cultural environments that minimise HIV infection. Acknowledging that culture has both positive and negative attributes, traditional leaders are in a position to address or discourage negative cultural practices that heighten HIV risk and promote positive practices in a culturally-sensitive manner. Their influence is wide-reaching and they have at their disposal traditional fora that they can use to educate their constituents and confront those socio-cultural norms, beliefs, and practices fuelling the spread of HIV. They have government backing and can in turn support government, NGOs and other actors' efforts to curb HIV and promote healthy behaviours and practices in local communities. In this manner, they will be creating dynamic protective cultural environments (see Diagram 2) that lead to positive outcomes.



*Diagram 2: A dynamic protective environment. (Diagram by Mandi Chikombero, PhD)*



Over the past three decades of interventions to tackle HIV and AIDS, the traditional leadership sector has not been meaningfully and strategically involved in the response to the HIV epidemic yet they are the ones who work with people every day. Traditional leadership structures were there even before the first case of HIV was discovered. One author once said “traditional leaders should bring NGOs on board not the other way round”. This shows that traditional leaders are key players in the response to HIV and AIDS. NGOs come and go but traditional leaders are always there for the people.

Traditional leaders preside over customary law courts that exercise legislative power and which maintain law and order at grassroots level in communities. They reach thousands of people in their communities. Through “imbizos/lekgotlas/indaba” or community dialogues; they advise government on traditional affairs and influence policy making that affects the lives of millions of people in mostly rural populations. It is important to document the role of traditional leaders as champions in HIV prevention in order for others to replicate and also cross-learn from such good practices. SAfAIDS intends to document such case studies for cross-learning and sharing in southern Africa and beyond.

## References

1. d’Engelbronner-Kolff, M., Hintz, M.O, and Sindano, J.L. 1998. *Traditional Authority and Democracy in southern Africa: Proceedings from the workshop of Traditional Authority in the nineties-Democratic Aspect of traditional government in southern Africa*. Windhoek, 15-16 November 1995.
2. Native Economic Commission. 1930. *The report of the Native Economic Commission of the Union of South Africa*. Johannesburg: University of the Witwatersrand.
3. Ntsebeza, H. 2003. *Democracy in South Africa’s countryside: Is there a role of traditional authority?* Johannesburg: Interfund.
4. Oomen, B. 2005. *Chiefs in South Africa: Law, power and culture in post-apartheid era*. Pietermaritzburg, University of KwaZulu-Natal Press.
5. Keulder, C. 1998. *Traditional Leaders and local government in Africa: Lessons learnt for South Africa*. Pretoria: HSRC

# Indigenous leaders and the control of HIV and AIDS

**Prof. Claude G. Mararike**

## **Introduction**

Indigenous leaders, sometimes referred to as traditional leaders, preside over the oldest social, political and economic institution in Africa. They include kings/queens, chiefs, headmen and kraal heads whose power and authority is hereditary. They are like the soil which has long been there before trees started to grow on it.

This chapter examines what the role of traditional leaders ought to be in the prevention and control of HIV and AIDS, using cultural values of their communities. The assumption is that culture and cultural value systems must be part of the solution to the HIV and AIDS problem. Challenges such as HIV and AIDS should be used as an opportunity to find solutions to peoples' health and development problems.

## **Characteristics of culture**

Culture may be perceived as what a people in any society have, what they do and how they think together. Culture is a people's data base. To understand it, one needs to know society's password. One must be initiated in a society's cosmology and moral geography. Culture is concerned with the content and meaning of a particular way of life, in other words, with values. Language plays a major role in the understanding of a society's moral geography. We must also know that people get infected with HIV in a social setting. That is why we must understand all the social circumstances under which HIV is contracted. This is also why indigenous leaders are relevant in the search for solutions to HIV and AIDS.

We need to appreciate the other view that diseases easily "cross" cultural boundaries but each culture must find remedies in the context of its own social, economic and political setting, without ignoring the possibility of learning from each other.

## **What traditional leaders can do**

We should recognise that the role of traditional leaders in most former colonised parts of Africa has been a source of conflict. This source of conflict has largely been over rules of resource accessibility, ownership, control and utilisation [Mararike, 2003].

As we attempt to explain what the role of traditional leaders ought to be in the prevention and control of HIV and AIDS, we note that the conflict between them and other administrative structures has persisted. Their roles as reference points, advisors, counsellors, psychologists, social workers and sociologists to their people continue to be undermined. However, we suggest that in dealing with HIV and AIDS, traditional leaders should dialogue with the following groups and institutions.

