THE ROLE OF PRISON GANGS AS PRECIPITATING AGENT IN THE SPREAD OF HIV/AIDS IN SOUTH AFRICAN PRISONS WITH SPECIAL EMPHASIS ON SOCIO-CULTURAL FACTORS

Michelle Minnie
Department of Psychology

Annette Prins
Department of Student Affairs

Eugene van Niekerk
Department of Psychology
Vista University
Bloemfontein Campus

INTRODUCTION

Africa is under siege. Of those infected with HIV seventy-one percent reside in Africa (Van Dyk 2001). The estimated world-wide figure is quoted as 42.666747 million (Daily Mail & Guardian 2001) bringing the total estimate of Africans infected to a stunning 30.3 million. Ninety-five percent (12.1 million) of Aids orphans are from Africa. Sub-Saharan Africa - the region growing the fastest in terms of the epidemic - accounts for 68% (3.8 million) of all those newly infected in 1999 (Van Dyk 2001).

Aids may well be the greatest challenge facing South Africa today. Experts estimate that South Africa probably boasts the highest incidence of Aids infection in the world. The tragedy is that the progress of the disease was both unnecessary and disastrous in respect to human lives. South Africans were aware of the danger posed by Aids as early as 1985. In 1991, the national survey of women attending antenatal clinics reflects that only 0,8% were infected. In 1994, when the present government came to power, the figure was still relatively low at 7,6%. Present estimates put the figure at a staggering 22.4% (Whiteside & Sunter 2000). The percentage of pregnant women infected with HIV in KwaZulu-Natal, increased from 9.6% in 1993 to 32.5% in 1999 (UNAIDS Report June 2000).

As for the prison population - the focus of this paper - the situation is even more alarming. Pagliaro and Pagliaro (1992), for example, identify this population as the group most at risk of contracting Aids world-wide. The same author concludes that in 1992 Aids was already the leading cause of death amongst prisoners. This reinforces Tempelhoff’s (1996) argument that high-risk sexual behaviour - part of the prison subculture and a reality in South African prisons - results in prisoners carrying at very high risk of contracting this disease. Even more alarming is the fact that both social scientists and local authorities seem to have neglected or underplayed this topic.

In South Africa the first prisoner with HIV/AIDS was diagnosed in 1987 and he died soon afterwards. Since then the HIV/AIDS figure in prisons has risen dramatically (Coetzee, Kruger & Loubser 1995). In 1991, the official Aids death figure stood at 91. In 1998 it had risen to 2.486, and the figure for 1999 was 4.073 (Department of Correctional Services 2000). It is estimated that the figure may actually be much higher than the official documented figure. This is due to the fact that mandatory testing does not form part of the official policy followed by the Department of Correctional Services.

Aids-related deaths in South African prisons have increased by approximately 300% from 1995 to 1999. Given the present trend these figures are expected to rise exponentially. Of the more than 1.000 natural deaths reported by prison authorities during 2000, more than 90% were Aids-related (Daily Mail & Guardian 2000). It is estimated that the Aids related death figure amongst prisoners will rise to 45 000 within the next ten years (Die Volksblad 2001).
The South African authorities have recently entered the debate and now concede to the gravity of the situation. In a recent statement Ben Skosana, Minister of Correctional Services, admits that conditions within our prisons are such that it promotes the spread of the Aids virus (Grobler 2000). The minister further acknowledges that the incidence of HIV/Aids among the prison population far exceeds that of the general population.

In the same report Skosana attributes the unacceptably high incidence of Aids in prison, amongst others, to:

- Consensual sex;
- Sodomy or rape;
- the prevailing culture of violence (including sexual violence); and
- overcrowding in conjunction with poor living conditions that increase aggression and violence.

Little of the research conducted targets gang and gang-related behaviour within the South African correctional services. Available literature is, for the most part, restricted to American gangs (Lotter 1988). Gang-related activities represent some of the most pressing issues facing the Department of Correctional Services. Coetzee et al (1995), for instance, report that gang culture contributes to the high level of unrest within correctional institutions. Gangs may also be held responsible for the high incidence of assaults, smuggling, escapes and sexual malpractice. Powerful and influential gangs are typical to institutions of maximum security. Black and coloured men are relatively overrepresented within the prison population. This reflects the broader South African population ratio (Lotter 1988). These men are apparently also highly represented in prison gangs. There seems to be little evidence to suggest that female prisoners are involved in gang activities.

