

Culture and African contexts of HIV/AIDS prevention, care and support

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ABSTRACT

Culture plays a vital role in determining the level of health of the individual, the family and the community. This is particularly relevant in the context of Africa, where the values of extended family and community significantly influence the behaviour of the individual. The behaviour of the individual in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV/AIDS prevention and control efforts. As the impact of HIV/AIDS in Africa remains unabated, a culture-centered approach to prevention, care and support is increasingly recognised as a critical strategy. In this article PEN-3, a model developed to centralise culture in health promotion interventions, is presented as a framework to be used in HIV/AIDS prevention, care and support in Africa. The three domains of the PEN-3 model incorporate specific constructs: relationships and expectations, cultural empowerment, and cultural identity. The cultural empowerment and relationships and expectations domains are 'assessment/appraisal' domains used for cultural assessment. Community identity is the 'application/transformation' domain that helps the public health practitioner assist the community to identify the point of entry of the intervention. In this paper the authors describe PEN-3 and then present examples of how the assessment/appraisal domains can be utilised to frame HIV/AIDS-related concerns in the context of Africa.

Keywords: culture, Africa, HIV/AIDS, model.

RÉSUMÉ

La culture joue un rôle très important lorsqu'on détermine le niveau de santé d'un individu, d'une famille et d'une communauté. Ce dernier a un rapport particulier dans le contexte Africain où la valeur attribuée à la famille étendue et à la communauté va influencer d'une manière significative le comportement de l'individu. Le comportement de l'individu vis-à-vis la famille et la communauté est un facteur culturel majeur qui a des conséquences sur le comportement sexuel et sur les efforts de prévention ainsi que le contrôle du VIH/SIDA. Vu que l'effet du VIH/SIDA, en Afrique, reste toujours élevé, une approche de prévention, de soin et de soutien basée sur la culture est de plus en plus reconnue comme stratégie essentielle à mettre en oeuvre. Dans cet article, le PEN-3, un modèle développé afin de placer la culture au centre des interventions de l'avancement de santé, est présenté comme structure de base qui sera utiliser dans la prévention du VIH/SIDA, aux soins et au soutien en Afrique. Les trois domaines du modèle PEN-3 se constituent: des relations et des attentes, du développement par la culture et d'une identité culturelle. Les deux premiers domaines sont des domaines utilisés lors de l'évaluation culturelle. L'identité culturelle est un domaine de transformation grâce auquel le personnel du service de santé public peut aider la communauté à identifier le point de départ de l'intervention. Dans cette communication, les auteurs décrivent le PEN-3, ensuite, ils démontrent comment les domaines d'évaluation peuvent être utilisés afin de cadrer toutes les préoccupations du VIH/SIDA dans le contexte de l'Afrique.

Mots clés: la culture, l'Afrique, le VIH/SIDA, le modèle.

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Introduction

Culture has been shown to have both positive and negative influences on health behaviours. Indeed, culture is often shown to be a factor in the various ways that HIV/AIDS has impacted on the African population. These factors range from beliefs and values regarding sexuality (including when to become sexually active and the number of sexual partners) and condom use in South Africa (Shisana & Simbayi, 2002), to the cultural definition of sexual orientation in the context of HIV/AIDS in Senegal (Niang, Tapsoba, Weiss, Diagne, Niang, Moreau, *et al.*, 2003). While HIV infection in hospitals and clinics through use or reuse of unsterile needles has gained attention recently (Gisselquist, Potterat, Body & Vachon, 2003), preventing this route of infection would require an understanding of culture, including value and reliance placed on the importance of 'injection' that may lead to use of unsterile needles outside clinical settings. A related issue is the cultural practice that encourages vagina dryness for enhanced friction for the penis (Kun, 1998). Parker and Aggleton (2003) examined the influence of the broader contexts of culture in AIDS-related stigma and accompanying denial, and concluded that stigma could not be fully examined outside the cultural contexts that give it meaning. In a 3-year project funded by UNAIDS to develop a new direction for HIV/AIDS prevention in African, Asia, Latin America and the Caribbean, culture was one of the five key domains that was recommended to become central in HIV/AIDS prevention, care and support, particularly in Africa (Airhihenbuwa, Makinwa & Obregon, 2000). These and other socio-cultural issues stress the need for culture to be at the centre of Africa's prevention and control efforts.

