Contribution of Indigenous Knowledge Systems on the Prevention of HIV and AIDS in Zimbabwe: A Case of Bindura District

Tapfuiwa J Katsinde & Sasha K. Musemesi
Department of Peace and Governance, Bindura University of Science Education

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ABSTRACT

This study examined the contribution of indigenous knowledge towards the prevention of HIV and AIDS in Zimbabwe in Bindura District. The study employed the socialisation theory, within the symbolic interactionist school of thought. The study is qualitative in nature, which used a case study research design. The target population is confined to those above the age of 20. The study sample was drawn out through the use of a combination of convenience and purposive sampling. The sample size consisted of 30 participants, and 8 key informants. Structured interviews were utilised as the primary tool for data collection, whilst thematic content analysis was employed to analyse the findings. Findings reveal that IK has made significant contributions in terms of behavioural regulation, thus deterring individuals from exposing themselves to HIV/AIDS risk factors. However, the study also revealed that indigenous knowledge on the prevention of HIV/AIDS is quite fragmented, thus recommends that existing knowledge be compiled into an independent and unified knowledge base from which scientific inferences can be made. The study recommends further research into the efficacy and utility of measures suggested by IK in the treatment of HIV/AIDS.

Keywords: Indigenous Knowledge, Human Immuno-Deficiency Virus (HIV), Acquired Immune Deficiency Syndrome. (AIDS), HIV/AIDS Prevention.

INTRODUCTION

Globally, Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) have dominated health care and socio-economic development for over nearly four decades. There has been growing interest to apply indigenous knowledge systems (IK) into HIV/AIDS programing. Tanzania IK Gateway (2011) defines IK as local or traditional knowledge that is unique to every culture or society, which sometimes influences local decision-making in different areas. In some communities, IK is regarded as a problem-solving mechanism to rural communities in case of conflict, building harmony within the family or community. IK is recognized as having relevance to the daily life routine of most individuals, economic development, health, culture preservation and political transformation, leading to (HIV/AIDS) reduction (UNAIDS 2016). Indigenous Knowledge is entrenched in the culture of communities. It has to be noted that IK is not biological inherited, but learned by observation and practical experience in community where one is socialised. This knowledge is transmitted from one generation to another either verbal or in writing (Kayombo, 1999).

Furthermore, like other forms of knowledge IK is dynamic. New knowledge from technological development and innovation within and outside the community is continuously being gathered, added and internalised in day to day's activities in a community. UNAIDS (2006) avers that IK evolves as communities go about their day to day activities. Furthermore, as communities adapt external knowledge, they indigenise it such that it is compatible with the local environment and their socio-cultural practices. The quality and quantity of knowledge that individuals possess varies with age, education, social and economic status, daily experience, outside influence, roles and responsibilities in the home and within the community,

profession and available time. In addition, UNAIDS (2006) points out that IK is influenced by curiosity, observation skills, the extent to which one travels, aptitude and intellectual capability as well as degree of autonomy and control over natural resources. In general, IK is implicit knowledge and thus, difficult to systemize. Although each member of different groups in a country draw from common culture, precision and defence of important traditional facts is often valued inheritance of some families. In some cases, it is restricted to specially gifted or ordained members of community such as traditional health practitioners (THPs).

HIV and AIDS is a pandemic documented worldwide as a pathology in public health. The most devastating effects of HIV and AIDS have been confined to developing countries where there are fewer resources for the treatment and management of the virus (UNAIDS 2009). The relationship between HIV and AIDS is that HIV is the virus that causes AIDS. This virus is passed from one person to another either through blood or sexual contact as well as through mother to child transmission. UNAIDS (2018) says that sexual contact accounts for as high as 90.67% of all new infections in Zimbabwe. Avert (2018) points out that mother to child transmission accounts for 6.39% of all new HIV cases. The remainder 2.95% is attributed to transmission via blood transfusions.

The effects of HIV and AIDS can be construed from different perspectives, from an anatomical perspective. HIV virus attacks the immune system which is the body's security force that fights off infections. When the immune system breaks down, the patient loses these protection immune systems and can develop many serious health problem, often deadly infections such as cancers, diarrhoea, fungal, herpes zoster, and many others which are referred as "opportunistic infections". Most of these people will develop AIDS as a resultof HIV infection progression in human body. People living with HIV and AIDS have a higher risk of falling ill, due to the fact that their immune systems would have been weakened.

Furthermore, the disease exerts influence on the socio-cultural practices. Within the African context, HIV is surrounded by a veracity of myths some of which are related to taboos on sexuality. One of such myths being that HIV and AIDS came about as punishment for homosexuality. The myths also relate to the available treatment options based on indigenous beliefs. Some of these myths have resulted in dire consequences, for instance quite a number of very young children were sexually abused following a mythhat intercourse with a young person would cure the AIDS. Within indigenous circles, HIV and AIDS is linked to promiscuity, thus those who are diagnosed with the disease are heavily stigmatised. HIV andAIDS is a stigmatised health issue in the whole world since it started thus creating insistent difficulties forthe health sector. The HIV and AIDS pandemic has had devastating direct and indirect effects. The direct effects include the loss of life, severely reduced functioning among those living with AIDS and this this has indirect effects such as widespread orphan-hood, depleted household functioning and poverty. What is of concern is that despite a noticeable decline in HIV prevalence in recent years, it seems developing countries are finding it difficult to consolidate the achievements so far.