Despite their potential for malevolence, gangs fulfil certain important functions (Tempelhoff 1996). According to this author gangs satisfy certain physical, psychological and social needs within prison culture. For example, they may provide for comradeship, status, protection against competing gangs and serve to satisfy sexual needs. It is the latter that holds the potential for the further spread of HIV/Aids.

This article serves to highlight the increasing incidence of HIV/Aids within South African prisons. Theoretical perspectives or epistemic frames are advanced that assist us in gaining some understanding of the multi-faceted dimensions representing this complex problem. The article argues that the gang subculture, prevalent in South African prisons, is linked to high risk sexual behaviour and hence, serves to contribute to the increasing spread of the deadly Aids virus. Gangs typical to South African prisons are identified and briefly reviewed. Focus then shifts to high-risk behaviours as precipitating factors in the spread of Aids. Finally, we proceed to highlight a broader perspective - within a science of prevention - that may serve to assist in addressing this problem. Special emphasis is placed on cultural influences that seem to sustain the spread of HIV/Aids.

**THEORETICAL PERSPECTIVES**

The emergence of the prison subculture has as yet not received much attention from social scientists. The little that there is seems to emanate from two models, namely the ‘direct importation model’ and the ‘deprivation model’. In brief, the direct importation model suggests that prisoners are socialised to accept particular values before entry into the prison system (Coetzee et al 1995). This, in turn, contributes to shape prison ethos (Feld 1981). Additionally, the deprivation model serves to explain the deprivation experienced by prisoners when admitted into the system. Such forms of deprivation may include, amongst others, loss of status, freedom, privacy and conjugal rights together with poor living conditions such as overcrowding, and harsh treatment by prison authorities (C F Schurink 1989). The shortcomings in explanatory power of these two models led Best and
Luckenbill (1982) to develop a more comprehensive framework - a ‘social organisation model’ - that explains the social organisation of deviant subcultures. The interested reader is referred to Schurink (1989) for a more in-depth coverage of these theories.

While these models are helpful in explaining the emergence and existence of the prison/gang subculture, we need to recognise that penal institutions form part of a broader socio-cultural environment. To better understand the prison dynamic within this broader social context, we need to take some distance and observe the bigger picture. To provide for such a view we will apply the general systems approach.

The notion of systemic thinking was first introduced in the 1950s by a biologist Ludwig Von Bertalanffy. Building on the initial ideas of Von Bertalanffy, a psychiatrist - George Engel (1980) - developed a biopsychosocial model proposing that the person may best be conceived to be a biopsychosocial unit. In 1997, Winiarsky who worked with Aids patients, proposed a further modification of this model by adding a spiritual component. This model has subsequently become known as the biopsychosocial/spiritual model. As this model is adequately discussed elsewhere (Van Niekerk & Prins 2001) only the most essential features will be alluded to here. In contrast to linear stimulus response (S-R) explanations, the biopsychosocial/spiritual approach is based on the following assumptions:

- Every person (prisoner) operates on a number of systemic levels.
- These systemic levels may include the biological, the psychological, the social (including the cultural) and the spiritual levels of functioning.
- An object of study such as AIDS has important implications for the different levels at which individuals function.
- A change at any particular systemic level affects both the intra- (biological and psychological) and supra- (family and community) systems dimensions.
- Systemic thinking provides for a more holistic and inclusive way of accounting for human experience.
- This approach advances inter-disciplinary cooperation.

**PRISON GANGS**

As already indicated, little research specifically targets South African prison gangs. The most prominent research dates back to the work of Lotter and Schurink (1984). Despite the fact that their research is dated, recent personal communication (Redelinghuiz 2000) leads us to believe that the basic structure and function of prison gangs remain essentially faithful to the characteristics as authored by Lotter and Schurink in the mid 1980s.