### **Families**

Families are normally centres for reproduction and production. Issues related to reproductive health are critical in the control and prevention of diseases. Traditional leaders should take a keen interest in health issues, particularly those related to marriage, reproduction and nutrition. Also, families are centres of production of goods and services. These include food and education. Primary socialisation takes place in the context of families. Traditional leaders must share with their constituents what the content of such socialisation must be. Traditional leaders may find it useful to keep an inventory of each family's assets. This may help them in making decisions about the nature and type of intervention.

Traditional leaders ought to play a major role in the socialisation process; that is how members of the community are instructed in what they are expected to do by their community. This socialisation process is normally a collective responsibility. It has a bearing on how people act and react to external and internal stimuli. In other words, their behaviour is determined by the type of socialisation they will have received.

### **Schools as socialising agents**

Education in its widest sense, refers to the socialisation process through which a person learns his/her way of life in accordance with the expectations of his/her society. It is supposed to be a continuing process from birth to death. Schooling, on the other hand, refers to a restricted aspect of education which limits its use to those processes of teaching and learning carried out at specific times, in particular places outside the home, for definite periods, by persons especially prepared or trained for the task. The assumption is that schools, as formal organisations, should transmit appropriate values and value systems of a society to people of that society.

Schools must be concerned with the content and meaning of a particular way of life, in other words, with values. Traditional leaders must therefore, take a keen interest in what schools transmit to pupils. Regular meetings with heads of schools in their communities may enrich their thinking on a whole range of social issues.

### **Religious organisations**

Religious organisations are supposed to address a person's spiritual capital; that aspect of human personality which is supposed to be in harmony with the principles of hunhu/ubuntu. It should furnish a person with deeper insights into the non-material world. Its composition includes a person's ability to deal with issues such as: How do we account for our wrongdoings? How must we relate to one another? Traditional leaders should, from time to time, hold meetings with religious leaders in order to establish how issues such as HIV and AIDS can be handled and how to minimise conflicting teachings. Spiritual capital also deals with the relationship between the living and the dead, a rather difficult subject!

### **Political party leaders.**

Traditional leaders and political party leaders share the same constituents. They must exchange notes on a number of issues, including HIV and AIDS. They must agree on how the problem can be controlled, how the spread of HIV can be minimised and how people's behaviours can be influenced in order to curb the spread of HIV.

### **Health delivery organisations**

Hospitals, clinics and other community-based health service providers play an important role in minimising the spread of diseases in a community. They make people aware of possible causes of ill health, provide medicines for known illnesses and advise people on how to prevent the occurrences of diseases.

Traditional leaders who normally have the advantage of working with both indigenous medical practitioners as well as orthodox western medicines should use their knowledge and experience to reduce tension between the two health delivery systems. Holding meetings with representatives from both systems should be encouraged. Areas of possible conflict can be addressed during such meetings. This is likely to bring about an understanding and appreciation of each system's ways of approaching health delivery.

### **Urban/rural dichotomy**

Traditional leaders interact with people who may live in rural as well as urban settings. The lifestyles of such people may present a challenge to traditional leaders who may want to encourage and enforce traditional values and norms, particularly in the light of HIV and AIDS. Generally HIV is acquired by people while working in urban areas but move to rural homes where they eventually die. The challenge to traditional leaders is how to devise ways of minimising the spread of HIV from urban to rural areas. The separation of husbands from wives because of employment is a challenge. Traditional leaders can hold regular meetings to advise couples to stay together as much as possible and adopt safer sexual practices.

### **How people react to problems such as HIV and AIDS**

Traditional leaders should know how people react to problems so that they prepare themselves on how to advise them. Generally, people may react in one or more of the following ways:

They may ask for assistance. In situations where pandemics like HIV and AIDS strike, affected people seek help. Traditional leaders should know this and advise their communities on what sort of help to solicit and from who. It must, however, be stressed that seeking assistance must go hand in hand with the ability to try to help one's self. Self-help projects must therefore be encouraged. People who live with HIV and AIDS must be supported to be able to support themselves.