Mazrui (1986, p. 239) defines culture as 'a system of interrelated values active enough to influence and condition perception, judgment, communication, and behavior in a given society'. Hahn (1995) emphasises the role of culture and society in relation to sickness and healing, and highlights the use of language in the understanding of illness concepts. Furthermore, Brody (1987) posits that one's cultural belief system influences one's social roles and relationships when one is ill. Finally, Lupton (1994) postulates that the practice of medicine is a cultural production, particularly with respect to the focus on the body rather than the contexts that define and shape the body.

Regardless of the disciplinary basis on which the definition is advanced, it is generally understood that culture is the foundation on which health behaviour in general and HIV/AIDS in particular is expressed and through which health must be defined and understood. This realisation of cultural centrality to health has resulted from the need to question and examine critically the assumption inherent in Western-based conventional theories and models, which postulate that health behaviour is a-cultural. It is not that the study of culture is new; nor is its relationship to health behaviour recent. The scholarship of questioning the epistemological assumptions inherent in knowledge production is exemplified in the work of scholars like Frantz Fanon (1986), Valetin Y. Mudimbe (1988), Oyeronke Oyewumi (1997), and a number of others. These scholars provided the framework within which to recognise the limitations of Western models and the possibilities of hitherto marginalised African ways of knowing as the appropriate anchor for a cultural model for understanding Africa and its people. Culture as a central feature in understanding health behaviour by social and behavioural scientists is recent, both in the approach taken and the representations it provides.

A central feature in the study of culture is the role of tradition and it is in this respect that the role of HIV/AIDS has been most devastating. In the area of mental health, culture and language are demonstrated to be key in providing effective mental health services to South Africans and indeed other Africans who need such services (Swartz, 1998). This is particularly relevant in Africa, where HIV has either eroded or threatened many positive traditional responses to disease prevention in African cultures. Indeed, not only is the traditional mechanism for addressing health and illness eroded, but failure to adopt new practices and new behaviour is often seen as cultural retrogression. One example is the isolation (resulting from stigma) of the sick HIV-infected person in cultures where the sick are traditionally cared for by families and communities. This reality makes it even more critical that we understand the role of culture in defining, regulating and maintaining behaviour in the context of health in general and HIV in particular.

Results of several years of research and programme evaluation in African countries show that centralising culture and language in health behaviour interventions is crucial to health promotion and disease prevention.

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The primary objective of this paper is to offer a conceptual analysis for using a culturally based strategy for implementing and evaluating HIV/AIDS prevention, care and support in Africa. In order to meet this objective, we will apply the PEN-3 model, a model that addresses culture in the development, implementation and evaluation of health promotion programmes (Airhihenbuwa, 1989, 1993, 1995, 1999).

Limitations of the past

The reliance on intervention strategies developed for Western countries to 'solve' health problems in African countries owes its origin to institutions of higher learning that train students under the assumption of a universal approach to learning and behaviour. According to Mudimbe (1988), both Western and African scholars have been using categories and conceptual systems of learning which depend on Western cultural logic. While the pre-independence generation of African intellectuals (such as Nkrumah, Nyerere, and Senghor) focused on Africanising political power by transforming strategies for ideological succession, the new generation of scholars prefers to advance an African-based cultural strategy to address African issues and problems. One process to achieve this goal is what Mudimbe refers to as 'epistemological vigilance'. This process is used to challenge scholars to critically examine Western cultural logic that is being masqueraded as a universal truth, so that a more culturally appropriate strategy is advanced based on African ways of knowing.

In his classic book entitled *Black skin, white masks*, Frantz Fanon (1986) lamented the impoverished yet strangulating methods and contents of school curricula developed for colonial education in African countries. According to Fanon, the coloniser's educational goal was to turn the African into a 'white man' through the educational system. When in the end these Africans retained their cultural ways of knowing and resisted being Westernised in their thinking and behaviour, the colonisers abandoned them and told them that 'you have an indisputable dependency on the white man' (Fanon, 1986, p.216). This practice of promoting inadequate curriculum strategy for educating a population and subsequently blaming them for failure to achieve expected outcomes, holds true today. Only this time, the curriculum focuses on individual behaviour change when the reality is that behaviour, particularly health behaviour, occurs in the context of cultures and, furthermore, is either reinforced or

resisted through family, government and spiritual institutions.