The next section of this article will attempt to briefly reflect on generic qualities typical to South African prison gangs. Lotter and Schurink (1984) identify two prominent categories of gangs typical to the South African prison system, namely the Number gangs (Supergangs) and the Fourth camp. Number gangs include the 26, 27 and 28 gangs. Gangs typical to the Fourth Camp include the Big Five, Air Force, Fast Elevens and Desperadoes (Lotter & Schurink 1984).

Gangs typically create characteristic identities and ethos, and may be identified according to their vision, mission and aims. Members are recognised by particular identifying symbols such as tattoos. The behavioural components that typify gangs include organising escapes, smuggling goods and sodomy. Gangs are subject to the division of labour whereby members are accorded specific functions and responsibilities. Rules govern the life of a gang. When rules are violated, gang members are disciplined and often violently so. As already alluded to, gangs are subject to certain rules and symbols that provide for cohesion and a sense of identity and belonging. For example, the 26 gang traces
its origin back to Chicago in the United States and members often refer to themselves as the Chico-boys (Lotter & Schurink 1984).

Gangs are also subject to behavioural codes. These include:

- An oath of allegiance to the gang.
- Respect and support for the gang to promote a sense of cohesion and harmony.
- Demonstrated loyalty to the gang by, for example, not associating with members of other gangs or prison staff.

From what has been stated it is clear that prison gangs satisfy certain basic needs that seem to perpetuate their continued existence within the prison system. They provide for companionship, status and protection against other gangs as well as sexual gratification (Coetzee et al 1995). It stands to reason that sexual gratification may be viewed as high-risk behaviour in spreading the HIV-virus. The focus will now shift to an examination of high-risk behaviour as precipitating factor in the spread of HIV infection.

HIGH-RISK BEHAVIOURS AS PRECIPITATING FACTOR IN THE SPREAD OF HIV/AIDS IN PRISON

Consensual sex or ‘homosexual’ behaviour

Evidence suggests that institutionally induced homosexual acts are rife and historically form part of the prison context (Potler 1988; Tempelhoff 1996; Vaid 1987; Versluis 1996). One of the chief aims of the 28 gang, for example, is to actively recruit ‘wyfies’ (young men with feminine traits) and promote sodomy amongst its members (Lotter & Schurink 1984). The fact that victims are men and not women is due to the force of circumstance (Sykes 1958). Sodomy within the prison context provides an outlet for sexual needs (Lotter & Schurink 1984). However, Scasso (1975) reminds us that homosexual acts in prison are also a result of power relations and should not merely be viewed as an act that provides for sexual gratification (cf. deprivation model). This ‘deviant’ but functional sexual behaviour further contributes to the spread of Aids in prisons.

Male-on-male rape

Even more alarming than the practice of consensual sex, is the increasing evidence of male-on-male rape. According to Siegal (1992: 1544), male-on-male rape in prisons is the ‘most closely guarded secret’. Male-on-male rape in prison reflects power relations that govern the prison subculture. It is a product of traditional social expectations regarding male dominance and a violent means of social control. It is a ritual of male power rather than an act of sexual passion. For rape victims, submission is the only means to survival (Brownmiller 1975).

Notwithstanding the alarming incidence of rape within the prison system, relatively little research has been done in this regard both locally and internationally (Davidson, Clare, Georgiades, Divall and Holland 1994; Kupers 1996). Following an investigation on the extent and magnitude of rape in South African prisons, Maritz (1997) reports that:

- 1.84% of the total prison population are victims of male on male rape;
- victims are, for the most part, young and black;
- most incidents of rape (87%) occur in the confines of the prison cell at night; and
- it is estimated that only half (50%) of the incidents are reported to the authorities.

There is good reason to believe that these figures represent only the tip of the iceberg. It is estimated that between 70 and 80 percent of all awaiting-trial prisoners (45 000) are sodomised by fellow prisoners before they are officially charged and many of these prisoners are raped within the first 48 hours of being detained (Daily Mail & Guardian 2000).
Given the culture of fear and secrecy, hard evidence regarding sexual practice is difficult to come by (Lotter & Schurink 1984). Hence, much of the evidence is anecdotal. Saum and Surratt (1995:2) concur: “(A)necdotal accounts of prison life have invariably depicted the routine occurrence of rape and consensual sex behind prison walls”. Several investigations concerning these allegations have revealed that sex in prison, although prohibited, is a reality. In the light of these findings, Tempelhoff (1996) has suggested that the issue of male rape be revisited as a matter of urgency.