Sometimes people run away from problem situations or areas. This scenario may be useful if one is not part of the problem. There are times when causes of ill-health such as HIV and AIDS are thought to be emanating from our environment and people may decide to move away. Traditional leaders should assist members of their communities to examine their own behaviours before blaming others. Blaming something or others is sometimes resorted to when illness strikes. In villages, witchcraft accusations occur even if it is a clear case of HIV and AIDS. Traditional leaders should hold meetings with their constituents in order to exchange information and knowledge about the causes and symptoms of HIV and AIDS. Once people are armed with relevant knowledge, they are likely to face the problem head-on and seek correct solutions.

In conclusion, let me suggest a tool kit which traditional leaders may want to use during their meetings with their constituents.

### **Preparedness and readiness**

Almost all human activities require that one be physically and mentally prepared and ready. It does not matter whether the activity is going to buy groceries or waging a military war against an enemy. Participants in such activities must be mentally and physically prepared and ready. Traditional leaders must know this when dealing with people.

### **Awareness**

Awareness starts with an assessment of a participant's physical and mental condition. One should be able to know whether one's body is ready to tackle the proposed task. Traditional leaders must assess the awareness of their constituents on a whole range of issues, including HIV and AIDS.

## Willingness

Willingness, like awareness, is an attribute which emanates from within a person. It expresses one's readiness and commitment to undertake a task. The amount of time, energy and dedication which one puts in may be a reflection of one's willingness to see the task accomplished. In this regard, traditional leaders should assess people's willingness to tackle the HIV and AIDS problem [Mararike, 2006: 4-15].

## Ability

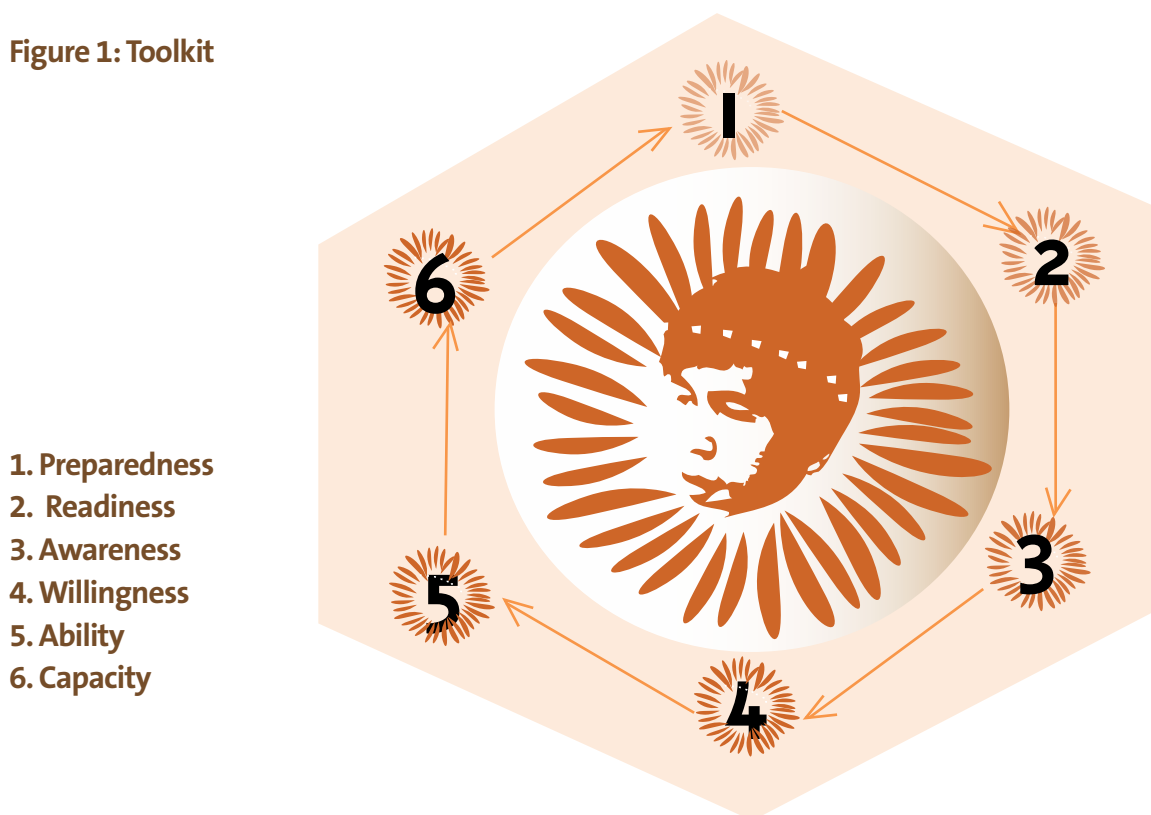
Ability is an inward conviction which a person ought to have. This conviction is then translated into visible results when one will have carried out set targets such as minimising the spread of HIV and AIDS. Ability is also a result of training and practice. People involved in HIV and AIDS, including traditional leaders, must accept and appreciate the need for training.