The study looks into indigenous knowledge systems, which are relatively a new area of focus within health systems at large. The study draws its significance in that it explores indigenous knowledge in the context of community health security whilst HIV and AIDS programing is the object of focus. Furthermore, the research is intended to broaden both the audiences' and researcher's understanding of the nexus between indigenous knowledge systems and community health security. Moreover, the research will contribute to new body of knowledge and act as a yard stick to researchers who may wish to undertake research in the related field.

THEORETICAL FRAMEWORK

On a broader scale this study is based on the symbolic interactionist perspective initially propounded by the Chicago School then further developed by Blumer 1969; Berger and Luckmann 1967; Shibutani 1961 . Within the symbolic interactionist school of thought the study makes particular reference to the concept of cultural relativism. This concept entails that each culture has its tenets which can only be understood through a subjective point of view.

The concept of cultural relativism propounds the idea that no culture is superior to the other, and no culture should be judged against the tenets of another. Symbolic interactionism propounds the idea that as people interact with each other in social settings they develop their sharedmeaning for social phenomena. The meaning attached to social phenomena becomes shared within one community, thereby accounting for the fact that similar social phenomena may have different meanings across societies. The manner in which societies develop meaning of their social world may be understood as the process of knowledge creation. It is this process which leads to the creation of indigenous knowledge systems. The developed knowledge is then shared across the community through the process of acculturation and socialisation. With this in mind the symbolic interactionist perspective was adopted in the study to demonstrate how HIV/AIDS is locally understood in Bindura and the manner in which thisunderstanding has shaped interventions towards the prevention of the pandemic.

Indigenous knowledge in Zimbabwe

Indigenous Knowledge (IK) in Zimbabwe is grounded in culture. Shoko (2017) propounds that as societies became more organised in precolonial Zimbabwe, traditional healers began to surface, and were responsible for diagnosing and prescribing treatments for ailments affecting local people. Traditional healers did not only create information, but they also became the major gatekeepers of knowledge. Epidemiology within the pre-colonial Zimbabwe was solely understood basing on knowledge provided by traditional healers. Shoko (2017) states that traditional healers within the African context varied in accordance to practice methods and source of power. In existence were spirit mediums who claim to have divine inspiration and herbalists whose practice is based on knowledge of herbs and other traditional medicine used to cure ailments. The various traditional healers within the Zimbabwean context were mainly responsible for the development of an indigenous knowledge base across the country. Nevertheless, noteworthy is that societies in Zimbabwe are not homogenous, thus concepts of indigenous knowledge differ. The Zimbabwean government officially recognises Zimbabwe to be composed of 16 cultural groups all of which have both major and subtle differences. Bindura is largely composed of people who identify themselves as part of the Shona 'Zezuru' culture, which is the main cultural grouping within the country.

HIV/AIDS in Zimbabwe

In Zimbabwe, the first cases of HIV/AIDS were diagnosed in 1980s with the first case being diagnosed in 1985 (Avert, 2018). As a consequence, for almost four decades indigenous people have witnessed theimpacts of HIV/AIDS either within their own households or communities. Through close interaction with relatives or neighbours that are infected with HIV and AIDS, people have accrued a lot of IK about HIV and AIDS. Although such IK may not be scientifically verified, local communities still use it in their informal discussions of and behavioural interventions against HIV and AIDS. For example in Shona, HIV is called "shura matongo" which means a disease that is frightening. That label means that HIV/AIDS is deeply embedded into modern living conditions. AIDS was also called "the disease" or "the three-letter-illness",and the terms "HIV" and "AIDS" are rarely used. The country has shown considerable progress in the management of HIV/AIDS. The government of Zimbabwe has introduced various policies including the National HIV Policy 1999, National AIDS Council Act, which provides for the AIDS levy and the Zimbabwe National HIV and Aids Strategic Plan (ZNASP) 2011-2015. The Zimbabwean government has been working with both local and international NGOs in the managing the epidemic.

Indigenous knowledge and the management of HIV/AIDS

Several studies by Mutswanga, Tom and Tsvuura (2014) document indigenous understandings of HIV/AIDS amongst the general populace in Zimbabwe traditional healers included. Various categories of meaning of HIV/AIDS has been based on various perspectives including both bio-medical and cultural perspectives. The cultural understanding of HIV represents the indigenous knowledge framework surrounding the pathology. Initially from an indigenous perspective HIV and AIDS was associated with sorcery and punishment from divinity for engagement in sexual delinquency. It was noted that indigenous beliefs have a measurable association with attitudes to HIV and AIDS prevention. For example,

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since the transfer of semen is culturally considered to be important for optimal foetal development during pregnancy,it was difficult to change attitudes against unprotected sex between an HIV positive husband and a pregnant wife that was HIV negative.