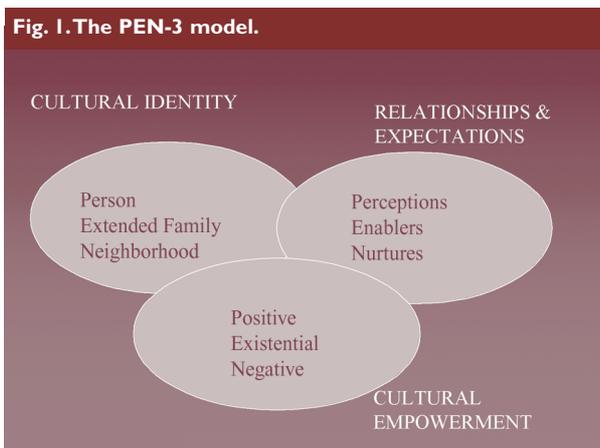
However, one primary area where Africans maintained their cultural logic, even though they were exposed to Western ways of knowing, is in the role of the collective rather than that of the individual in health behaviour (Gyekye, 1997). When it comes to health behaviour research, it has been shown that the individual-based public health intervention strategy has failed Africans. This was the primary conclusion of the 3-year project funded by the UNAIDS to examine existing strategies for HIV/AIDS prevention and recommend future direction (UNAIDS/Penn State, 1999). In this 100-page report, the limitation of the individual-based prevention model was addressed in detail. This framework, with culture as the domain that transcends all other domains, is now used by the Southern and Eastern African region of UNICEF as its model for HIV/AIDS communication activities. The framework has been adopted in Ethiopia in the development of the national response to HIV/AIDS (UNAIDS, April 2003). The PEN-3 model was identified in the framework as an organising frame for implementation and evaluation of the domain of culture. Subsequent reports echoing the importance of social culture contexts of behaviours, and the limitation and failures of the individual-based model of HIV/AIDS prevention, have been published by such international organisations as the Panos Institute in London (Dean, 2002). What is needed is a cultural model that addresses the health behaviour of African collectives rather than their individuality.

Possibilities for the future

PEN-3 is a cultural model that was developed by Airhihenbuwa in 1989, to guide a cultural approach to HIV/AIDS in Africa. It has been applied to child survival intervention in Nigeria (for case analysis, see Airhihenbuwa, 1993, 1995) and HIV/AIDS in Zimbabwe (Gwede & McDermott, 1992). More recently it has been used for planning and analysis of health intervention research related to cancer (Erwin, Spatz, Stotts, Hollenberg & Deloney, 1996; Paskett, Tatum, D'Agostino, Rushing, Velez, Michielutte, *et al.* 1999) and intervention research related to cardiovascular risks reduction (Walker, 2000). Finally, it has been used to guide an evaluation of cultural interpretations and meanings of the use of female condoms to reduce HIV/AIDS in South Africa (Webster, 2003). It has also been used to describe the

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planning, implementation and evaluation of health interventions (Green & Kreuter, 1999; Huff & Kline, 1999). The model is composed of three primary domains, each with three components. The three primary domains are: cultural identity, relationships and expectations, and cultural empowerment. Once a health issue has been identified, such as HIV/AIDS, a 3×3 table is created to assess and appraise the interaction between the domain of relationships and expectations, and the domain of cultural empowerment. These two domains will be discussed first, followed by a discussion of the third domain of cultural identity. The cultural identity domain is used to determine the point of intervention entry. Once the critical issues have been agreed upon through group consensus using the 3×3 table (see Table 1), a decision is made as to the nature and focus of and reason for the intervention, based on the cultural identity domain. Fig. 1 shows the PEN-3 model. A discussion of the three domains of the PEN-3 follows.



Relationships and expectations

Conventional individual-based models of behaviour change tend to focus on perceptions, resources, and the influence of family and friends in making health-related decisions. This domain of PEN-3 focuses on these same characteristics of behaviour, but from the point of view of how cultures define the roles of persons and their expectations in family and community relationships. In this way, personal actions are examined as functions of broader social cultural contexts.