## Capacity

Capacity refers to how well and able one can handle a task. Capacity addresses questions such as: does he/she have the energy, endurance, skills, experience, technical know-how and know-why and the resources needed to tackle the task?

In short, the toolkit may be represented as shown in Fig 1.

**Figure 1: Toolkit**





# Traditional leaders' efforts to address HIV and AIDS, gender and sexuality issues in their jurisdictions

Eliezer F. Wangulu

## Hosi Nwamitwa of Baloyi people in Tzaneen, Limpopo, South Africa

In addressing HIV and gender-based violence, African communities accord great respect and honour to traditional leaders. Most of what they say is often respected and acted upon. In some instances, they can play the role of a judge or magistrate on simple matters that can be addressed at the community level, and their judgments are upheld. Traditional leaders can play key leadership roles in HIV and gender awareness, prevention campaigns and in supporting treatment and redirection of care as they are the closest to the people on the ground.



Hosi Tinyiko Nwamitwa was a member of Parliament for 15 years but returned to Limpopo to devote herself to the developmental needs of her community. The Valoyi Traditional Authority was established in 2004 with the aim of improving the social and economic well-being of the Nwamitwa (Valoyi) community near Tzaneen in the Limpopo province of South Africa. Considered one of the most impoverished provinces in the country, 70% of the residents in the Nwamitwa region of the Limpopo Province live below the poverty line. Twenty two percent of the local people have no education and HIV and AIDS rates are estimated at 20.7%.

Hosi Nwamitwa has the distinction of becoming the first woman formally recognised as a 'traditional leader' in South Africa, a title previously exclusive to men. She is one of the very few women among South Africa's approximately 750 traditional leaders.

*Hosi Na Mwitwa II, African queen and traditional leader*



A tiny number of tribes pass authority from mother to daughter, and some women lead as placeholders for underage sons. But the dominant succession tradition, written into law by colonial governments in many African nations, is father to first born son.

Hosi Nwamitwa's primary pursuit is to promote women's rights through a job-and-life-skills training programme and by empowering women to believe that they are as capable of leadership as men. But her top priority is development for her rural area, where low employment levels and HIV rates remain high.

The Valoyi Traditional Authority, after witnessing the success of the Etafeni Centre in Nyanga (Cape Town), was keen to replicate their model of a community-built, community-staffed centre in Nwamitwa. Using Etafeni's "Fit-for-Life, Fit-for-Work" programme as its model, the Nwamitwa Centre that focuses on promoting sexual and reproductive health (SRH) through economic empowerment, has been built by members of the community. The "Fit-for-Life, Fit-for-Work" programme is housed at the centre. From there, the project will broaden its scope to the wider community.

The programme provides a critical strategy for empowering young rural women, in particular enabling them make healthy life choices in terms of their sexual and reproductive health. Young women and men with Grade 12 would, after the Fit-for-Life training, be enrolled for English, computer skills, driving lessons, catering, training for the hospitality industry, etc – skills to help them find work in the labour market.

Those with Grade 10 level education and girls that have dropped out of school as a result of teenage pregnancy are offered work skills training or an opportunity to complete high school. The key focus for this sub-group is to prepare them to start their own small businesses, enter into the informal work sector, or return to school to complete matriculation. Work skills for Grade 10s consist of block and brick making, bricklaying, plastering, painting, carpentry, plumbing, food gardening, community caring skills (counselling, home care, etc), educare, administrative skills and craft or other income-generating skills.

Hosi Nwamitwa was called again to serve as a member of the South Africa Parliament in 2010. She is leveraging this position to complement her tireless efforts to make a difference among community members especially the youth and women. Through Fit-for-Life-Fit-for-work, the youth are empowered to stand on their own. Girls and boys who enrol in the programme are encouraged to abstain or postpone sexual interaction.