**Tattooing**

Prison culture is reflected in a system of signs and symbols. Entry into the prison system coincides with the loss of identity and gang membership serves to compensate for this loss of identity. It comes at a price, however. The new recruit has to succumb to both the implicit power relations regulating gang activities and to the identifying tattoo that exemplifies the new (gang) identity (Phelan & Hunt 1998). Identity is important psychologically as it promotes a sense of self. Over and above the psychosocial function that tattooing performs, it is identified as high-risk behaviour with regard to the spreading of Aids since prison ‘artists’ do not have sufficient access to facilities for sterilisation of their equipment.

**Overcrowding and the climate of violence**

Overcrowding further exacerbates the spread of HIV/AIDS in South African prisons. As already suggested in the introduction, the Minister of Correctional Services, Ben Skosana, admits that conditions within our prisons such as overcrowding contribute to the further spreading of Aids (Grobler 2000). Current reports estimate the prison population at 151 000. In actual fact, correctional services can only accommodate 100 000 prisoners (Daily Mail & Guardian 2000).

Authors such as Bowker (1980), Shenson, Dubler and Michaels (1990) support the notion that overcrowding in prisons impacts negatively on prisoners. Overcrowding influences inmates’ levels of stress tolerance, aggression, etcetera. They argue that aggression within the prison context may give rise to an increase in sexual malpractice such as rape. Shenson et al (1990: 655) state the problem of overcrowding succinctly:

*Prisons have now become the new tenements, overcrowded compounds, fertile and accommodating to disease.*

The Department of Correctional Services has moved to ease the high rate of overcrowding by releasing awaiting-trial prisoners (Daily Mail & Guardian 2000). However, the Department cannot indefinitely continue releasing prisoners to address this problem, since this will only serve to further augment crime.

According to the direct importation model, aspects of prison culture are reflective of the broader socio-cultural society. This is then further superimposed on and exacerbated by the prevailing conditions in prisons (deprivation model). Hence, to effectively address this issue, we need to reflect on a broader perspective before contemplating relevant strategies.

**The biopsychosocial or spiritual approach**

It is clear that despite spectacular medical advances there is still no cure for Aids. Traditional approaches to Aids prevention have often been steered either from a medical or a behavioural perspective. Our contention is that strategies emanating from such approaches may be short sighted. We therefore argue for a more inclusive approach to Aids prevention. To this end, we turn to the meta-model introduced earlier on namely the biopsychosocial or spiritual model. Such an approach, we believe, will provide us with the advantage of a ‘wide-angled lens’ and in the process highlight the multidimensionality of the problem at hand. As no one discipline is able to singularly address the problem, a
A multi-disciplinary approach is called for. The biopsychosocial or spiritual approach is therefore proposed as a conduit to assess the problem and contemplate possible strategies.

Successful strategies rely heavily on an effective and holistic assessment of the presenting problem. In order to address the malignant spread of HIV/AIDS in the South African prison system, special emphasis is placed on the prevailing culture that seems to provide a fertile breeding ground for the spread of HIV/AIDS. This culture needs to be examined both within the prison system and in the broader South African society. In this regard relevant aspects of the reigning prison subculture were highlighted.

We now wish to reflect on aspects implicit in the broader South African society that may serve to maintain the present ‘culture of denial’ (Mkhatshwa 2000). Furthermore, we wish to highlight the current approach followed by the Department of Correctional Services.