The construction and interpretation of behaviour are usually based on the interaction between the perception we have about that behaviour, the resources and institutional forces that enable or

disenable actions, and the influence of family, kin and friends in nurturing the behaviour. The three categories of relationship and expectation are:

- **Perception** — knowledge, beliefs and values in decision making that are focused on either individuals or groups, or the complementarity of emotion and rational cues to behavioural actions. An example of this component is the knowledge/belief that HIV causes AIDS and the knowledge/belief that HIV/AIDS is a problem of Africans/blacks as may be represented on billboards.
- **Enablers** — resources and institutional support, socio-economic status, wealth (assets over liability) as a measure of resources and power, and costs and availability of services such as drugs for treating HIV. An example of this category could be the absence of antiretroviral (ARV) therapies and a culture of activism that have led social movements to force drug manufacturers to reduce the price of AIDS drugs.
- **Nurturers** — supportive and/or discouraging influences of families and friends including eating tradition, community and events, spirituality and soul, values of friends (e.g. alcohol consumption), and marriage rules and expectations. An example of this category could be a culture of caring for the sick at home on the one hand and on the other hand a patriarchal practice of subordinating a widow's autonomy to the authority of her in-laws as in wife inheritance.

Cultural empowerment

Culture and empowerment are two words that are almost never used as a coupled term because of the way in which culture is often represented as a barrier and empowerment as a strength. The domain of cultural empowerment is thus an affirmation of the possibilities of culture, which range from positive to negative.

Culture as an instrument of empowerment is born of the belief that culture represents the continuum of good, indifferent and bad. The goal of cultural empowerment is to ensure that an intervention is developed with the idea of *not* only the bad in mind, but to also to promote the good and recognise the unique or indifferent aspects of culture. As a result, this model insists that regardless of the point of intervention entry, the positive aspects of behaviour

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and culture must be identified as the first priority, otherwise the interventionist could become part of the problem (Airhihenbuwa, 1999). The cultural empowerment domain is thus composed of three categories:

- **Positive** — values and relationships that promote the health behaviour of interest. An example is the traditional healing modality, given that each culture has its strategies for dealing with health problems including sexually transmitted infections. There are also factors such as non-market values, to the extent that cultural values cannot all be subsumed into measurable parts that are quantifiable in monetary gain or loss. An example of this category is *ukhusoma* (a Zulu term for the cultural practice of non-penetrative sex).

- **Existential** — values and beliefs that are practised in the culture but pose no threat to health. Interventionists should not blame these values for failed interventions. An example is what Airhihenbuwa (1999) refers to as *language elasticity* in relation to the various codes and meanings of languages whereby language of flexible principles should not be judged by the rules of language of rigid principles. Even the same language, such as English that may be spoken in different parts of the world, has different meanings that are culturally coded. Another existential quality is represented in cultures of face-saving, particularly in Asia and Africa, in the sense of the importance of family judgment of action taken or not taken relative to a given behaviour. A final existential quality is orature or orality in terms of interventions that should ensure consistency between the intervention communication strategy and that used in the culture. For example, there are some common characteristics of many African cultures, such as the value of extended family. However, there are also different political experiences, such as that of apartheid in South Africa, that directly affect the present constitution of South African culture. For example, racism is an important factor to be considered in the internal politics and social arrangement in South Africa compared with other African countries.

- **Negative** — values and relationships examining the contexts of behaviour, including policy environment; income and wealth of individuals, communities and society, the position of women in society relative to decisions about sexuality, and the spiritual contexts of

the health behaviour in question. Examples of this category include social arrangements that lay a foundation for inequity such as racism, differential housing and education, a caste system that may privilege certain families over others in leadership, the militarisation of behaviour that has resulted from years of military dictatorships in a country like Nigeria.

Cultural identity

Identity as a cultural marker has always been a contentious point for scholars. Since demographic variables as identity markers are commonly used to measure how individual differences may explain and/or predict problem behaviour, identity is considered useful almost exclusively in measuring problems and deviance. This tendency to use identity to explain problems is the reason for the existing debate about the use of race and ethnicity as identity markers for US ethnic minorities. W.E.B. Dubois' (1969) celebrated prophesy that the problem of the 20th century would be the problem of the colour line has emblemised the tensions that result in this debate – determining whether race and ethnicity or culture is the more important marker. However, the only issue to be addressed is not between race and culture, but how embracing multiple identities (hybridity) is experienced by men and women in different cultures.