Indigenous knowledge has been applied in the management of HIV and AIDS for varied reasons. Kayombo (1999) highlights that the shortage of drugs and treatment facilities which characterised the onset of the epidemic in most countries left people with no other choice but seek help from traditional systems. Following the onset of the epidemic most people resorted to traditional medicine as they did not understand the epidemiological structure of the disease. The symptoms of the disease were often misconstrued as an indication of bewitchment thus an indigenous response was seen as a necessity. Mutswanga, Tom and Tsvuura (2014) claim that indigenous knowledge has always been in use to regulate the manner in which people behave and interact with each other. As HIV began to be construed as a behavioural problem, IK began to be employed especially in counselling and behavioural change programmes. UNAIDS (2000) highlights that the use of indigenous knowledge demonstrated significantly positive results in boosting PLHIV's immune systems as well in the management of opportunistic infection. For example, Chudi,(2010) indicates that Tanga AIDS working Group has treated over 5000 AIDS patients with opportunistic infections using herbal medicine. Herbal remedies are argued to have shown results which include; increased appetite, weight gain, stopped diarrhoea, reduced fever, treated oral thrush, resolve skin rashes and fungus, cure herpes zoster and clear ulcers. Most patients reported seeing positive results within 7-30 days during the treatment. In addition, Tanga AIDS Working Group has become the referral centre for patients who came to hospital for testing, treatment or counselling (Chudi, 2010). This demonstrates a collaborative relationship between conventional medicine and traditional medicine in the management of HIV/AIDS.

LITERATURE REVIEW

The HIV/AIDS and Traditional Medicine Project (2002) of the Institute of Traditional Medicine (ITM), Muhimbili University of Health and Allied Sciences (MUHAS) on other hand reported 155 HIV/AIDS were being treated by THPs in Dar-es-Salaam and Arusha (UNAIDS, 2002). The findings from this study have shown over 70% of the clients had clinical symptoms like headache, dizziness, abdominal pain, vomiting, herper zoster, skin rushes and diarrhoea (ibid). All these were being managed by THPs. In the period of study, no serious side effects of the traditional remedies were reported. In collaboration with THPs, the ITM of MUHAS has come with five formulations from herbal remedies. These were cough mixture, *morisela* for various opportunistic infections, *Alovera* cream for skin infection, *tumbo* mixture for stomach ulcers, *ini* remedy for liver infection.

Again Kayombo et al. (2012) in East African Network of Traditional Medicine and Medicinal Plants project (2004-2008) have shown that health workers in rural areas reported most of the HIV and AIDS patients went to THPs because there were no drugs to alleviate the suffering of different ailments in their respective health facilities. Also Kayombo (1999) in his study in Njombe District documented several herbal plant that were used to treat AIDS and AIDS related patients. These patients got relief from the pains and symptoms were eliminated.

Statement of the problem

Zimbabwe has managed to lower the HIV prevalence rate in the past few years. Bateman (2011) states that the HIV prevalence rate within the country dropped from 30% in 1998 to less than 15% in 2011. The ratehas further fallen to 13.1% in 2017 (AVERT, 2017). This shift parallels global efforts to reduce incidence of HIV especially among the most vulnerable populations, which in Zimbabwe includes adolescents. Local strategies to reduce the impact of HIV have included scaling up access to treatment facilities and HIV prevention programmes. The emphasis has been on behavioural change, thus methods such as promoting abstinence, condom use and the reduction of sexual partners have been encouraged. Consequently, these methods had implication on indigenous knowledge systems within the Zimbabwean landscape. In thisregard indigenous knowledge has also been employed in the management of HIV and AIDS. Indigenous knowledge's efforts are notable and have made important contributions to reducing infections. But the

problem still exist as HIV and AIDS continue to affect citizens in Zimbabwe as indicated by the rate which is still over 10%. Therefore, the study examines the nexus between indigenous knowledge systems and HIV and AIDS prevention with special focus on the management of HIV and AIDS within Bindura district.

Aim

The aim of the study was to analyse the contribution of Indigenous Knowledge in the prevention ofHIV/AIDS within Bindura.

Objectives

1. **a)** To explore the general indigenous knowledge on HIV prevention, treatment, care and support in Bindura District.
2. **b)** To examine the positive and negative aspects of the contribution indigenous knowledge to HIV prevention, treatment, care and support in Bindura District.
3. **c)** To explore the challenges encountered by indigenous knowledge systems in the prevention of HIV and AIDS in Bindura.

Research Questions

1. Which indigenous knowledge frameworks have been employed in HIV and AIDS prevention, treatment, care and support within Bindura District?
2. How does indigenous knowledge contribute positively to HIV and AIDS prevention, treatment, care and support within Bindura District?
3. What challenges are experienced by indigenous knowledge systems in HIV and AIDS prevention, treatment, care and support?

RESEARCH METHODS

The study was explorative in nature, guided by tenets of qualitative research and basics of quantitative research. The research employed case study research design. Case study was employed so as to satisfy the explorative nature of the study. Through this design the researcher probed into subjective perceptions ofthose engaged as participants. The case study design allowed the researcher to understand the contribution made by IK towards the prevention of HIV and AIDS. Using case study design the researcher was able to probe into the challenges and opportunities within the interplay between IK and HIV and AIDS prevention.

The study was conducted in Bindura district which according to ZIMSTAT (2012) had an urban population of 125 219. The study was confined to Bindura urban, which had a population of 43 675. The target population was streamlined to engage those above the age of 20 on the basis that they are the ones mostlikely to possess information on indigenous knowledge employed in preventing HIV/AIDS. The target population stood at about 24 489.