The following dimensions of the biopsychosocial or spiritual approach receive attention:

**Spiritual or value dimension**

Any behaviour, including sexual behaviour, is value driven therefore intervention strategies should investigate people’s value systems that act as a driving force in instigating and maintaining (sexual) behaviour. In a contentious and thought provoking article (Leclerc-Madlala 2000: 3) enquires: “what makes the African Aids problem so stubborn, so unrelenting and so smug in its silence?” She argues that the lack of behaviour change (once attributed to scant information) requires further investigation. Her argumentation sets the stage for the following questions:

- Why has the pandemic in the Republic of South Africa been met with such apathy, under-reaction and denial?

- To what extent is the reigning (South) African ethos - that for many may include an external locus of control (e.g. the role of supernatural forces) - instrumental in driving the Aids pandemic?

In this regard the following may serve to broaden our understanding:

**Gender and power relations**

According to Leclerc-Madlala (2000: 4) the role of irresponsible male attitudes and behaviour - introducing the death sentence for both themselves and millions of women and children in this region - requires special attention. African governments and leaders, she argues, need to take firm measures to foster sexual attitudinal and behaviour change among young and middle-aged men. She further proposes that such action is not implemented, since, in introducing such measures, leaders “… will run the risk of inciting the hostility of, politically, the most dangerous section of the population”. This, according to her, explains why the issue is so carefully avoided whilst the “much lauded social transformation that everyone professes to desire, and the ‘breaking of the silence’ will remain elusive”. It may, by the same token, be useful to reflect on the traditional African worldview regarding illness and sexuality.

**The traditional African worldview and illness**

Despite differences between Africans in regard to geography, religion, linguistics and ways of life, a dominant socio-religious philosophy seems to be shared. An overarching African worldview may be distinguished from a Western or Eastern perspective (Van Dyk 2001). This traditional worldview reflects a holistic and anthropocentric ontology that places man in the centre of our universe. Man, together with nature, spirits and God, form an inseparable cosmic whole (Mbiti 1969). This cosmic whole may be distinguished into three different

**Macro-cosmos**

The macro-cosmos consists of God, the ancestors and the spirits of the chosen dead (Sow 1980). No indication exists that God or the ancestors are seen as causative in the spread of AIDS. Those with a Christian perspective may, however, believe that AIDS is God’s punishment for immorality and sin (Van Dyk 1991).

**Meso-cosmos**

Traditional Africans ascribe most forms of illness to this level (Viljoen 1997). They believe that illness has a specific cause and intention. Cure follows on the counteracting, uprooting and punishment of the causal factor. Causes are seen as both immediate and ultimate. Thus, AIDS may immediately be caused by a germ, but, ultimately, it is caused by the magical manipulation of ‘someone’ who had ‘sent’ the cause to the specific person. Thus, the ‘why’ and ‘who’ provides for an answer to the cause of illness. Hammond Tooke (1989), for example, found that traditional healers divined the cause of illness to witches and sorcerers in 72%, the ancestors in 8% and to ‘non mystical’ factors in 17% of their clients. To blame external sources such as witches and sorcerers for the occurrence of AIDS is functional, since it protects against feelings of guilt and alleviates anxiety. A belief in external causal factors provides meaning and answers that science cannot provide. By the same token, the belief that all that happens to a person may be attributed to supernatural or external powers or people, relieves individuals of personal responsibility and accountability in regard to their own (sexual) behaviour. Personal initiatives and searching for solutions are therefore repressed (Viljoen 1997). Since many Africans do not consider their own behaviour as instrumental in the causing of AIDS, they do not see the need for applying personal preventative measures in regard to this illness.

**Micro-cosmos**

Explanations of illness on this level is done via siki and nyoka. These illnesses are traditionally believed to have natural causes such as germs. Sexually transmitted diseases (STDs) would fall into this category of illness. Traditional healers believe that siki can be prevented via sexual behavioural change and herbal treatment (Van Dyk 2001).

**Sociocultural dimension**

Apathetic and reckless attitudes and behaviour seem to characterise the attitude of the South African youth to the deadly virus. Leclerc-Madlala (2000: 3) notes that, for example, in Europe and Australia, “markers of sexual behavioural change indicated drastic developments in the first year of HIV/AIDS”. However, “no such reaction was recorded for Africa”. The following conditions that exemplify the South African experience may relate to the apathy with which the deadly diseases had been met.