The notion of double consciousness advanced by Dubois (to explain the simultaneously lived experience of a black man living in both black and white worlds) is extended and deepened by Darlene Clarke-Hines (1993, p. 338) who counter-posed that 'instead of writing, "One ever feels his twoness", he (Dubois) would have mused about how one ever feels her "fiveness": Negro, American, woman, poor, Black woman'. Thus, multiple identities for many combined race and gender in producing a subject who either has voice or is voiceless. Multiple identities may very well be the reality of many people of African descent. An African South African (such as a Zulu) might out of necessity embrace the lived experiences of being a Zulu (ethnicity), English (language), Afrikaans (oppressed experience) and poor person. Thus, McKoy (2001) in the book entitled *When whites riot* argued that the discourse on race is a critical politics in South Africa, as it is in the United States. However, there are many African countries that experience a different kind of multiple consciousness, which may not include a factor of race in their national politics, at least not in their nation-state social arrangements, even

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though race continues to play an important role in their international politics.

However identity markers are signified, a central issue is how such identities influence decision making, as we have observed in the funding of ARV drugs by Western governments or the indifference shown by the United States and Europe over the control of malaria in African countries (Garrett, 2000). Specifically, how are health behaviours such as HIV/AIDS-related stigma produced through these multiple identities that are manifested in individuals in the contexts of families and communities? Whatever one's knowledge/beliefs about forms of identity, what is key is that cultural identity is an important intervention point of entry.

In the application of PEN-3, as will be discussed later, the interventionist first creates a 3×3 table. Having completed the categories in the table, it is necessary to identify the point of intervention entry with the understanding that there could be multiple entry points for addressing the social contexts and behaviours that have been identified for promotion and/or change. This process removes the assumption that all interventions should focus on the individual, thus leading to the development of billboards and other media messages that may not address the context of behaviour change. The three components of the domain of cultural identity are:

- **Person** — the degree to which the person may be dealing with the notion of double consciousness, the degree to which the cultural context and language of the culture focuses on seniority (as with the Edos and the Yoruba of Nigeria) rather than gender (as with the English and French), and qualitative reasoning which means the behaviour does not change as a result of quantitative reasoning, such as knowing the prevalence rate of HIV in one's community or knowing how to put on a condom. For example, for intervention point of entry, some programme interventions have focused on training wives about condom use when the problem is the husbands' refusal to use condoms. A husband's refusal however may be conditioned by what he perceives to be his role (positive or negative) and expectation as a 'good husband'.

- **Extended family** — intervention may need to focus on gender and generation depending on the focus of the intervention, consumption patterns

relative to the role of food in maintaining good health, and communication channels relative to the direction of communication, particularly in cases where an older person believes that they cannot discuss sex with a younger person. The former Health Minister of Zambia, Dr Luo, expressed this cultural value in an article in *The New York Times* (McNeil, 2002, p. A11) where she was quoted as saying that 'in my country, it's taboo for a person like me to discuss sex with someone younger'. In another example, a husband's mother might be the source of certain behaviours that need to be changed, given her influence on the relationship and expectation of the wife and her husband, particularly in sexual negotiation. Thus, certain interventions could focus on the mother-in-law in her role within the context of the family.

- **Neighbourhood** — this relates to a community's capacity to decide on billboard advertising and communication in their community, or the economic status and power structure of the community in dealing with HIV education from a culturally appropriate perspective. For example, in South Africa some billboards on HIV/AIDS prevention in white communities have black/African faces on them. This has raised concern among Africans, in what is considered to be an example of the racialisation and 'othering' of HIV/AIDS that has led to a false sense of security among whites. If indeed billboards influence behaviour change, then assessment of one's vulnerability could be formed based on the images to which one is exposed in the community.

The PEN-3 model can be used effectively to address HIV-related stigma, which continues to impede prevention and control efforts in African communities, as in other places. What follows is a description of HIV-related stigma and its impact. Stigma examples are used to show how the PEN-3 model might be used to guide interventions.

HIV-related stigma

Donor agencies and governments have, in recent years, come to recognise the prevailing need to address HIV/AIDS-related stigma in order to impact HIV prevention, treatment and care. For example, the 13th International AIDS Conference held in Durban, South Africa in 2000 had as its theme 'breaking the silence'. This was the first time since its inception that the conference was held in Africa, a long overdue attempt

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to highlight the devastating effect the disease has had on the continent. In his speech at the conference's opening ceremony, Peter Piot, Executive Director of UNAIDS, stated: 'HIV stigma comes from the powerful combination of shame and fear. HIV is transmitted through sex and so is surrounded by taboo and moral judgment... giving in to HIV/AIDS by blaming others for transmitting HIV creates the ideal conditions for the virus to spread: denying there is a problem, forcing those at risk or already infected underground, and losing any opportunity for effective public education or treatment and care' (Piot, 2001 paragraphs 4 & 5).