Hosi Nwamitwa makes sure that the basic services are delivered at the community. These include basic water, shelter, roads, electricity and health. Geared towards nurturing a healthy community, Hosi Nwamitwa (who leads 34 headmen and women) encourages the community through her headmen to identify their needs so that they can be addressed. Fit-for-Life-Fit-for-work incorporates an HIV programme for the youth and women empowerment.

The Nwamitwa Centre will house a pre-school and after-school facility for HIV affected and vulnerable children, a skills training and income generation programme for HIV-positive women and a food garden. Narrating the story of how she is responding to the impact of HIV in her community, Hosi Nwamitwa said: “For 15 years when I was a parliamentarian, each time I went home, I knew that the parliament was in Cape Town but that my community was in Limpopo, in the most rural area. I attended many HIV and AIDS workshops that sensitised me on the disease but I didn’t have the mandate [to act before I assumed the chieftaincy]. People in my community were having real problems with HIV.” But people in her community did not want to come out and speak about the disease openly and therefore the queen’s first task as hosi (queen) was to visit the health clinic. “Now we have got 1,000 people on ART but strangely enough, people would only come between 4 a.m. and 6 a.m. because they were afraid to be seen.” She encouraged people to live with HIV openly. “Now when they take ARVs you immediately see the change,” she says.

She adds: *“When we have the weekly lekgotla [royal meeting] with all my indunas [village headmen], we speak about HIV. It is not a myth, it is a reality. We even have rural doctors coming to the lekgotlas to talk about HIV.”*

### Message of Hosi Nwamitwa to all the women

“I am the type of person who never gives up; people can never fail if they really want to achieve their goals. Being a female traditional leader, you are like a mother, you have passion for what you do, you have feelings for people especially youth and aged.” She says a woman is a gift from God to make peace and make things happen, adding “If there was no woman, there would be no Nelson Mandela.”

The story of Hosi Nwamitwa bears ample witness that traditional leaders can play a vital role in reducing risks and vulnerability related to SRH, including gender-based violence and HIV.



*Women from Hosi Nwamitwa's community*

## Richman Rangwani

The 44-year-old Richman Rangwani serves in the chieftainship of Paramount Chief Murambwa in Mhondoro Ngezi, Mashonaland West in Zimbabwe. As a headman and community leader, he presides at the court of the paramount chief. The former police officer says he was appointed to serve in this position because he was conversant with the culture of his Shona people.

Mr Rangwani retired prematurely from the police force due to illness. Even as he was seriously ailing the paramount chief invited him to be a presiding headman in his court. One day, his wife who was pregnant, went to St Michael's Mission Hospital for antenatal clinic. It was at this point that she was found to be HIV-positive. Mr Rangwani also went for the test and the results showed he was living with HIV. He did not take it well. With hindsight, he says his reaction was driven by stigma which was rife then.



*Richman Rangwani at the Indaba*

His condition drove him into lobbying St Michael's Mission Hospital to address the needs of people living with HIV (PLHIV). The hospital accepted his request and registered 15 PLHIV who were very ill. He later worked at the hospital's opportunistic infections (OI) unit.

The manner in which he disclosed his HIV status to the community was unprecedented. Mr Rangwani requested the paramount chief to convene a big meeting at which another paramount chief and two other chiefs were present. It was at this meeting, before a crowd of about 2,600 people, that he disclosed his HIV status. During the disclosure, he sent out an appeal to the government to provide ARVs to PLHIV. "People shed tears during my disclosure, others despised me but the worst was that relatives deserted me," he said during an interview in Johannesburg, South Africa, on the sidelines of the Indaba summit. In the meantime, Mr Rangwani and his group of 15 PLHIV started a support group. He had used his \$38,000 pension dues on Simbarashe National Network for People Living with HIV, the support group he founded, before they attracted any funding. Later, as Simbarashe, they approached the European Union to support them to strengthen their group so that they could train people to provide home-based care for PLHIV. They also needed money to start herbal gardens since treatment was not available then.

It was a great relief when ARVs were brought at St Michael's. "My wife and I were number 18 and 19 respectively to be enrolled for ARVs," the headman said. After taking ARVs for some time, he became healthy and strong and was recalled to the police force but he declined. "I have HIV work, I like serving people," that is how he responded to the call.

The paramount chief's court works on Sundays only giving Mr Rangwani enough time to do HIV work from Monday to Friday. Unlike the time when he disclosed, he has won many friends who are keen to learn from him.