In conducting the current study, the sample consisted of those between 20-60 years of age, who were assumed to possess knowledge on indigenous knowledge. The sample also consisted of key stakeholders involved in either HIV/AIDS programming or those considered as the gatekeepers of culture.

In selecting study participants, the researcher utilised purposive sampling and convenience sampling. Purposive sampling was utilised to select key informants amongst stakeholders knowledgeable on the application of indigenous knowledge towards the prevention of HIV and AIDS in Bindura Urban. The method involved deliberate selection of participants on the basis of the prospective value they add to the research. Under this method, sampling is left at the researcher's discretion who decided on the qualities ofthe individuals. In relation to the study at hand, key participants were selected on a criterion including their

work in HIV/AIDS, experience working in HIV/AIDS programing as well as age which consequently came with knowledge on indigenous knowledge systems.

Convenience sampling was used in selecting the main participants engaged in the study who answered the questionnaire. Given that the urban area was large and presented a problem of where to get the participants, it was decided that health centres would be ideal place to get participants. After getting permission from relevant authorities, participants were selected from those who visited the three health centres. At each health centre the researchers spent two days to get 10 participants who were willing to take part in the study. After three days 30 community members between the ages of 20-60 were selected who filled the questionnaire.

Data was gathered using interviews and questionnaires. The interview guide had questions to guide but this was complemented by follow-up questions to clarify issues raised by respondents. This was important in this research as the knowledge about HIV and AIDS in relation to indigenous knowledge is scarce. The data was either written down as notes or recorded for those who agreed to be taped.

A self-administered questionnaire was used to collect data about indigenous knowledge and HIV and AIDS. The questionnaire consisted of both closed and opened-ended questions. Closed questions were important in order to get common views about how indigenous knowledge helped in the fight against HIV and AIDS. Open-ended questions assisted in getting detailed individual perceptions on the problem of HIV and AIDS and how it related to indigenous knowledge.

Thematic data analysis was employed in analysing data gathered. Gathered data was translated from Shona to English such that coding may be done in English. Data was analysed mainly through an inductive process, seeking to capture the key themes emanating from the data collected. This is in line with Gentles et al (2015) who avert that qualitative research aims to obtain useful inferences towards the understanding of complexities surrounding the subject of research. The thrust of data presentation was to arrange data in a manner that satisfied the research objectives at the same time answering research questions. Data from various respondents was grouped according to theme and synthesized to come up with critical analysis ofthe findings. Data from interviews was presented as quotations. Furthermore, descriptive statistics were presented on tables.

RESULTS AND DISCUSSION

Background of respondents

Out of a total of 30 respondents 23 (77%) were female whilst 7 (23%) were male. In terms of ageparticipants were evenly distributed with 10(32%) in the age group of 31 – 40 years, 7(23%) in 21-30, 7(23%) in 41-50 age group, and 6 (18%) were 50 years and above age group. Eleven 11(38%) participants were married, whilst the least number of participants 5(18%) were widowed. The other respondents 6(21%) were divorced, 7(23%) were single. The majority of participants 16 (53%) had attained tertiary education, 11(37%) had attained secondary education, whilst the least 3 (10%) participants had only completed primary education.

Indigenous Knowledge and its contributions to the prevention of HIV/AIDS

Respondents were asked on their knowledge on the contribution made by indigenous knowledge to the prevention of HIV/AIDS in Bindura district. Table 1 below indicates the various aspects of indigenous and the frequencies as perceived by respondents.

Table 1: Indigenous knowledge and HIV and AIDS prevention (No. 30)

Indigenous knowledge on HIV/AIDS	Frequency	Percentage (%)
Fidelity and respect for husband	4	14%
Abstinence	3	11%
Punishment for adulterous behaviour	6	21%
Value for virginity	10	33%
Traditional nutritious food(herbs and fruits)	3	7%
Traditional Medicine	4	14%
Total	30	100%

Value for Virginity

The value for virginity was identified by 9(30%) as important general indigenous knowledge system that helps in the prevention of HIV/AIDS. This was supported by other respondents during interviews. One ofthe respondents explained that:

"Our elders taught us that preserving your virginity exempts you from contacting diseases and viruses such as HIV/AIDS, once you preserve your virginity you are safe from disease and viruses. If you preserve your virginity it is impossible for you to contract or spread HIV/AIDs because the virus is spread through sexual intercourse so if a girl stays a virgin, they are automatically safer from contracting the virus". **(Participant 7, 35 years old)**

Respondents argued that within the Shona culture, virginity is a symbol of self-preservation which attracts both personal and familial pride as those who maintain their virginity until marriage would bring honour to themselves as well as their families. This is echoed by one of the key participants who also argued that:

The girl-child was supposed to safeguard her chastity until marriage as this would earn her honour and respect among her people and the family she is married to. Any woman who lost her virginity before marriage was not respected and could not command the same from her husband. **(Key informant 2, 51 years old).**

The quotes reveal that virginity in an important cultural trait which assists in the prevention of HIV and AIDS. This concurs with George (2008) who claims that maintaining one's virginity is quite important in African cultures, and consequently virginity testing is a prenuptial custom. Through this custom, women are tested for their virginity through methods which differ from culture to culture. Out of fear of bringingshame to their respective families, young women often maintain their virginity until marriage. The narratives placing value on virginity promote abstinence or in some cases delay young women's sexualdebut, all of which are instrumental in reducing young people's exposure to HIV/AIDS risk factors. Given that UNAIDS (2018) highlights that sexual contact accounts for as high as 90.67% of all new infections in Zimbabwe, indigenous knowledge which delays sexual debut and promote abstinence can be regarded as making a very significant contribution to the prevention of HIV/AIDS. In Bindura district it can be notedthat there is a drive among most cultures and religious sects to revive the practice, despite virginity testing having been abolished by the law.