The 14th International AIDS Conference held in Barcelona, Spain in 2002 continued emphasising the importance of eliminating stigma in combatting the epidemic, with a series of stigma-related keynote addresses, panel discussions, workshops and lectures (XIVth International AIDS Conference, 2002). In addition to international conferences, donor organisations and international NGOs have conducted HIV/AIDS-related stigma and discrimination research and developed reports and other documents to assist governments and relevant organisations in addressing stigma in their populations. As part of its Best Practices Collection, UNAIDS (2000a) developed '*A conceptual framework and basis for action: HIV/AIDS stigma and discrimination*' as part of its focus for the World AIDS Campaign for the years 2002 - 2003.

Africa is not immune from HIV/AIDS stigma-related discriminatory practices and human rights abuses, particularly in the light of the overwhelming impact of the disease in the region. Discrimination and abuses take place in families, communities, schools, places of worship and employment, and in health care settings (UNAIDS, 2002b). Given the increasing devastation of the pandemic in the region, it is critical that solutions to control the epidemic be based on African realities — hence the focus on a culture-based solution.

Application of the PEN-3 model

The first step is to develop a 3×3 table to produce nine categories. This is done by crossing the components of the domain of cultural empowerment (i.e. positive, existential, negative) with the domain of relationships and expectations (i.e. perception, enabler, nurturer).

Table 1. CULTURAL EMPOWERMENT AND RELATIONSHIPS OR EXPECTATIONS

Domains	Positive	Existential	Negative
Perceptions	1	2	3
Enablers	4	5	6
Nurturers	7	8	9

The following are the nine categories and HIV-specific examples from African lessons learned:

1. Positive perception — refers to knowledge, attitudes and/or beliefs that positively influence decisions about HIV/AIDS prevention, care and support. A critical aspect of this category is contextual values that allow one to see HIV as the result of one's behaviour rather than one's identity. It has been argued (Airhihenbuwa, 1999) that identifying positive aspects of community perception should be a requirement for initiating any behavioural intervention that is anchored in culture. An interventionist who is not able to identify positive aspects of a culture relative to a given disease has no business being in such cultural contexts, because he or she would end up blaming the culture for their failure at the end of the programme. For example, it is indeed the cultural practice of taking care of loved ones at home that made it possible to capitalise on home-based care as an effective strategy for care and support of persons living with HIV and AIDS.

2. Existential perception — refers to knowledge, attitudes and/or beliefs that influence decisions about HIV/AIDS prevention, care and support in a manner that could be described as unique to that culture. Such perceptions are often not positive or negative but do reflect characteristics and qualities that help to explain certain values of the people. Family and/or community are stigmatised but may also be protected if an individual family/community member is HIV-infected. Adoption as a practice has often been used to describe the caring for a child by parent/s who are not the child's biological parents. When addressing the issue of adoption in African cultures, it is not unusual for some cultures to be referred to as not believing in adoption. However, the very notion of extended family means that adoption becomes a normal feature of such an arrangement, even though those parents in extended family caring for a non-biological child may not consider those children as adopted.

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3. Negative perception — refers to knowledge, attitudes and/or beliefs that negatively influence decisions about HIV/AIDS prevention, care and support. This represents quite often the only focus of behaviour intervention, to the exclusion of others. Myths and misconceptions about HIV infection lead to discrimination and human rights abuses. Changing these perceptions often depends on a clear understanding of the other category of perceptions described above. For example, addressing the belief that HIV is somebody else's problem often requires an understanding of what is considered (and why) a health problem within the cultural frame of reference and what types of health behaviours are considered to be positive. Mothers who claim that their child died of witchcraft, when AIDS is the actual cause of death, are considered ignorant of HIV knowledge and transmission. In a climate of stigma, it is quite plausible for a mother to defer to a culturally acceptable explanation for a child's death even when she is aware of the actual cause of death. This is not unlike an overweight woman in a study, whose explanation for her weight status was to state falsely that she was the mother of two children. When she later gave an explanation, it was that being overweight was culturally more acceptable for a woman who had had children than a woman like her who had never had a child.