What is his driving force? "I have this inborn drive to conquer. I normally stop at nothing until I achieve what I set out to get. HIV cannot kill me. It is God who will kill me," he says. He is a happy man because he motivates people. He says: "It gives me pleasure to know that people who had been on the brink of death have remarried and some have children."

The EU donated € 60,000 to the group which was used to train 30 people in home-based care (HBC) while 90 others were assisted to acquire skills in herbal nutrition gardening. The Paramount Chief Murambwa donated six hectares of land for this activity. It is also on this land that a resource centre, four offices and other buildings for Simbarashe network have been built. It is through Mr Rangwani's effort that an OI clinic was built at the St Michael's Mission Hospital. The clinic was opened in 2010. Up to date, 53,434 people have been reached by Simbarashe with messages on how to prevent HIV, and living positively among others.

Currently, Simbarashe membership stands at 4,920 and it is drawn from all the nine administrative provinces in Zimbabwe. The organisation has started children's support groups. Recently, 210 children were tested and 83 were found to be HIV-positive. Consequently, five children's support groups have been founded to cater for the children's needs. The children living with HIV are receiving psycho-social support while others are on prophylaxis. All are receiving assistance.

## Chief Malambule Mdluli: MMC advocate

Chief Malambule Mdluli, 30, of Mbilaneni Chiefdom in Swaziland leads a population of over 10, 000. He was among the traditional leaders who attended the Indaba summit in Johannesburg, South Africa.

He stood out among the leaders at the summit after testifying that he had undergone male circumcision. In his testimony, Chief Mdluli said that he had made it his responsibility to motivate boys and men in his community to get circumcised through talks and campaigns on medical male circumcision (MMC).

Chief Mdluli has also motivated members of parliament in the southern Africa country to go for circumcision and some have heeded his call. He said: “I got motivated to get circumcised after hearing about the advantages of circumcision through radio announcements and campaigns on MMC, and then I decided to get circumcised.”



*Chief Mdluli making a presentation at the Indaba*

Before being circumcised, Chief Mdluli went for the HIV test after he was counselled on MMC. “I was told that I should have no sex at least for six weeks after circumcision and that I should always wear a condom even after circumcision,” he said. The chief, who is yet to marry, said the other advice he got from the counselling session was the need for him and his future spouse to test for HIV before having children. Besides reducing their risk of HIV acquisition by 60%, men who undergo MMC also have a lower risk of contracting STIs, he added.

## How Chief Mdluli popularises MMC

The chief motivates boys and men to get circumcised by sharing his personal story through posters and flyers with his picture and messages on advantages of MMC, via MMC dialogues at which he is invited and by trying his best to be a role model.





## King Ukongo Petrus of Namibia

Ukongo Petrus is king of Aodaman people of Namibia and he ascended the throne after the death of a former king in January 2002. Of the three candidates, his tribesmen settled on him because “... I was interested in the culture of my community.”

One of his primary objectives as leader was to inculcate in his people a sense of pride for their culture. Children started receiving lessons on the cultural aspects of the tribe. He has been consistent in spearheading the unity of the tribe which had been disrupted by many years of the Boers’ rule in Namibia.

*King Ukongo (centre) addresses delegates at the Indaba*

In a bid to empower his people whose population is 20,000, he has allowed his constituents to till the communal land and produce food for subsistence and commercial purposes and also keep livestock to fight poverty. Women are particularly encouraged to apply for land and each female applicant is given 0.8 hectares of land to till. He plans to step up his support for women, especially those living with HIV, by supporting their support groups.

He acknowledges that poverty is rampant in his constituency and that concerted efforts should be made to address it. Besides the government, he hopes to liaise with those managing four lodges and six campsites in his commune to contribute towards the eradication of poverty.

He recalls with nostalgia days when young girls spent a week in a darkroom being tutored by elderly women about the culture, sexuality, men responsibility, and marriage among other things. “This is no longer the practice and now we see girls as young as 13 years getting pregnant because they engage in early sexual activities due to lack of education,” he says. He also regrets the fact that young people no longer respect elders and that they are eager to ape western culture.