Punishment for adulterous behaviour

Six (21%) respondents identified punishment for adulterous behaviour as one of the contributions of IK to the prevention of HIV/AIDS (**Table 1**). This was also noted by respondents in interviews. One of the participants said,

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HIV/AIDS is usually transmitted by promiscuous people and they bring the virus to their partner. Punishment for adulterous behaviour makes men and women refrain from being promiscuous and it may reduce the transition of HIV/AIDS to your partner. ***(Participant 19, 24 years old)***

Participants highlighted that within IK narratives HIV/AIDS was the ultimate divine punishment for engaging in premarital sex and adulterous acts. Participants raised the argument that HIV prevalence was higher among those who were engaged in premarital and extra marital sexual activities. The traditionalbelief therefore is that if one wished to remain HIV/AIDs free, one must not engage in premarital sex andone must remain faithful to their sexual partner, and not be involved in adulterous affairs. This narrative is consistent with the messages on HIV prevention conveyed by both local and international stakeholders engaged in the fight against HIV (UNAIDS, 2018; Avert, 2018). Being faithful to one's sexual partner is promoted as the best way to prevent HIV/AIDS amongst married people. Narratives on the punishment for adulterous behaviour served as a deterrent, preventing individuals from engaging into activities which may pre-dispose them to the HIV virus.

Furthermore, besides considering HIV/AIDS as divine punishment for extra marital sexual contact, participants also highlighted that there were indigenous institutions which would enforce punishment in accordance with indigenous norms. Traditional chiefs and village headmen were seen as the responsible authorities to punish those alleged of having committed adultery committing adultery. One of the key participants pointed:

Traditionally, once a woman reported to the chief's court about a missing husband, he was reprimanded when found. In the Shona culture, once a married person was caught engaging in sexual activities outside marriage they were charged with consequent penalty at hand. A man found having sexual intercourse with another man's wife or just touching her breasts, paid a cow to the husband ***(Key informant 2, 51 years old).***

Respondent 20 added:

Long ago we used to get our hands cut off or the cheating man would be asked to pay a cow to the married woman's husband she has been cheating with ***(Participant 20, 63 years old).***

The citations indicate that traditionally people involved in extra-marital affairs were punished. These findings are in line with Mazire (2012) and Majome (2017) who highlight that adulterous acts were frowned upon on the basis of culture and thus attracted shameful punishment. Mazire (2012) indicates that cultural punishment for adultery had also inspired adultery law in the country, where one can take legal actionagainst the cheating spouse and his "*mistress*" or "*boyfriend*". Those engaged in premarital sexual activities can also claim damages from the other party, however this is mostly applicable to the woman's family, who can sue men for damages. The underlying argument is that the punishment attached to premarital sexual activity as well as extra marital sexual activities, deters individuals from engaging in adulterous acts which reduces the extent to which they are exposed to HIV/AIDS risk factors. The results seem to suggest that IK relating to punishment for adultery contributes to HIV/AIDS prevention.

Traditional Medicine

Four (14%) respondents, all over 50 years of age, identified traditional medicine (*Runyoka effect*) as one of the contributions of IK to the prevention of HIV and AIDS. (Table 1). Chavhunduka in Mazire (2012: 1) defines '**runyoka**' as a "traditional charm believed to cause profound suffering to a cheating spouse". In an interview one of the key informants said,

Our elders told us that if you remain faithful to one sexual partner (your wife or husband) you will not contact HIV/AIDS virus. Runyoka is punishment for adulterous behaviour which makes men and women refrain from being promiscuous and it may reduce the transition of HIV/AIDS to your partner ***(Keyinformant 3).***

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This came with the realisation that most of the respondents in Bindura believe that if a man has sexual intercourse with a married woman that man will be affected by a disease called *runyoka*. The English translation evades many, however the basic assumption is that the condition consists of endless diseases within one's reproductive health system. According to Chisanyu cited by Chimuka (2019) runyoka is a myth grounded in tradition communicated orally from generation to generation through indigenous knowledge systems, however lacking scientific backing. The myth is used to teach people the consequences of cheating and importance of remaining faithful to each other. One key informant explained:

Once you have sexual intercourse with someone's wife you will die or suffer a life time illness that cannot be treated known as 'runyoka' in our own language. We believed in 'runyoka' because it prevented men and women from cheating and the fear prevented the spread of the disease and viruses ***(Key informant 4, 51 years' old).***

The concept of punishment for sexual deviance is believed to have been an addition to the indigenous knowledge. Chimuka (2019) cites a traditional healer, who states that r*unyoka* is an invention of traditional health practitioners to preserve marriages. This is a spell used by a man to catch those who commit adultery with his wife. Men are always busy and sometimes they go out of the country for different types of duties. As a result, sometimes they do not have peace of mind if they don't "lock up" their wives if they suspect them of committing adultery. Furthermore, it was revealed that spouses "lock" each other as a way of safeguarding themselves from contracting HIV/AIDS. With this in mind, one may argue that r*unyoka* reduces the risk for individuals to contract HIV by virtue that it deters promiscuity, which is considered as one of the key drivers in the spread of HIV/AIDS. Recognising the fact that IK reduces individual exposure to risk factors one may argue that the contribution made by IK to HIV/AIDS prevention is significant to a greater extent.