4. Positive enablers — refers to availability, accessibility, acceptability and affordability of resources needed to support positive preventive health decisions and actions. National leaders' (presidents and heads of state) openness about discussing HIV can decrease stigma and guide effective policy (Diop, 2000). The role of government policy has been noted in the success of the consistently low incidence and prevalence of HIV/AIDS in Senegal, and the continuous decline of new cases of HIV in Uganda and more recently Zambia.

5. Existential enablers — refers to availability, accessibility, acceptability and affordability of resources that are traditionally available in the community or society for support of preventive health decisions and actions. It is now evident that traditional healers in Senegal have developed a treatment regimen for successfully treating HIV. A similar effort is currently in progress in South Africa, where an AIDS treatment drug developed by traditional healers is currently undergoing clinical trials at the Medical Research Council, with promising initial results.

6. Negative enablers — refers to the lack of available, accessible, acceptable and affordable resources needed to promote positive preventive health decisions and actions. Religious leaders' reluctance to discuss HIV openly can promote stigma or blaming HIV/AIDS on other groups. The refusal of governments to provide ARV treatment to persons living with HIV/AIDS clearly presents a disabling environment for effectively addressing HIV/AIDS. Clearly, one reason that has been cited for refusing to be tested for HIV has been the absence of ARV treatment. An enabling environment is critical to effectively reducing and eliminating stigma.

7. Positive nurturers — refers to influences of significant others and community contexts in making positive health decisions and choices. Persons openly living with AIDS are breaking the silence that fuels stereotypes about who has HIV and AIDS. While much emphasis has been placed on the prevention of sexual transmission of HIV, cultural practices such as *ukhusoma* have received little or no attention in the literature as a way of promoting cultural practices that encourage positive sexual relationships.

8. Existential nurturers — refers to influences of significant others and community contexts in making health decisions and choices within certain traditional values and practices. Burial societies, common during apartheid South Africa, have re-emerged in response to AIDS-related deaths. These societies come together in order to provide financial support for families who cannot afford to bury their loved ones who have died from AIDS. They also provide spiritual and emotional support to these families. Home-based care has become an important aspect of HIV/AIDS care and support that is anchored in cultural practices of supporting and caring for a sick relative at home. This kind of service continues to be provided by family members, often with little or no support from government and other local resources — not even support for the protection of caregivers in the families to prevent HIV transmission is available.

9. Negative nurturers — refers to influences of significant others and community contexts in negatively shaping health decisions and choices that contribute to the spread of HIV/AIDS, while rendering no support for persons living with HIV/AIDS. Stigma, as a negative nurturer, discourages testing for HIV, promotes a false sense of security by

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encouraging unsafe sexual behaviour, and forces infected persons underground, which leads to isolation from social support and available treatment that could have enabled the infected to live with the disease in dignity.

Having framed relevant sociocultural issues into these nine categories, a collective decision must be made to prioritise the point of intervention entry, given what research results show about the context of prevention that is likely to lead to a significant change in controlling the epidemic. In the examples cited above, a collective decision would be made based upon whether any changes would take place at the level of a person, the extended family, or the neighbourhood/community. In a conventional model, we often begin the intervention by discussing individuals.

In the PEN-3 model the identity component is the last component, because it is the nature and context of the issues that determine which of the identity categories have the most impact in reducing the spread of HIV/AIDS. For example, the explanation of witchcraft as the cause of HIV could not effectively be examined simply at the individual level. An examination of the belief would involve a qualitative evaluation of the cultural contexts of such a belief and the role that a disabling environment may play in the construction of HIV meanings at the individual level. In the final analysis, people's behaviour reflects their explanation of several factors in their environment.

Conclusion

Culture is central to HIV/AIDS prevention, care and support in Africa. Behavioural analysis and intervention points of entry into a community should focus on culture rather than on individual behaviours, as commonly done in HIV/AIDS interventions. PEN-3 is a model that addresses culture in the development, implementation and evaluation of health promotion programmes. It is presented to allow HIV/AIDS researchers and interventionists to conduct culturally based research and develop interventions to combat HIV/AIDS in Africa effectively. PEN-3 can be used to address AIDS-related stigma and accompanying discrimination and human rights abuses effectively. Rather than focusing almost exclusively on negative health behaviours, the model provides an opportunity for interventionists to address positive and existential behaviour so that negative practices, values

and behaviours are located within the broader context of culture. The cultural contexts as well as family and personal behaviours should be addressed simultaneously to ensure that targeted changes that result from planned interventions are sustainable beyond the life of the project.

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