## HIV and AIDS

According to the Namibian Ministry of Health, Namibia's HIV prevalence is 14%. The king has been involved in initiatives to prevent HIV infections in his commune. For example, he has been playing a leading role in the implementation of the Changing the River's Flow programme implemented by SAfAIDS in Namibia. He sees this as his responsibility because the Namibia Third Medium Plan clearly articulates the need for traditional leadership to play a key role in the prevention of HIV.

He has also been in the forefront of empowering women to participate in leadership. "Before, men dominated traditional leadership structures. But things have changed. Currently we have almost an equal number of men and women in leadership." To achieve parity, he has been campaigning for women to join leadership at various levels. "I visit secondary and high schools to encourage girls to take up leadership roles once they leave school. But I also advise them to ensure that they are not distracted by getting pregnant and dropping out of school or abusing substances."

## His lessons from the Indaba summit

He was impressed by the efforts of Hosi Nwamitwa in her endeavour to improve the welfare of her Valoyi people. "She has challenged us to take after her by being humble in service to our people. Power should not make us arrogant." the king said.

*Translation during this interview was provided by Alexia Naris.*



## Samuel B. M. Hlatshwayo

Induna Yenkhundla, Mbabane East Constituency



*Mr Hlatshwayo during the Indaba Summit*

Samuel B. M. Hlatshwayo, aged 42, is a former teacher. He is married under Swazi customary law and is a father of three children (one boy and two girls). He is educated up to Form two. He presides over 5,000 people in his chiefdom and he is the secretary of Indunas in his region. Among his chief responsibilities is overseeing general development and resolving conflicts among his constituents. He is a civil servant elected in 2008 to serve a five-year term which ends in 2013.

While vying for office, he promised to address a raft of issues as they affect various demographic groups in his constituency. Some of his achievements include registering people with disability to get social grants, addressing the needs of the elderly and lobbying various institutions to support youth initiatives.

SafAIDS' Changing the River's Flow programme is implemented in his constituency by Swaziland National Network of People Living with HIV (SWANEPHA).

He was instrumental in organising community dialogues under this programme. "Changing the River's Flow programme has enabled us to openly address issues such as polygamy and multiple concurrent partnerships. It has made us realise the need to re-examine some policies and practices as we endeavour to achieve the three zeros," he said in an interview during the Indaba summit in Johannesburg, South Africa.

### HIV and AIDS

Mr Hlatshwayo was tested for HIV in 2003 and the result was positive. He immediately disclosed to his family before joining Swaziland AIDS Support Organisation (SASO). He later disclosed to his friends, relatives and workmates and sensitised them on how to avoid HIV infection and also how to live positively with the disease. He started taking ARVs in 2004 and visited VCT and clinics openly to collect ARVs in order to unveil the stigma related to HIV infection.

He lobbied SWANEPHA to help establish inkuntla networks of people living with HIV and there are now 55. His region has 14 such networks. His openness in living with HIV has attracted many AIDS service organisations (ASOs) to his inkuntla to initiate HIV and AIDS activities. He is currently advocating for traditional leadership structures to be meaningfully involved in the fight against HIV and AIDS.

At the end of the Indaba, leaders identified roles they could play in order to address HIV and AIDS and gender-based violence. It has been scientifically proven that male circumcision helps in the prevention of HIV. Leaders at the conference recommended that traditional leaders seek adequate information on male circumcision and share it with the family and practise it at home. Where possible, traditional leaders should be circumcised to set an example for community members.

## Conclusion

The conference participants stated that the starting point in addressing rape and sexual abuse is for traditional leaders to recognise that rape is a crime and then put in place measures to prevent it. Traditional leaders should collaborate with other structures to fight rape and sexual abuse. A deliberate effort should be made to ensure that there are women in the traditional leadership. Women leaders can easily detect violations against women and take appropriate measures.

Widow inheritance makes many women in southern Africa vulnerable to HIV. At the summit, participants came up with various ideas on how to ensure that women's health is protected. A recommendation from a group of leaders from Malawi suggested that instead of engaging a man to have sex with a widow to cleanse the evil spirits of the dead husband, a couple should instead be hired to have sex during the cleansing ceremony. It was also suggested that where widow inheritance should take place, both the widow and the man who is inheriting her should go for HIV counselling and testing to ascertain their HIV status before deciding whether to go ahead with their plan to stay together or not. Other harmful traditional practices were discussed at the Indaba which traditional leaders can help in ensuring that they do not make community members vulnerable to HIV and gender-based violence. By addressing these practices and taking other measures, there will be zero new HIV infections, zero discrimination of PLHIV and zero AIDS-related deaths.