However, in as much as the use of runyoka is successful in the prevention of HIV/AIDS it is a problem in that the affected may end up dying or falling very ill. A respondent was quoted saying:

Sometimes people whom the runyoka effect have affected end up dying especially if the husband or wife who locked the partner comes late to their rescue ***(Respondent, 23, 49 years old).***

Thus, this traditional belief upholds faithfulness in married couples since they will stick to one partner in fear of contacting a lifetime illness or dying and this reduces or prevents the spread of HIV/AIDS. However, the use of *runyoka* is deadly as it may result in death and serious illness to the affected partner.

Fidelity and Respect for Husband

Four (14%) respondents believed that fidelity and respect for husband was an aspect of indigenous knowledge which significantly contributes to the prevention of HIV/AIDS in Bindura district (Table 1). Fidelity in this instance refers to being faithful to one's sexual partner, however among female respondents the notion of fidelity also entailed respect for one's husband. One of the key informant asserted that:

If we all remain faithful to one partner, chances of contacting the virus are very low. If a person has sexual intercourse with several partners he/she automatically put oneself and partner at risk of contracting and spreading the virus to you **(Key informant 1, 29 years old)**.

Another participant also added:

It is a very simple equation, remain faithful to one partner and you will not in any way contract diseases and viruses (***Participant 11, 43 years old).***

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Indigenous knowledge on faithfulness and respect for husband reduces exposure to the risk factors of contracting HIV/AIDS. This also concurs with many other authors (NAC 2015; UNAIDS, 2018; Majome, 2018) who maintain that upholding faithfulness to one sexual partner goes a long way in preventing the one from contracting the HIV virus given that they were both tested and found to be negative. In traditional knowledge fidelity in a marriage is hinged on the principle of respect, thus infidelity is construed as a sign of disrespect. Thus in order to show respect for their spouse individuals are inclined to maintain fidelity within a marriage. In this regard fidelity can be perceived as a positive contribution of IK to the preventionof HIV/AIDS as it reduces exposure to HIV/AIDS risk factors.

However, the contribution of IK toward the prevention of HIV/AIDS on the grounds of upholding fidelity is now weak. This is because according to the interviews conducted nowadays infidelity within marriages is quite rampant. One of the participants explained:

*In as much as women may respect their husbands and refrain from sexual encounters with other men it must be noted that men on the other hand rarely respect their wives and there is an increase in cases of extra marital affairs which increase the chances of contracting the virus and passing it on to their wives. Husbands are giving us all sorts of diseases because of their promiscuity(***Participant 7, 40 years old**).

The findings seem to suggest that fidelity plays an important role in preventing the spread of HIV and AIDS but now has challenges as infidelity appears to be common. These findings are in line with Mavaza (2017) studies which show that both men and women cheat but infidelity is more rampant among men. Mazire (2012) states that high levels of infidelity within marriages have been attributed to the uneven distribution of wealth between men and women. As a result, women from poor families would engage in extramarital affairs in order to earn extra income, whilst the more money a man acquires the more they engage in promiscuous activities. In this regard, the persistence of rampant infidelity dents the contribution of fidelity as IK to the prevention of HIV and AIDS.

Traditional food, herbs and fruits

Knowledge on traditional foods and medicine was also identified as part of the contributions made by IK to the prevention of HIV/AIDS. This line of thought was conveyed by 2 (7%) participants who averred that traditional nutritious food (herbs and fruits) helped in the prevention of HIV/AIDS (Table 1). One of the participants remembered:

*Growing up we were just told that eating foods such as muboora, tsenza, manhanga boosted your immune system and prevented you from getting infections. (***Participant 7, 35 years old)**

Findings from interviews further revealed that traditional nutritious food (herbs and fruits) helped in the fight against HIV/AIDS by slowing down the development of HIV into AIDS as well as helping the immune system in fighting against opportunistic diseases. These results are in line with Chudi (2010) who found out that Tanga AIDS working Group had treated over 5000 AIDS patients with opportunistic infections using herbal medicine. Tanga AIDS Working Group, further showed that herbal remedies had increased appetite, gained weight, stopped diarrhoea, reduced fever, treated oral thrush, resolve skin rashes and fungus, cure herpes zoster and clear ulcers. A study conducted at Mefopla centre in Bamenda Cameroon showed that the immune system of AIDS was boosted by indigenous plants with enzyme rich in food which included oils from plants like soya, cashew and shear butter saturated fats, wild fruits, vegetation with high fibre content, which the patients were encouraged to consume. These were helpful in cleansing alimentary canal system. Therefore, it can be concluded that knowledge on the nutritional significance of some traditional foods is being employed to slow the progression of HIV into AIDS, rather than preventing the contraction of HIV.