**Apartheid:** To what extent has this policy engraved in the (African) psyche, a spirit of helplessness, the concomitant shedding of responsibility, and a culture of blaming while in the process reducing personal agency?

**Androcentrism:** The patriarchal society imbeds male hegemony. This culture implicitly makes women’s (sexual) wishes and behaviour subordinate to that of men in our society and enhances their vulnerability to this fatal disease.

**Biological or physical dimension**

In African culture (Leclerc-Madlala 2000: 3), widespread beliefs exist promoting the notion that “… males are biologically programmed to need sexual relationships...
regularly with more than one woman, and often concurrently”. This belief is consistent with traditionally polygamous societies. It reinforces the notion that addressing a complex phenomenon such as HIV/Aids requires a multi-dimensional focus since the different causal factors are difficult to extricate. Beliefs, culture, psyche and biology are all interwoven.

Furthermore, De Villiers (2001) propagates that sexual dysfunction, a serious health problem, may also contribute to the spread of Aids. He conducted a study relating to male erectile dysfunction (MED) in brown and black patients (mean age 48, none younger than 35). The subjects were patients (not including those with chronic illnesses) visiting day hospitals in Khayelitsha and the Strand. The study found that 70% of the patients experienced slight to serious MED. Forty-five percent indicated that they, at times, and in many instances, never experience an erection. (Causal factors include hypertension, diabetes, depression and gastric problems. Life-style factors, including alcohol misuse and cigarette smoking, also contribute to the problem). Alarming is that most of the men in this study manage the problem not by seeking professional advice, but by seeking a new partner. This holds severe implications for the spread of HIV/AIDS since these men cannot use condoms. And, although they are not able to retain an erection, they can still spread the deadly virus during sexual contact. Attention now shifts to the policy in relation to managing HIV/AIDS in prisons.

**POLICY IN RELATION TO HIV/AIDS IN PRISONS**

The main aim of the Department of Correctional Services is to safely secure prisoners. HIV/AIDS places a further burden on the department in providing for the ultimate well-being of inmates. The first official HIV/AIDS policy was implemented in 1993 and revised during 1996. Due to the lack of a viable vaccine at the time of implementation, the department employed strategies from the behavioural and medical sciences. Present approaches embodied in a document entitled; “Strategies: Aids in prison” (1996), highlight the following:

**Educational campaigns**

Aids educational campaigns are used to educate prisoners regarding HIV/AIDS, modes of transmission and ways to protect themselves from becoming infected. Research, however, informs us that knowledge about HIV/AIDS does not necessarily cause behavioural change in prospective patients (Sheehan 1991).

**Prophylactic measures**

Condoms are freely available in prisons. This strategy has created a paradox in that sodomy is rife in prison and is viewed as a crime and yet prisoners are provided with condoms. No research evidence exists to suggest that prisoners actually use the condoms appropriately during sexual acts. The fear exists that they may, in fact, use condoms to hide contraband.

**Gang activities**

Gang activities are closely observed and monitored. Gangs, however, strongly oppose any form of investigation into their structures and hierarchies, since great emphasis is placed on secrecy and the maintenance of internal power structures through fear and coercion.

**Vulnerable prisoners**

Prisoners deemed vulnerable for male-on-male rape may be protected by placing them in single cells. However, this is impractical since many prisons are overcrowded and function 500% above capacity (Versluis 1996). Some vulnerable prisoners are transferred to prisons where gang activities feature less prominently.

**AIDS testing**

On admission prisoners are screened for possible HIV/AIDS infection. Pre- and postcounselling is provided
to prisoners who consent to an Aids test. The aim of the counselling is to explain the importance of testing, to discuss high-risk behaviour and to induce prisoners to refrain from high-risk behaviour in order to promote their own health.

Counselling services

Correctional services aim to provide counselling services for HIV positive prisoners. However, not all prisons are equipped to provide in the need for the services of psychologists or social workers. Furthermore, severe staffing restraints exist. According to Landman (2000), 43 psychologists serve approximately 151 000 prisoners, whilst the ratio for medical staff to prisoners is estimated at 1:313.