In a nutshell, the leaders who attended the Indaba Summit committed themselves to transforming their communities by reducing new HIV infections; addressing gender and societal cultural norms; ending violence against women and girls; enhancing social protection for people living with HIV (PLHIV) and preventing mothers and babies from dying of HIV.

# Indaba Summit in Pictures



*Delegates at the Indaba keenly follow proceedings at the summit*



*A traditional leader from Namibia making a contribution during the summit*







*Swazi delegates dancing at the Indaba*



*SAfAIDS Executive director, Lois Chingandu (second from left) with some of the traditional leaders who participated in the Indaba*





**Traditional leaders on the frontline against harmful cultural practices, gender-based violence and HIV...** It is now three decades since the first case of people living with HIV (PLHIV) was identified but still HIV and AIDS remain the most devastating challenge to development efforts in southern Africa. The effects of the epidemic continue to be felt by many communities across the region despite substantial efforts aimed at stemming infections and also providing quality treatment and care for those infected by HIV.

In stepping up efforts to tackle the pandemic, innovative approaches need to be devised. These include bringing on board as many stakeholders as possible in an effort to achieve zero new infections, zero discrimination and zero AIDS-related deaths. It has now been realised that traditional leaders are critical to the achievement of the three zeros in southern Africa. This book documents key deliberations at the Indaba (traditional leaders' summit) which was held in Johannesburg, South Africa in April 2011. It also profiles some of the leaders who attended the summit.

In her introductory chapter, Mandi Chikombere states that the southern African epidemic has a number of key HIV and AIDS characteristics one of them being that the epidemic is largely generalised and goes on to give reasons why this is the case. She then lists factors that increase people's vulnerability to HIV infection among them culture and multiple and concurrent sexual partnerships (MCP). Among her other arguments is that time is ripe for tapping into the influence of traditional leaders in order to achieve sustainable outcomes in tackling the HIV and AIDS pandemic in southern Africa.

Addressing cultural practices that predispose communities to HIV and gender-based violence by Gillian Makota, Lois Chingandu and Ngoni Chibukire discusses harmful traditional practices that predispose community members, especially girls and women to HIV and gender-based violence.

In the chapter titled the role of African culture in tackling HIV and AIDS, Risimati Samuel Khandhela argues that since culture can play an important role in the fight against HIV and AIDS and because traditional leaders are recognised first and foremost as custodians of culture and tradition, a case can be made that they can champion the fight against HIV and AIDS by promoting certain cultural practices. They could also achieve this through sensitising their communities about harmful cultural practices that should either be discarded or adapted to the current circumstances.

Maserame Mojapele, Lois Chingandu and Ngoni Chibukire grapple with the issue of traditional leaders as HIV and AIDS champions in southern Africa and call for meaningful and strategic involvement of this cadre of leadership. The three authors argue that effective deployment of the influential power of traditional leaders can play a key role in trying to achieve the goals of zero new HIV infections, zero discrimination and zero HIV-related deaths by 2015.

In Indigenous leaders and the control of HIV and AIDS, Professor Claude. G. Mararike examines what the role of traditional leaders ought to be in the prevention and control of HIV and AIDS. The assumption is that culture and cultural value systems must be part of the solution to the HIV and AIDS problem. Traditional leaders' roles as reference points, advisors, councillors, psychologists, social workers and sociologists to their people should be exploited to fight HIV and AIDS. He argues that traditional leaders should dialogue with families, schools, religious organisations, political party leadership and health delivery organisations as they seek to find solutions to the HIV and AIDS problem. However, they can only accomplish this if they are prepared, ready, aware, willing, able and have the capacity to tackle the problem.

In the book's final chapter, Eliezer F. Wangulu documents the HIV and AIDS prevention efforts of five traditional leaders from Namibia, South Africa, Swaziland and Zimbabwe who attended the Indaba. Among those profiled is Queen Nwamitwa of the Valoyi community in the Limpopo Province of South Africa. Her efforts to tackle HIV and empowering her community members, especially women and girls, are inspiring. Chief Richman Rangwani of Mundoro Ngezi, Mashonaland West in Zimbabwe is an HIV advocate walking the talk. His efforts to fight HIV stigma have had a great impact in his community.



Southern Africa  
HIV and AIDS Information  
Co-ordination Service