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The challenges of IK in the prevention of HIV/AIDS

Participants were asked on their perceptions on the challenges encountered in the application of indigenous knowledge in HIV prevention, treatment, support and care. Twelve (40%) participants believed that openness in sex education was a challenge, whilst 10(33%) indicated that cultural dilution was a keychallenge. Only 5(17%) highlighted the persistence of unfaithfulness as a prominent challenge, with 3(10%) subscribing to the fact that modern ways of dressing were a significant challenge. (Figure 1)

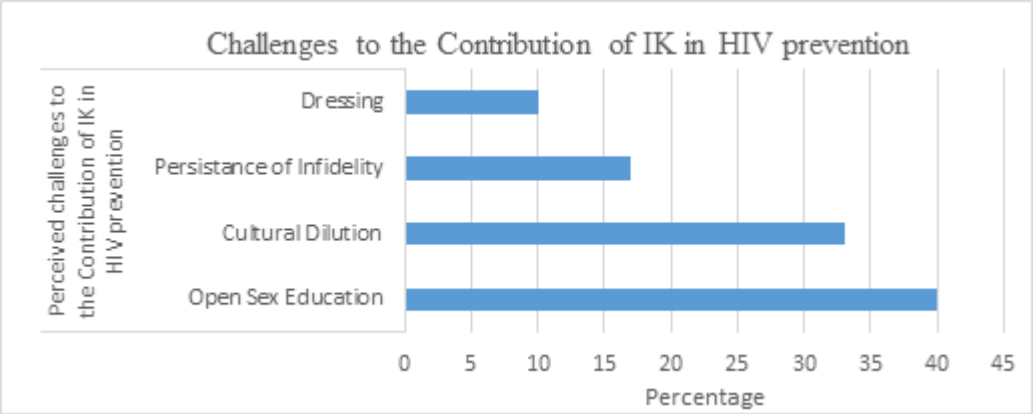

Figure 1: Challenges in the prevention of HIV and AIDS using IK (No.30)

Open sex education

Participants highlighted that the modern primary and secondary school curriculum provided actual information on sex and child bearing which was not taught long ago and this had eroded the teachings of IK to the youth. One of the respondents explained that:

We can no longer tell the youths that sex is sacred. They are taught everything to do with sex in primary schools. You even hear a very young child talking about sex. **(Key informant 2, 51 years old)**

Another respondent added:

In school youths are being taught openly about sex. The teaching of sex and reproduction issues in life skills and Biology at primary and secondary school levels exposes the youth to all facts about sex and pregnancies at a very young age. **(Respondent 16, 35 years old).**

The citations show that sex education in schools is being taught. These results are similar to what was found by Bridges and Hauser (2014) that the youth are being taught Science subjects with sexual education content from primary schools. Previously such science subjects was only taught from secondary school level. According to Bridges and Hauser (2014) primary schools should have a sex and relationship education programme tailored to the age and the physical and emotional maturity of the children. Therefore, it can be concluded the teaching of sex education in primary and secondary school although beneficial in the prevention of HIV/AIDS it is dangerous in that it has corroded our own history and Traditional Indigenous Knowledge Systems through which information was traditionally conveyed. Open sex education in schoolsis therefore the main challenge which affects IK's effectiveness in its fight against HIV/AIDS.

Cultural Erosion

Ten (36%) participants engaged in the study indicated that their cultural values were eroded (Figure 1). Taylor et al (2017) define cultural erosion as a process whereby a culture loses its central tenets, and individuals within that culture no longer conform to the cultural norms. One of the participants was worried that:

The youth of today are always on their phones sharing and receiving as well as exchanging cultures through the use of social media. They always want to be connected. They are always watching the popular DSTV, which has eroded our cultures. Surely, modernization has made us to lose our own cultures and trends as we are now in competition with what we see on national television. If I do not pay DSTV my children will not talk to me. They say their Zimbabwe television that teaches them morals bores them, l surely do not know how to stop this. **(Respondent 7, 40 years old)**

This was mirrored by another participant who explained that:

Our children now want to experience what they see on the internet and on television. They have even changed the way they talk and dress to suit that of other cultures. They have forgotten our culture we canno longer sit them down and explain to them how dangerous these boys they enjoy playing with especially interms of HIV/AIDS **(Respondent 17, 56 years old).**

Findings indicate that modernization weakens indigenous knowledge systems. This is similar to the assertion by Taylor et al (2017) which state that the concept of cultural erosion is grounded in the conceptsof cultural imperialism through the processes of westernization and modernization. In addition Allen(2006:316) believes that "the arrival of modernity extinguished all pre-modern societies" Participants indicated that following western had resulted in people being more individualistic and young people filled with curiosity have been experimenting what they see on the television and on social media. This dented the messages preached by IK, relating to sex being sacred, and the maintenance of family relations being paramount, thereby presenting a challenge to the utility of IK in HIV/AIDS prevention.

Use of modern medicine

The study revealed that modern medicine took precedence over traditional knowledge and thus ruins the contributions of IK to HIV prevention. Participants demonstrated lack knowledge on the ways which IK can contribute to HIV prevention. One of the participants said that:

I do not know of any African herbs that cure diseases I have only heard from my grandparents that long ago they had plants that they used to use but l am not aware of these **(Respondent 13, 21 years old).**

Those in the age group 21-30 said that they did not have deeper understanding of IK. This indicates a gap between the older generation and the younger generation when it comes to their knowledge of IK. This can be attributed to one of two factors, either incomplete socialisation as suggested by Taylor et al (2017). The study is inclined towards the fact that modern medicine has largely taken precedence over traditional health promotion methods. This is so because traditional medicine is usually mystified and construed as unsafe, thus individuals simply rely on western medicine. This therefore, compromises the extent to which indigenous knowledge contributes to HIV/AIDS prevention.