Against the background of those cultural factors that seem to sustain the spread of HIV/Aids in Sub-Saharan Africa, strategies in regard to preventative measures, including education and prophylaxis - also within the Department of Correctional Services, may be enhanced by taking cognisance of Van Dyk’s (2001) views in this regard.

Implications of the belief in witches for Aids education in Africa

Meso-cosmos

According to Van Dyk (2001: 62) Aids education in Africa will only be successful once the deep-rooted beliefs of Africans are acknowledged and become part of AIDS prevention programmes. It is suggested that programmes should recognise both the immediate (germs) and ultimate (witchcraft) cause of illness. The help of traditional healers may, for example, be solicited to ‘fortify’ condoms with protective power. In this way they may be used in the same way as charms and amulets, traditionally applied to prevent and protect against diseases, death and misfortunes. This may indeed “... encourage traditional Africans to take responsibility for the immediate cause of the HIV infection by obstructing the entry point of evil or HIV”.

Micro-cosmos

Aids is seen as a modern, foreign and deadly disease and is not generally acknowledged as siki or nyoka. However, if Aids could be accommodated under the siki diseases (Green, Jurg & Dgedge 1993), the knowledge and assistance of traditional healers could be used to actively control and prevent Aids in Africa.

The traditional African worldview and sexuality

Macro-cosmos

Against the background of the extreme importance of personal immortality (gained through children) and therefore the occasion of polygamy, it seems futile to advocate monogamy (also in prisons). Much more may be achieved if loyalty and fidelity amongst a husband and all his wives (prison partners) are emphasised.

The challenge is therefore not to condemn exotic traditional sexual practices, but rather to understand the cultural logic that drives the resistance to condoms and to find ways to work around these (Scott & Mercer 1994). Such resistance is rooted, inter alia, in the belief that condoms block the flow of fluids involved in sexual intercourse or the ‘gift of self’ that is deemed very important in a (prison) relationship.

Readers who seek a more in-depth analysis of specific intervention strategies are referred to Whiteside and Sunter (2000).

CONCLUSION

Central to the Aids debate is the question regarding the underresponse that the advent of Aids has elicited on the individual, communal and national levels of (South) African society. Recent research seems to indicate that
contemporary sexual mores together with aspects of the traditional African belief system provide fertile soil for the spread of HIV/AIDS. Therefore a deeper structural analysis may be called for. Freud, in trying to understand the human psyche, advanced the ‘structuralist method of analysis’. He tried to comprehend surface behaviour by unmasking the deeper sexual structures. Levi-Strauss, a French speaking social anthropologist, expanded on this approach. Distinctive to his work is an attempt to uncover universal rules underlying everyday customs and activities. “Culture is held to embody principles which mirror essential features of the human mind” (Jary & Jary 1991: 355). He argues that deeper cognitive structures underlie surface social or sexual activity. Although, according to Levi-Strauss, “… the layers of structure are systematic and ordered, they are not directly available to the consciousness that is constituted by them: they are unconscious structures of consciousness, reconstructable in scientific logics” (Jary & Jary 1991:355).

One approach through which further understanding of this phenomenon could be gained and through which cognitive structures or constructs that serve to advance sexual behavioural patterns could be uncovered, is the personal construct theory of George Kelly (1955). In this respect the interested reader is referred to Du Preez (1988) and Van Niekerk (1996).

In conclusion we need again to reflect with seriousness on what makes the “African Aids problem so stubborn, so unrelenting and so smug in its silences” (Leclerc-Madlala 2000: 3). It is clear that culture, including the nature and shape of contemporary sexual mores and the traditional African belief system, is influential in the spread of AIDS. Academic debates on the origins and existence of AIDS invites attention away from sensitive issues surrounding sexual culture. Medication does not provide for a final answer and we should be cognisant of and address the socio-cultural context that fuels the spread of HIV/AIDS.

BIBLIOGRAPHY


Davidson, FM; Clare, ICH; Georgiades, S; Divall, J & Holland, AJ. 1994. Treatment of a man with a mild learning disability who was sexually assaulted whilst in prison. Medicine Science and Law 34(4): 346-353.