Persistence of infidelity

The results also show that the persistence of infidelity 5(17%) was also a challenge to Indigenous Knowledge in Bindura District. During an interview woman (8) said:

Nowadays it is no longer shocking to find out that your husband is cheating on you. What we were taught growing up about being faithful to one sexual partner is no longer applicable. However, it is during cheating that our partners come into contact with HIV/AIDS.

Another woman (7) added,

The main cause of the spreading of diseases nowadays is infidelity within marriages, it is as if it has become normal.

Unfaithfulness is defined as a sexual and or emotional act by a person who is in a relationship of commitment, with this act occurring outside the primary relationship and constituting a breach of trust andor violation of the rules agreed by the couple, by one or both individuals in an emotionally and or sexually exclusive relationship (Moller & Vossler, 2015). Infidelity is therefore a challenge to Indigenous knowledge that strongly advocated for faithfulness and punishment for extra marital affairs. Infidelity is a major causeof the spread of viruses such as HIV/AIDS nowadays in Bindura District.

Modern fashion trends/ dressing

Some of participants 3(10%) highlighted that modern fashion was one of the factors hindering the contributions of IK towards the prevention of HIV. For example dressing was also identified as a challengeto indigenous knowledge. The way that some women dress around men can tempt them to cheat on their wives and bring HIV/AIDS in the home. A participant (9) said:

Dressing, wearing miniskirts, tight trousers, leggings, high cuts that show curves of a woman's body is tempting for men. Wearing revealing garments that reveal a lot of a woman make men fail to be faithful to their wives or partners as they are tempted. Men end up pursuing such women which exposes them to HIV and AIDS.

These results seem to indicate the way women dress has been a challenge to the contribution of IK in the fight against HIV and AIDS. Men seem to be attracted to women with attractive dress. Wearing revealing clothes in schools, colleges, markets even churches arouses sexual desires among men. The modern dressing has also reported to be responsible for the increase in rape cases and sexual assault among women.

CONCLUSION

The results of the study suggests that IK in the district plays an important role in the prevention of HIV and AIDS. Study participants were able to identify narratives within indigenous knowledge frameworks and effectively link them to HIV prevention.

The study concludes that the contribution of IK is based in its role in behavioural change and modification rather than suppressing HIV viral load or treating the disease. IK in Bindura has narratives which provide for the shameful punishment and of those who engage in extra marital affairs, early sexual debuts and even sets standards on the ways to dress. In addition, traditional medicine such as "*Runyoka"* deter individuals from engaging into extra marital affairs. Therefore, IK leads to a reduction in engaging in risky activities which may expose them to HIV and AIDS. Thus to a certain extent IK has an important role in promoting good health and well-being as envisaged by SDG 3.

Moreover, the research also revealed the challenges faced in employing IK to the prevention of HIV/AIDS. The major challenges lie in the fact that cultural dilution induced by globalisation has diminished the value put on indigenous knowledge systems. This is due to the fact that individuals have become more reliant of information provided via various media sources and some even shun indigenous knowledge, relegating it to witchcraft and dark magic. In addition, the research also revealed that IK has been used as the basis upon which harmful acts have been practiced on the pretext that they are part of culture or they are natural remedies for the cure of HIV/AIDS. Such harmful activities include, sexual abuse subjected to infants and virgins based on the misconception that intercourse with virgins would cure the virus. This has compromised the extent to which IK can be considered as valuable in HIV/AIDS prevention. Thus the contribution of IK to SDG No 3, good health and well-being, is compromised.

Indigenous knowledge in Bindura district has remained largely unreliable, besides narratives shared from one person to another, there is no other source from which one may gather indigenous knowledge. The lack of a formalised source of information has led to myths being peddled and given that most of these myths portray indigenous activities in a negative light, indigenous knowledge has attracted a lot of stigma. Furthermore, although the sample as a collective demonstrated high knowledge of IK narratives instrumental in the prevention of HIV/AIDS, the study concludes that such knowledge is fragmented. There are a lot of inconsistencies and contradictions in what participants consider to be real or fiction as well as what they consider to be useful and not useful. This is an indication that there is lack of adequate socialisation about indigenous knowledge contribution to the problem of HIV and AIDS.

There is need to document indigenous knowledge such that information is preserved and a degree of consistency regarding indigenous knowledge narratives is established. There is need to strengthen thepositive aspects of the contribution of indigenous knowledge to HIV/AIDS prevention and at the same time the weaknesses should be addressed in a systematic manner, including the enactment of statutory instruments to abolish the perpetuation of negative forms of knowledge. There is need to address thechallenges faced in employing indigenous knowledge in HIV/AIDS prevention, this maybe in the form of awareness raising initiatives to prevent the misrepresentation and misinterpretation of indigenous narratives.

Further research should focus on the impact of indigenous knowledge on HIV/AIDS prevention, care and support.

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